

Fifth Edition

JOHN PINTO'S LITTLE GREEN BOOK OF OPHTHALMOLOGY

*Strategies, Tips, and Pearls
to Help You Grow and Manage
a Practice of Distinction*



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Strategies, Tips, and Pearls
to Help You Grow and Manage
a Practice of Distinction

Prepared under contract to ASOA•ASCRS

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*If you wish to drown, do not torture
yourself with shallow water.*

BULGARIAN PROVERB

*You don't drown by falling in water;
you only drown if you stay there.*

ZIG ZIGLAR

**To my working, yachting, diving, fly fishing, hunting,
cooking and all around life partner Corinne Wohl,
who has convinced me that our floating office
“Castella,” anchored off of Catalina Island,
is much better than a desk on land.**

**To Whitney, whose forbearance over decades was
exceeded only by her ability to remind me—
with a loud whisper up the ivory tower stairwell—
that life is not entirely about work and
that love can renew itself daily.**

**To Graham, much older now, who told me when he was
three years old, “I want to be a consultant when I
grow up because they get to have all the fun.”
(And now he is one.)**

**To my mother Irene, who first gave me an affection
for the sound and the meaning and the correct
spelling (mostly) of the English language.**

**And to “Big Al” Kildow, my first real boss, oldest
true friend and keeper of the flame for Stephen Potter’s
Ancient Axioms of Lifemanship. Your wisdom, humor, and
gift for occasional mayhem still guide my daily work.**



Foreword

(This forward was written for the Fourth Edition by Dr. Herve Byron shortly before he passed away, following a long, productive career. Herve was an early, even radical, pioneer in bringing IOLs to America, and he was among the first eye surgeons to cross over and become a deep student of the business of ophthalmology. We all owe him much, and I more than most. JP)

BEWARE! As you read my comments below, please keep in mind that I am a huge fan of John Pinto. This makes it difficult for me to be perfectly objective about the book you are now holding, his latest aid to our profession.

I had the privilege of writing the prologue for earlier editions of this book. I stated then that it should have been called *John Pinto's HUGE Green Book of Ophthalmology*, it having long since outgrown its original modest title.

In this latest edition, John picks up where he left off, addressing the profound changes occurring in the constellation of ophthalmology. Only someone with John's vast consulting experience with eye surgeons of all ages and at all stages of practice—in every state in the nation and in many countries, as well—could precisely pinpoint these dramatic changes and outline workable solutions to the problems of every career stage.

He addresses how ophthalmologists can still maintain a viable practice in the face of rising costs and markedly falling reimbursements. As surgeons young and old are increasingly exposed to future challenges, this new edition will increasingly come off the shelf to help the cause.

This book continues to resonate with many core issues and ideas I started teaching to residents in the 1980s to help them develop and control their patient care practices, their eventual businesses, and ultimately their very lives. Four of these core issues back then were:

Flexibility . . . which is obviously essential to cope with change.

Prevention . . . doing your homework before making any significant career decision.

Feelings . . . which are at least as important as cerebral input in decision making.

Balance . . . between professional and personal activities.

Now that I am beyond the far reaches of a happy career which spanned more than 50 years, I especially appreciate what John has written here about career transitions and the importance of not retiring in the traditional, abrupt manner.

I have always enjoyed reading the expanding collection of quotes that John includes with each new edition.

These quotes reflect the perspicuity, humor, and uniqueness of John Pinto's approach to life. I found myself coming back to reread these quotes many times. One of my favorites comes from Helen Keller: "The most beautiful things in the world can neither be seen nor touched but felt in the heart." And so it is with this book, which will teach you—if you are willing to listen—an entirely new way to experience your practice.

John Pinto's new and now *MAGNIFICENT Little Green Book* is a treasure, and a firmly established classic text in our profession. I believe this book and the inevitable future editions to come will be in the hands of our colleagues for the next century or more. Like any classic, it should be picked up from time to time, well after the first full reading, to gauge your own development as a medical practitioner, as a business owner, and as a person.

Herve Byron, MD
1930–2012
New York, NY

* * *

*Life is a tough proposition and the
first 100 years are the toughest.*

WILSON MIZNER

About the Author



John Pinto is the most-published author in America on ophthalmology practice management topics. He founded J. Pinto & Associates, Inc., an ophthalmic practice management consulting firm, in 1979. Since then, he has provided strategic planning, operations, and marketing advice to pharmaceutical companies, basic science centers, hospitals, multi-specialty clinics, and single-specialty facilities. For more than 30 years, a majority of the firm's service has been to ophthalmic practices ranging from small solo practices to high-volume market leaders, teaching centers, and ophthalmic product companies. He has been active as

a practice consultant in North America and Europe and has worked and lectured in South America, New Zealand, Australia, and the Far East.

Pinto is best known as a strategic planning and economic advisor to practices large and small. In addition to covering most dimensions of modern practice operations management, he is a career advisor, providing individual coaching and contract negotiation services to new graduates and midcareer employed ophthalmologists. As a subspecialty interest, Pinto is active in the ever-evolving sphere of refractive surgery and is among the most experienced advisors in this domain, helping surgeons with the growing challenges of this field. His professional life today is rounded out with succession planning, practice appraisals, partner dispute mediation, merger/acquisition counsel, and leadership development for administrators and managing partners.

A prolific writer, Pinto is the author of several books beyond the classic text you now hold:

- *Turnaround: Twenty-One Weeks to Ophthalmic Practice Survival and Permanent Improvement*
- *Ten Eyecare Practices: Benchmarks for Success*
- *Cash Flow: The Practical Art of Earning More from Your Ophthalmology Practice*, coauthored with E. Anne Rose
- *The Efficient Ophthalmologist*
- *Legal Issues in Ophthalmology: A Review for Surgeons and Administrators*, written with Alan Reider and Allison Shuren
- *The Women of Ophthalmology*, written with Elizabeth Davis, MD
- *Ophthalmic Leadership: A Practical Guide for Physicians, Administrators, and Teams*

- *Simple: The Inner Game of Ophthalmic Practice Success* (which is a companion text to *John Pinto's Little Green Book of Ophthalmology*)

Pinto is also the author of *Marketing Your Ophthalmic Practice* (Slack Books, 1987), the first book devoted to the topic. Most titles are currently published by the American Society of Ophthalmic Administrators/ASCRS and can be ordered by visiting the ASOA web site www.asoa.org.

Pinto is a member of the editorial boards of *Ocular Surgery News*, *Ophthalmology Management*, *Ophthalmology Business*, and *Premier Surgeon*, and a regular contributor to other eye care publications.

John Pinto is available for individual, practice, and corporate consulting services to supplement this book at:

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A majority of the author's fee associated with this book has been donated to the American Society of Ophthalmic Administrators to further its mission in eye care management education.

* * *

"He who can copy can do."

LEONARDO DA VINCI

Acknowledgments

Consulting, unlike medicine, is not a profession that arises from a linear career path. My career as an ophthalmologistologist emerged from a series of extremely fortunate accidents. A succession of early teachers encouraged my 3rd-grade fixation on becoming a pediatrician, which yielded by the 8th grade to gynecology and matured late in high school to orthopedics. By college, I was too interested in mountaineering to muster for medical school. Indulgent bosses (including four Nobel Laureates) and a thankfully uninterrupted flow of equally bright and indulgent clients have steered me throughout my life's work as a business and personal advisor to doctors, rather than being a physician myself.

For many of the happiest years on this path, an especially large "Thank-You!" is owed ASOA founding director Lucy Santiago and current executive director Lauren Rowland, along with Dave Karcher and his new successor Steve Speares, and every other staff member of the ASCRS/ASOA (with a loud shout-out to Susan Younker) for their ongoing support and encouragement. Special thanks to Cynthia Rosso for her attentive editorial support with the 5th edition. Every time I'm delayed in some lonely airport departure lounge and feeling grouchy about the isolation one labors under as a roving consultant, I remember the virtual team that makes all the books, articles, site visits, and lectures possible.

It would be impossible to dream up business-contacts-turned-friends like David Schneider, Bernie Milstein, Michel Arowns, John Corboy, Herve Byron, Dick Lindstrom, The Astonishing Arbissers, Craig Piso, Mike "*What's an igniter?*" Minadeo, Gene "Wildman" Schoch III, and others too numerous to mention. These are the kind of people a novelist couldn't dream up—people the most fortunate of us gather along life's path until we realize that knowing them has been the richest compensation for a life's work.

I would like to humbly acknowledge the influence of every client and every staff member for whom I have ever worked. Without a single exception, I have learned more from each of you through these years than you have ever learned from me. This book is dedicated to everyone who has ever told me, "This city is different," "My practice is different," or "I'm different . . . from anyone you've ever worked with." You were all right.

I would once again like to express sincere appreciation to all my fellow consultants. We know each other largely by reading one another's articles and commiserating in meeting hallways over ophthalmology's rising challenges. Just

as our shared physician clients are converging their clinical approaches to one agreed, best way, I expect to see the day when our specialized knowledge base is more formally shared, our standards are elevated, and all our clients are better served.

* * *

*In Particularly Fond Memory of My
Parisian Brother Jean-Philippe Atger.*

LA VIE APPELLA LA VIE.

*"The beginning is the most
important part of the work."*

PLATO

Introduction

My people, the Portuguese, have a lovely, melodic, aching word that, even when spoken poorly with an English accent, sounds exactly like it means on the streets of Lisbon. *Saudade* refers to a special kind of nostalgia for a past happiness that one perhaps never really possessed.

Saudade is the best word I can muster for the feelings of many eye surgeons today, who gaze wistfully, and with no small measure of reactive depression, at the past and feel that the best business years for their practices are behind them. They often look only at the fees they once received instead of examining the balanced scorecard of benefits present in modern practice. They fail to appreciate the happiness and success that can still be found in abundance. I hope that this book is the continuation, dear reader, of you finding this for yourself.

This is the revised and expanded fifth edition of *John Pinto's Little Green Book of Ophthalmology*, which was first written 22 years ago. It is no longer so little. Many dated items have been removed. Some entries have been edited for clarification or to reflect reader input and client experience. In all, the content has increased somewhat.

In the first edition of this book I wrote:

We are passing through a transitional stage when it's natural to for most people to project ahead from current trend lines and assume the sky is falling . . . and that we will all be crushed."

Five years later I wrote:

"Much has changed in ophthalmology and the business of health care in general. We emerged after scores of articles and seminars on 'Surviving Managed Care' only to find that the buying public had rebelled against the abuses of pre-paid care, and that a buoyant economy had reduced employer efforts to peel back health benefit costs at least for the immediate moment."

Five years further on I wrote:

That moment is now swiftly passing. As the last several cycles of health reform have taught us all, the dollars available to pay for all forms of eyecare rise and fall with the general economy. As this book goes to press, the national economy looks as solid as midwinter lake ice. Employment and wages are holding steady. Consumer confidence has been rising for months."

Today, the wheel has turned once again. We are still not crushed, and there is much reason for cautious optimism borne of experience and current facts. In the last 45 years, the innate, inflation-adjusted value paid by society for a cataract surgery has dropped more than 90%, and yet, despite such dour economics, most practices survive. Many even thrive today. But an increasing number will not.

As this book goes to press, the profession is under considerable regulatory pressure, which, compounded by a baby-boomer cohort of peri-retirement surgeons, favorable tax treatment and low capital costs, is attracting the acquisitional interest of private equity firms (some 30 or so at last count). About half of these firms are heading down the same rabbit hole we did on Wall Street in the 1990s, with the "physician practice management" firms. But some of these firms will survive and be a force accelerating the consolidation of the profession away from its historic boutique scale. Proceed with caution.

For all its virtuous outcomes . . . obvious to patients and providers alike . . . U.S. ophthalmic expenditures are approaching an unsustainable plateau. As this book reaches you, America is spending 18+% of its still-wobbly national economy on health care, an unsustainable figure. Another familiar bubble. When the bubble pops—and it will, within another edition or two of this book—eye care economics will be diminished. Ophthalmology will not.

The demand for ophthalmic care is rising about 5% per year, yet we are only seeing a gain of under 1% more ophthalmologists per year. As you and I get older and more cynical, it's important to keep remembering: There are now over 650 million eyeballs in America. Most of these millions of lovely eyes progressively diminish in function in ways that can almost always be effectively treated. There is an almost unlimited market demand for not going blind. We'll do just fine. I think.

* * *

Despite my best efforts, through books like this and visits to help one practice at a time, about half of the seven thousand or so ophthalmic practices in America are still performing below average. More eye surgeons seem to be

going bankrupt each year than in the past, or they are scratching out an income that is out of proportion to their intelligence, education, effort, and potential.

I have written this book both for the overachievers and the underachievers in the profession. As the title suggests, this is not an encyclopedic text outlining every recipe for success. It's meant to be a supplemental cookbook, most useful to experienced chefs ready for a few fresh ideas. The topics covered are arranged under narrow headings but have been kept mixed enough to encourage your discovery of concepts you would otherwise not take the time to explore. A detailed index is provided to help you find specific topics.

* * *

There is no such thing as a perfect practice. And the larger the practice, the more the problems are magnified by the sheer number of moving parts.

We rarely eliminate management problems. We more often simply exchange large problems for small ones. The answers are simple, really. When you're in a deep hole, stop digging. Find and fix your problems quickly. Do the basic things well. Find the easiest, least costly way to get things accomplished. Target your market narrowly. Stop providing care in far-flung satellites or subspecialty domains where you can't make a profit. Exceed each patient's expectations. Know your numbers COLD. And take care of your people.

After all these years, coaching eye surgeons in the business of ophthalmology continues to be my an absorbing passion. Although nothing is more fun than to watch a client win the slow-motion chess game of business, I firmly believe every patient should win, no matter which ophthalmologist's side they're on. So whether you're a client or a client's competitor, I hope this book helps you serve your patients better.

As an old UCSD biochemistry professor of mine said nearly every lecture, "Life consists of only two things: teaching and learning." The life of a consultant is teaching, and learning . . . and traveling,. Looking back at those millions of air miles, I've really been in the import-export business. Examining each new client problem adds more inventory to the warehouse every year.

Every so often, the mental warehouse gets crowded enough for a little mid-career organizing. The result is the book you now hold. I look forward to making future editions as our environment continues to change. My "LGB-VI" file has already started.

John Pinto
San Diego, CA

PINTO'S TEN COMMANDMENTS

1. Hire the best people you can afford. Treat them right.
2. Provide staff with one hour of education for every 79 hours of work.
3. Keep tomorrow's appointment book 100% full.
4. Treat every patient as though he or she were your only customer.
5. Ask every patient to refer a friend.
6. Know your numbers. Cold.
7. Find a surgeon more competent than you, and copy what he or she does.
8. Sweat every detail. Even the ones that bore you.
9. Financial success is measured in profit per hour, not cases per month.
10. Live on less than 80% of your after-tax income. Invest the rest, intelligently, either back into your practice or in a judicious portfolio.

CHAPTER 1

STRATEGIC BUSINESS PLANNING



*Life is what happens
to you when you're
busy making other plans.*

JOHN LENNON

How High Is Up?

The concept of homeostatic “set-points” is well understood in biology and medicine. A healthy six-foot male patient of average build will settle in at about 180 pounds. A healthy ecological niche will reach a carrying capacity of just so many frogs or robins, and no more. Healthy cells will multiply and divide to make a tissue; healthy cells don’t grow rampantly to form a cancer. But what about a healthy practice? What should be the set-point of a growing solo or group ophthalmology practice? Should your practice even have a defined set-point, a growth boundary, at which point it stops and reverts to a homeostatic operation without growing? Can a practice grow inappropriately to unbridled “cancerous” levels?

After more than four decades of examining thousands of practices and their revenue growth curves, I’m struck by the fact that most practices don’t grow steadily. Instead, they often reach periodic plateaus, rest at that level for longer or shorter periods of time, and then take off again to higher levels. Examining the historic financials of these practices as a consultant is a little like a forester looking at the cross-section of a large tree. Adjacent rings on a tree stump show periods of fast and slow growth, periods of quiescence, and even stunting.

Some practitioners stay put once they reach a plateau, although few seem to do so any more *consciously* than a tree. Most eye surgeons want to keep pushing through successive cycles, growing to reach new and higher benchmarks. And, of course, some practices remain stunted despite their owners’ very best efforts.

Factors Influencing Your Practice’s “Set-Point”

The largest single influence on a practice’s development trajectory is the physician’s ambition and a willingness to risk personal capital as well as the jealousy of colleagues. A gung-ho physician in a tough, doctor-saturated market is generally far more successful than an average physician operating in a market that is underserved and ripe for

ALL PROGRESS IS
BASED UPON A
UNIVERSAL DESIRE
ON THE PART OF
EVERY ORGANISM
TO LIVE BEYOND
ITS INCOME.

Samuel Butler



conquest. The same competitive instincts that drive some surgeons to the top of their class often lead them to be winners in a raw commercial sense as well. A manager's ambition can be more important than the physician-owner's, although each year I meet a few managers who, in their commendable zeal for the practice, get a little too far ahead of their physicians.

Innate market factors rank just after physician ambition as growth barriers or enhancers. The size of the practice's market and the number of competing providers critically influence how large a practice can become. A large urban hub has more potential patients. Unfortunately, large markets are often the most crowded with excess ophthalmologists and optometrists. Large markets are also ground-zero for managed care competition, which more often than not reduces reimbursement and utilization and distributes patients to the physicians who are most willing to discount, capitate—and capitulate—on fees. The result can be a market with a top tier of a few large practices operating at extremely low profit margins. It's critical in such practices that subsequent development work be focused on gaining new, higher margin patient sources.

Are There Enough Patients?

In crowded, competitive urban markets with only 5000 or 6000 people per ophthalmologist (when norms are around 20,000), the only options for independent providers may be to build or join a larger single-specialty or multi-specialty practice, sell out to an institution, downsize to a niche practice (with a bias toward elective care), relocate to a less competitive market, or retire. In the future, these options may dwindle as panels fill (where contract access is restricted), purely elective care becomes too competitive, and rural service vacuums are filled.

OUTSTANDING
ENTREPRENEURS ARE
THOSE WHO DESIRE
AND STRIVE TO LIVE
EXTRAVAGANTLY.

Peter Drucker



Using “Poor Operations” as an Excuse for Retarding Development

Development in all its forms—adding new services, new facilities, new staffing, or new patient volumes—is often perceived as the foe of smooth operations. So,

perfectionistic physicians who think their practice is unprepared for growth will keep holding up progress. This is extremely frustrating for their more progressive lay managers. It's clearly true that growth in any form will be accompanied by operational snags and that the faster a practice builds, the more snags will arise. Physicians should not use these snags as the pretext to halt development while they catch up with the volume of the practice. The bottom line is that no company, and certainly no practice, can be purely an operating organization—it must also develop, or risk falling behind those who are developing. Although it goes against the grain of every eye surgeon I know, practice operations can never be made perfect. Development should proceed in lockstep with constant operational polishing, which is destined to perpetually lag behind growth.

Recognizing the Hazards of Practice Growth

Although every practice setting is unique, I've observed that the most efficient size for a surgical specialty practice, at least in terms of profit per patient visit and physician satisfaction, is about three to eight surgeons. In practices that are much larger, there may be diseconomies of scale for a variety of reasons, such as:

- Practice growth may be linear, but complexity grows logarithmically.
- The practice outruns the skill set of its office manager and needs the deeper skills of an "administrator," "executive director," or "CEO."
- The practice overshoots its administrative needs and hires a larger management team than is needed at the moment to run the practice. Getting ready for the future shaves profits today.
- The practice outruns the skill set of its practice management counsel, accountants, or financial control systems.
- Decisions become more labored; older partners starve the practice of marketing, staff, facilities, or other resources needed to keep growing.
- Too much is spent too fast. Partners suddenly believe that with extra physicians to pay for everything, the

HOPE IS NOT A STRATEGY.

Keith Casebolt



checkbook is wide open. It's natural to be less careful with group money than with your own.

- Satellites, especially part-time ones, generate administrative burdens and doctor inefficiencies that exceed their segment profit contributions.
- Enterprise complexity grows faster than revenue or profits.
- Political or turf factions break out. Most commonly, subspecialists become concerned that they are carrying the practice or are unfairly compensated.
- Income disparities arise. This is especially dire in practices with growing elective volumes. Ways must be found to equitably spread the success around.
- Inappropriate or outmoded compensation methodologies create disincentives for physician productivity.

Is No Growth an Option?

Let's acknowledge that not every surgeon needs to be in a growing practice to be happy. Although it's rare today, many of us still remember when a significant percentage of specialists would close their practice to new patients. Some surgeons in today's over-amped, multitasking world are considering the modern equivalent of downsizing—to limit the practice to their core interests, whether refractive surgery, cataract surgery, or teaching. An increasing number of physicians would like to maintain a diverse practice but simply downsize their complex organization to a more manageable, perhaps more sustainable, scale. There's no dishonor in this, especially if the time and peace of mind gained are used to advantage in other dimensions of their lives.

Can Refractive Surgery Offset a Weakening Cataract Practice?

I once received several calls a month from surgeons who wanted help transitioning their practice from mostly geriatric care to a purely refractive surgery. I still get a few of these calls. I wish I could be more encouraging to these callers, especially those who are only now starting to get involved with this subspecialty. Experienced refractive surgeons know how challenging it has been to sustain a practice

during two decades in which competition increased, surgical options multiplied, our economy faltered drastically, and a prime pool of patients aged toward more lens-based care. In large and mature markets, where refractive surgery is becoming a price-sensitive commodity, the winners have been high-volume providers who have the scale and staying power to survive a competitive shakeout period. In many rural markets, the population base is too small to ramp up to efficient volumes. In both large and small markets, given the high promotional and capital equipment overhead, the refractive surgery profit per surgeon-hour is well below that for general ophthalmology. For the majority of providers, refractive surgery should not be viewed as a lifeboat for a sinking general ophthalmology ship. Instead, it should be thought of as one of several pumps and patch kits one can bring on deck to help stabilize and secure the main vessel. This is especially the case based on experiences during the Great Recession, when refractive surgery volumes dipped more than 50% in most settings.

The Great LASIK Retreat

Before the Great Recession, in most developed markets, about 1% of myopic people had refractive surgery each year. (Even in strongly developed, affluent, highly marketed cities, market penetration rarely exceeded 1.5%.) At a roughly 25% myopic rate and with 1.9 eyes per patient, this was about 4.5 eyes per 1000 total people per year. In many competitive settings, the most a practice could achieve was about a 20% market share, or about one case per 1000 total population per year. Since the Great Recession case volumes have roughly halved. And despite a booming economy and high consumer confidence as this book goes to press, volumes have not materially rebounded. I believe we can expect LASIK to remain a lower-profit niche market for all but a few committed market participants, while the majority of rank-and-file eye surgeons stick with their general/geriatric core business line. In the typical successful refractive surgery practice today, profit margins hover around 25% or less, while marginal participants lose money on every case.

IN A FIGHT
BETWEEN YOU AND
THE WORLD, BET ON
THE WORLD.

Franz Kafka



THE BASIC
QUESTION IS, WHAT
VISION DO YOU
ASPIRE TO?

Abraham Maslow



Cataract vs. LASIK Economics

Compare LASIK to cataract surgery, which has been cast as the red-headed stepchild of ophthalmology ever since LASIK was born. Although there are certainly exceptions, the average cataract surgeon is now running economic circles around the average refractive surgeon. Here's a rough comparison between a moderately successful 750-case-per-year cataract surgeon and a moderately successful 750-case-per-year LASIK surgeon:

- Both doctors work 2500 hours per year.
- The LASIK surgeon generates average per-case fees of \$1750 after discounts and has a total annual revenue of \$1.3 million (assume little or no other care is provided to this patient base). With a typical 25% profit margin, his net income per hour is \$130.
- A cataract surgeon with a 750-case volume per year will quite commonly generate not only about \$400,000 in direct professional fees, but another \$700,000 in facility fees and \$500,000 in ancillary services: special testing, optical, disease treatment, etc. And it's an annuity business, because most patients return year after year for ongoing care, while 100% of LASIK patients have to be replenished annually. So annual revenue is \$1.6 million and typical profit margins are around 40% . . . resulting in a net income of \$256 per hour. That's twice the hourly wage of a refractive surgeon.
- What's more, remember that in today's environment, it's vastly easier to become a 750-case-per-year cataract surgeon than a 750-case-per-year LASIK surgeon.

A LOT OF PEOPLE
RUN A RACE TO SEE
WHO'S THE FASTEST.
I RUN TO SEE WHO
HAS THE MOST
GUTS.

Steve Prefontaine



Seize Opportunity

An extremely successful, internationally active optometrist I admire once told me, "When I made the transition from being a doctor to being a businessman, I did a lot better in my practice . . . but things didn't really take off until I made the transition from businessman to opportunist." Remember, Mark Twain once said, "There is no security in life, only opportunity."

It Pays to Try Something Completely Different

The business of ophthalmology has changed significantly in the past decade, and it is still changing. This is no time for plodding orthodoxy in your practice management methodology. It's a time to be creative, even if this runs counter to what your colleagues are doing.

Here's a short tale that makes my point:

A fisherman named Bill came back to the dock with more fish than anyone else every day, which was unusual because he never seemed to carry a fishing rod or a tackle box. Early one day, the game warden showed up and asked Bill about his methods. Bill invited him along to see for himself. So into the boat they jumped. The engine roared to life, and a few miles later they put down the anchor. Bill reached into the bilge and pulled out a stick of dynamite, lit it, and threw it into the water. There was a tremendous explosion, and several fish floated to the surface; Bill calmly netted these fish. The warden was enraged and said, "You can't do that!" The fisherman, with a smile, reached for another stick of dynamite, handed it to the warden, and asked, "Are you gonna talk or are you gonna fish?"

BETWEEN TWO
EVILS, I ALWAYS PICK
THE ONE I NEVER
TRIED BEFORE.

Mae West



The Value of Written Planning in All Human Endeavors

Virtually all human achievements are exquisitely planned in advance on paper in minute detail. Ships, planes, skyscrapers, city parks, Danish furniture, and machinery of every stripe are created on blueprints or computer screens before they are ever created in reality. Circuit boards are diagrammed before they're welded, and prototype automobiles are modeled in clay. Diplomacy and wars are waged from written, branched contingency plans, and even the most artistic chefs make their best creations when working from a written recipe. Symphonic music, another wonderful human construction, is played from written

sheets of music. Movies are scripted. Novels are outlined. Professional athletes adhere to a formal, written training program and playbook. Even some paintings, and certainly most sculptures, are thumb nailed on paper before they ever become real.

But what about your surgical practice? In most settings, practice development is about as unstructured as fishing or writing poetry: There's not much advance planning, and certainly little thought given to how you want things to turn out. If you plan and build your practice like you plan and build your home, you're more likely to achieve your goals.

MIND IS
EVERYTHING;
MUSCLES, MERE
PIECES OF RUBBER.
ALL THAT I AM,
I AM BECAUSE OF
MY MIND.

Paavo Nurmi



IT AIN'T THE THINGS
WE DON'T KNOW
THAT GET US INTO
TROUBLE. IT'S THE
THINGS WE KNOW
THAT AIN'T SO.

Artemus Ward



Fast Facts About Your Market and Service Area

The first, easy place to go for a breakdown of your practice's service area is the Web. One helpful site is www.factfinder.census.gov, where you'll find, for any chosen ZIP code, city, county, or state, a treasury of data from the latest census. The data are already sorted in a way that's most useful to practice planners, with economic and age breakdowns as well as social and ethnic characteristics. Of course, the deeper into each intervening decade you go, the less accurate the data.

Subspecialty Versus Comprehensive/General Ophthalmology

The bloom of applied clinical science over the past several decades has created a mild tension within ophthalmology—and certainly in the minds of all surgeons trying to divine their career path—between the so-called “comprehensive” ophthalmologists and those who (with or without formal subspecialty fellowship training) pursue a subset of eye care. Those who choose the mile-wide, inch-deep path of comprehensive care are rewarded in terms of intellectual diversification, but they will probably find some loss of traction, both economically and in terms of professional depth. Of course, this tension is as natural as that which

once caused eye and ENT to become two distinct specialties. I suspect that in the years ahead, this tension will lead to a continuation of the tendency toward subspecialists of every stripe to partition themselves into smaller interest groups. This is particularly true for urban providers, who will find it more necessary than their rural colleagues to find a niche.

Practice Mission Statements

Some years ago, someone must have declared, “You can’t run a practice without a mission statement.” As a result, nearly every practice soon displayed placards describing its commitment to a lot of soft, comforting adjectives about quality and caring and comfort. Put some starch in your mission statement. Set specific financial and market share goals and declare a measurable, accountable endpoint. Here’s an example: “Smith Eyecare will provide care that exceeds community standards while growing practice revenue at least 5% per year for the next 10 years.”

Don’t Starve Your Practice

Being a conservative business owner is appropriate in most settings and comes perhaps all too naturally to most ophthalmologists. Excess business conservatism—starving the organization of needed capital, delaying hires, deferring maintenance—will result in the ophthalmic equivalent of a bonsai tree. Temper your conservatism with the advice of accountants, consultants and, perhaps best, trusted colleagues who have built successful practices by being somewhat more risk-taking than you.

Motivations for Higher Cataract Volumes

High-output surgeons achieve their volumes in several ways, including establishing long tenure in their respective markets, providing a superior experience for patients, developing regional referral networks, and paying for direct-to-consumer advertising. Few of these surgeons reach these higher volumes overnight. One common thread among them is a competitive drive to invest many years and much

THERE ARE SOME
REMEDIES THAT
ARE WORSE THAN
THE DISEASE.

Publilius Syrus, 42 BC



THE BEST WAY TO
PREDICT THE FUTURE
IS TO INVENT IT.

Alan Kay



capital to achieve leading status in their markets. Most important, given the lower professional fee reimbursement for surgery, higher volume surgeons are driven by a desire to reach the case volumes needed to support a private surgical center (in the range of 50 or more cases per month). An inefficient, low-volume cataract surgeon can only generate about \$800 in revenue per hour and perhaps \$300 in profit per hour in the OR . . . which is not much more than can be generated in an office practice. In contrast, an efficient and especially gifted cataract surgeon can generate \$7000 or more in hourly revenue and bring nearly \$3000 to the bottom line.

I DON'T MAKE
JOKES. I WATCH THE
GOVERNMENT AND
REPORT THE FACTS.

Will Rogers



IF YOU FOLLOW
EVERY DREAM YOU
MIGHT GET LOST.

Neil Young



Cataract Surgery Incidence on the Rise

Compared to a decade ago, the incidence of cataract surgery appears to be up. Ophthalmologists once performed about 40 surgical cases per 1000 seniors (65+ years of age) per year in a noncapitated environment. Then 50 cases. They now perform about 70 surgical cases per 1000 seniors per year. At least a part of this increase is the result of improved outcomes and the growing realization among patients and providers alike that the cost-benefit and risk-benefit ratios are very favorable. These expected future case volumes may be leveraged upward by the increasingly poor health and dietary habits of Americans and the observation that obesity may significantly increase the risk for cataracts, even among individuals who are not diabetic. With new technologies arising, one can expect case volumes to rise at least as fast as the growing senior population (about 3% per year), unless, of course, there are successful efforts to ration care in the years ahead. How bad could it get? In pre-paid HMO settings, the typical utilization rates are down around 25 surgical cases per 1000 seniors per year.

Total Vision Correction

Unless your refractive surgery practice co-manages more than about one-third of its LASIK cases with optometrists, you should be promoting and providing *total* vision correction. The myopic patients who call your practice have only one thing in common—a vision-correction problem.

Their clinical findings, acceptance of surgery, and incomes vary. Offering only LASIK is like a General Motors dealer having only Cadillacs on the lot. Everybody needs transportation—and nearly everyone needs vision correction. Only a few customers need or can afford the best model available. Indeed, a glasses- and contacts-wearing myopic patient, after just a few years' tenure in your practice, can be far more profitable than a discounted LASIK patient.

Driving Tips for Your LASIK Practice

Race cars need more dials and gauges than the family Buick, and for the same reasons, your volatile, high-octane LASIK practice needs more business monitoring than a stable cataract practice. Here are some additional instruments for the dashboard:

- Monitor the percentage of patients choosing a payment plan. Increases could simply mean that the plan is being better promoted or that patients are getting more tapped and sensitive to costs.
- Track and graph monthly leads versus screenings versus cases. Reduced conversion rates near-term could signal a future drop in case volume.
- Track the local business climate, especially the local unemployment rate. Track the national consumer confidence index figures published monthly by the Conference Board. These can nearly parallel the rise and fall of LASIK volumes nationally.
- Track and graph the global marketing cost per case and the cost per advertised case.
- Develop relationships with friendly competitors in the community to see whether volume trends in your practices match or whether yours is the only practice losing ground.

THE TROUBLE WITH
THE FUTURE IS THAT
IT USUALLY ARRIVES
BEFORE WE ARE
READY FOR IT.

Arnold Glasgow



WHO WOULD
BECOME A
PHYSICIAN IF HE
COULD FORESEE
THE HARDSHIPS
THAT ARE IN STORE
FOR HIM?

Johann Wolfgang
von Goethe



The Current National Health Care Scene: A True Fable

The best way I can explain the nexus of health care and politics is by telling you this true story:

I had a crazy artist friend I'll call Mike, who has now passed on to that great studio in the sky Every year, Mike would load up his ride (a black 1956 Cadillac that had been converted to a pickup truck, complete with diplomatic flags) with his best paintings for the year and head to Santa Fe, New Mexico. Just before he arrived at the rectangular street that surrounds the historic central plaza, Mike slowed down to three miles an hour. Traffic backed up for a half mile behind him, with much waving of arms and honking of horns. At just the right moment, with this backlog of noisy traffic, Mike and his followers enter the plaza, looking for all the world like a parade. Of course, the traffic soon dissipated and Mike spent the next week consigning his art to the local galleries by day and closing down the wildest crummo bars by night. Then he'd be off for another year's recess in his studio out west.

Such is the state of health care and politics in Washington today. Get to the front of an issue and slow down—it will appear you're leading the parade. This creates periodic excitement . . . some angry speeches . . . clears a few practical housekeeping matters . . . and it's back to business as usual. Showy central government attempts at health care cost containment and Medicare reform will rise and fall with every electoral and economic cycle. Meanwhile, you and your practice colleagues must realize that most of what's happening to your business is no longer coming from Washington. We are in the middle stages of what is likely to continue to be a glacially slow, frustrating transition from provider and patient control to payer and regional health system control over health care.

The U.S. Economy as the Ultimate Driver of Domestic Health Reform

Just before the Great Recession hit, I prepared an article for *EyeWorld* discussing what might happen to ophthalmology one day if the general economy started to flutter. I wrote,

If you thought that health reform efforts under Clinton or losing a few percent of revenue from Medicare each year were onerous, wait until the next turn of the business cycle combines with wage inflation, a clamp-down on consumer spending for elective surgery, and the rapidly aging population. What's been termed a "health care cost and access crisis" will be called a real emergency, and the regulatory wheels will spin in earnest. We have likely not yet lived through the toughest times.

As this book goes to press, federal deficit spending will mount faster under a new tax law, equity markets are poised for a steep correction, and GDP growth is well below ideal levels for a post-recession period. Unemployment is pleasingly low and inflation could ramp up sharply if this continues and the currency printing presses keep churning. At the same time, employers are rapidly shifting employee health benefit costs and private insurance costs continue to soar. It's an unfortunate and frustrating paradox that market demand (in the form of a rapidly aging population) and product sophistication (in the form of myriad new ways in which we can help these and other patients today) could well be swamped by a lack of money to pay for it all. Rationing of one kind or another now seems inevitable: rationing care from patients and income from your practice. How should you apply these unpleasant macro-economic trends to your own practice? There are several appropriate guidelines for the still-breath-holding times like these:

- *Work hard on developing marginal revenue.* In this fixed-cost, service-based profession, the profit margin is essentially 100% on the last few dollars you earn every hour. Said another way, 100% of every marginal dollar you don't collect is swept from your paycheck.

THOUGHT IS ACTION
IN REHEARSAL.

Sigmund Freud



WE ARE NOT
RETREATING—WE
ARE ADVANCING IN
ANOTHER DIRECTION.

General Douglas
MacArthur



- *Add any missing ancillary services.* For example, even if you don't have enough cataract cases personally to develop a free-standing ASC, you can still partner with others and gain \$200 or more in lost profits for each case you perform.
- *Closely examine your practice production statistics for habit-driven underutilization patterns.* Are you performing sufficient visual field exams? OCTs? Are you treating conditions like dry eye that may seem clinically ho-hum to you but rank high in patient demand? Are you referring out care that you could competently handle in-house?
- *Avoid practice investments with an uncertain return.* Unless there is a clear-cut economic incentive or standard-of-care demand, put away your wallet and count to 100. Don't purchase new equipment, facilities, or staffing on a whim.
- *Don't shy away from investments that increase your productivity.* For example, it's false economy to hold off adding an exam room, a technician, or technology if these resources will allow you to serve a backlog of patients.
- *Keep your ear to the ground.* It's unlikely that the next stages of national economic malaise or health reform will happen overnight. Scan national and local trends that will affect your practice. Examples of important signposts are orchestrated policy trial balloons out of Washington, the likes of which preceded the Medicare drug bill; news that two locally competing hospitals are merging; reports of the consolidation of influential primary care providers in your market; and the development of a local, employer-sponsored health cost containment panel.
- *Keep asking yourself, "Who in my market has control over my share of the specialty care premium dollar?"* At present, the overwhelming answer is the patient, who can call for your services at a whim . . . but a potential future trend will be to shift this control back to payers and primary care providers and health systems.

Health Care Is a Local Business

Every U.S. market has its own health care “fingerprint.” In a few smaller markets, a single hospital dominates and the distant endgame is obvious, even if for now hospital acquisition of practices has all but halted. All patients may eventually buy services from this one brand of care, with its own underwriting capability, that employs or contracts with all providers. The endgame in larger markets will be one, two, or at most a few dominant brands of vertically integrated care. However, in most markets today, the competition is still delicately balanced between three entities: payers, hospitals, and physician providers. As an ophthalmic specialist, depending on your local context, you should align with one or more of these entities. The research protocol detailed below can help you decide with whom you should align, how fast, and what form that alignment should take.

WE DON'T HAVE A
DESPERATE NEED TO
GROW. WE HAVE A
DESPERATE DESIRE
TO GROW.

Milton Friedman



A Simple Protocol to Study Your Community's Future Medical Business Environment

To write a practice business plan without the clearest possible picture of future market trends is like implanting an intraocular lens without doing a lens calculation. There is no more important strategic orientation for your practice than to find out what's really happening to the health care delivery system in your community. Here's a step-by-step protocol.

Whom to Ask

- Local hospital officials
- Benefits managers in leading local companies
- Administrators and medical directors of larger single or multispecialty clinics
- Locally based health management professors
- Provider relations managers (and above) in managed care entities

A Sample of How and What to Ask

- “I represent a group of Atlanta-area ophthalmologists and optometrists. We are in the early stages of merger discussions with several additional eye care providers. Like every thoughtful practice, our group is trying to determine the future service needs in our community. We would like to continue to develop a total eyecare/eyewear product that serves these needs. We think you may have some valuable opinions for us, and we would like a few minutes of your time to ask a few questions about your view of health care delivery here.”
- “Describe your impression of health care delivery changes in our area over the next several years. What are the larger trends? Percentage capitation in commercial and senior sectors? Emerging market share of the leading payers? Entry of new payers? Logical service area?”
- “How do you think ophthalmology and optometry will fit into this forecast?”
- “More specifically, do you believe there will be a role for eye care carve-out specialty contracts, or will a practice like ours need to reside within a multispecialty group or hospital to have durable access to managed care lives? Or, will access be wide open?”
- “If you were the administrator of a practice like ours, would you be moving toward the consolidation of a mixed ophthalmology/optometry practice to form a full-service eyecare/eyewear company? Or would you instead (or in addition) be seeking consolidation with any other health care providers or hospital entity?”
- “If you were leading our group, what else would you pursue or avoid?”
- “Can you suggest other informed sources in the market to whom we should be addressing these same questions?”

The Spectrum of Possible Relationships Between Practices

As you scan your own marketplace, you can simplistically and grossly divide your local colleagues into “friends,” “enemies,” and “neutrals.” But at a deeper level, there is a more subtle continuum of possible physician-to-physician and practice-to-practice interactions and models:

- *Razor wire.* Frank antipathy marked by active, reciprocal efforts to advance at the expense of the competition . . . a very uncomfortable way to practice for all but the alpha physicians in a market.
- *Good, but wary, neighbors.* Respectful, friendly (but not particularly embracing) competitors who work to become eventual “trusting colleagues,” or at least not devolve into “razor wire” . . . again, quite isolating.
- *Trusting colleagues.* Partially collaborative and periodically cross-referring (as by a general ophthalmologist referring a difficult patient to a fellow generalist with a subspecialty interest in glaucoma) . . . physicians in such arrangements trust each other to return patients.
- *Unconflicted specialist–subspecialist alliances.* Not competing . . . collaborative and cross-referring (as by a general ophthalmologist referring to a dedicated retinal subspecialist).
- *Independent practice association (IPA).* Physicians collaborating, usually with a narrowly defined mission, such as group contracting with managed care . . . usually involves minimum investment and commitment and is subject to rapid disintegration as soon as the sponsoring threat or opportunity dissolves.
- *Management services organization/facility joint ventures.* Like an IPA in terms of lower commitment levels, but involves higher capital/debt commitments; can include active joint venturing (e.g., physicians developing an ASC or laser center or central billing service together and sharing a significant group investment) . . . if successful, can be the precursor to deeper projects and the eventual economic integration of selected members.

ALL HUMANS
ARE OUT OF
THEIR MINDS.
THEY'RE NOT ONLY
DISTURBED. THEY
GET DISTURBED
ABOUT THEIR
DISTURBANCES.

Albert Ellis



- *Physician-hospital association.* Physicians and hospitals form a loose alliance to ultimately develop a contracting alliance or an insurance product . . . now somewhat falling from favor.
- *Expense-sharing associates.* Two or more physicians in the same building who share staff and certain other expenses but who maintain separate entities . . . like two lovers living together rather than marrying, can be successful or fraught with discord, depending on the maturity of the involved parties and the environmental stresses.
- *Classic single-specialty group practice.* The physicians are partners or shareholders in a common entity . . . the group is economically integrated.
- *Multispecialty group practice.* Often formed or grown through consolidation with soloists and single-specialty groups; once favored because of expected better access to managed care contracts . . . now troubled by significant diseconomies of scale and partner opposition—especially along low-producer/high-producer lines
- *Integrated delivery system.* Inserts a multispecialty provider into the context of an inpatient institution, with the ability to provide a full-spectrum of care . . . often includes one or more insurance products and competes with other third-party payers for a share of the employer premium dollar.

SUCCESS IS THE
ABILITY TO GO
FROM ONE FAILURE
TO ANOTHER
WITH NO LOSS OF
ENTHUSIASM.

Winston Churchill



No Ophthalmologist Is an Island

You have probably spent most of your career happily disengaged, not only from institutional medicine but also from primary care providers and your own specialist colleagues. This neglect may need to be reversed. In markets with excess providers, individual eye care specialists and single-specialty groups may one day thrive independent of hospital institutions only under one of two conditions. They must represent a significant percentage of the local ophthalmic provider base and be able to deal strength-to-strength with payers on a single-specialty basis or they must annex themselves to a multispecialty group practice with sufficient scale to control its destiny. The only alternative may be for surgeons fortunate enough to work in markets in which hospital and payer executives voluntarily grant them independence and open access to patients.

Urban Surgeons Play Musical Chairs

In larger managed care markets, reduced utilization and excess providers are creating a “musical chairs” environment . . . each time the music stops, a few more patients, cases, and opportunities are taken away. Some California and Florida communities that combine high-volume training programs with pleasant lifestyles are particularly hard hit, with only 4000 or 5000 people per ophthalmologist. This is just a quarter of the usual carrying capacity in an indemnity environment and perhaps a sixth or less of the population base needed to support an ophthalmologist providing care under capitation. In ecology terms, there are too many foxes and not enough rabbits. During physician searches, a significant percentage of the applications I receive arrive from midcareer surgeons who live in these oversupplied urban pockets.

IF THERE IS A WAY
TO OVERCOME THE
SUFFERING, THEN
THERE IS NO NEED
TO WORRY. IF
THERE IS NO WAY
TO OVERCOME THE
SUFFERING, THEN
THERE IS NO USE IN
WORRYING.

Shantideva



Hope for the Future

For the past several years, the mood has been pretty gloomy in ophthalmic America. Younger surgeons are particularly downcast. They look with envy at the generation or two before them and feel they missed the golden ring. Mid-career surgeons, whose successful businesses are starting to falter, are wondering whether they'll survive. Older surgeons are telling their sons and daughters to avoid a career in medicine. Please don't let the headlines bring you down. I predict that, in just a few years, things will get much better. Here's why:

- *A majority of the country's highest volume providers are now over 50 years old.* Most of these surgeons are financially secure, having built up a retirement portfolio during a period in which stocks were surging in value. Although they still enjoy medicine, just a little more hassle and a little less profit will cause many of them to seek early retirement.
- *The Age Wave is coming.* There are 14 percent 65+ seniors today. The total number of seniors will increase about 50% in the next 15 years. And seniors use about 10 times as many eye health resources as commercial-age patients.

WE ACT AS
THOUGH COMFORT
AND LUXURY
WERE THE CHIEF
REQUIREMENTS OF
LIFE, WHEN ALL
THAT WE NEED TO
MAKE US HAPPY
IS SOMETHING TO
BE ENTHUSIASTIC
ABOUT.

Albert Einstein



- *Seniors will remain the most powerful voting bloc in America.* Medicare entitlements are probably more secure than we think. As a well-known surgeon once said, “Nobody ever went broke working for the government.”
- *Prepaid senior care may never reach expected levels of market penetration.* There are new, strong second thoughts about how much money senior capitation really saves when applied to a full cross-section of patients. Even under capitation, it is possible to be acceptably profitable if you work efficiently.
- *There is a payer migration to seeking provider quality in managed care.* With or without so-called “any willing provider” legislation, the current politics of panel access will yield to rational choice—the best doctors will have access to patients.
- *The maldistribution of providers represents a remarkable escape path for failing urban surgeons.* There are still numerous rural service areas with only one ophthalmologist for every 40,000 to 100,000 people. Such chronically underserved populations typically include a higher senior ratio and have a backlog of operable pathology and very low levels of managed care penetration.
- *Primary eye care is another practice safety valve.* Given sufficient motivation, physicians will compete directly, and in many cases successfully, with optometrists for the routine care and dispensing market.
- *Eye care is provided by the smartest and best-compensated physicians, managers, and staff in America.* We’ll muddle through as well as or better than most.

Money and Happiness

A U.S. Census question some years back asked the public what it costs to live the American Dream. The surveys asked rich families and poor families—people who made millions and people living below the poverty line. The result? Just about everyone answered, “It takes roughly twice what I’m making today—*that* would make me happy and allow me to live the American Dream.” Ophthalmologists (and their spouses) too often step into the same happiness

trap, locked in a professional setting they dislike because they've become addicted to the belief that life would be less happy making \$350,000 a year (the rough national average income for eye surgeons) instead of \$500,000. That's not to say you shouldn't strive to grow and develop your practice and to improve in every dimension, including higher economic ground . . . but be clear about why you are striving. Is it for the thrill of professional competition, or is it the fear of others having a practice that is larger than yours? Is it for the deep personal satisfaction of doing your best work possible, or are you polishing your surgical skills out of some recurring, residency-inspired nightmare of criticism and failure? Are you economically fruitful as a by-product of giving your patients real value, or are you so fearful of falling behind that you're cutting corners?

Discriminate Between Regret-Free and Regret-Laden Practice Activities

Some tactics and strategies are a one-way street—once begun, they are hard, or at the very least expensive, to reverse and thus are very dependent on your advance critical judgment and deep vetting. Examples are the development of a large office building or establishing a free-standing LASIK satellite. Poor judgment will result in a lot of regrets. In contrast, there are far more numerous opportunities for “no regrets” strategies and tactics in your business. Example include projects that are easily halted and reversed . . . a trial marketing effort, a visiting subspecialist, or a new piece of equipment taken on trial for 60 days. The next time you and your managers are discussing a possible new direction, ask yourself, “Is this strategy or tactic potentially regret-free, or is it laden with the potential for regret?” If your answer is the latter, be sure to apply extra due diligence before proceeding.

EVERYONE IS IN
BUSINESS FOR
HIMSELF, FOR HIS
BUSINESS IS SELLING
HIS SERVICES,
LABORS OR IDEAS.
UNTIL ONE REALIZES
THAT THIS IS TRUE
HE WILL NOT TAKE
CONSCIOUS CHARGE
OF HIS LIFE AND
WILL ALWAYS BE
LOOKING OUTSIDE
OF HIMSELF FOR
GUIDANCE.

Sidney Madwed



OUT OF INTENSE
COMPLEXITIES,
INTENSE
SIMPLIFICATIONS
EMERGE.

Winston Churchill



CHAPTER 2

LEADERSHIP, GOVERNANCE, AND DISCIPLINE



*The more you know,
the less you understand.*

TAO TE CHING

You May Have to Work Harder

Dr. John Corboy, asked once by a wealthy gentleman what he did for a living, replied, "I'm an eye doctor." The wealthy man then asked, "Are you any good at it?" To which the surgeon replied, "I suppose—I have one of the largest practices in the country." The gentleman then asked, "Well, is that because you're smarter than the other doctors?" "Goodness, no," replied the surgeon, "I'm average at best." "Then," said the gentleman, "you've obviously found the secret to success . . . if you're not smarter than the other fellas, you have to work harder than they do." And so it goes. Some of the most successful surgeons in the world are B and C students made good.

Ophthalmic Decision Making: A 5-Point Test

1. Is it ethical and legal?
2. Does it reduce costs without decreasing the quality of care or improve patient care without increasing costs?
3. Does it help us serve the interests of our vital, invisible customer: *the payer*?
4. Will the *overall practice* be more financially secure or more profitable within one year because of this decision? (This profitability time frame should be individualized to your practice—faltering practices may choose one week, strong practices three years; some Japanese firms might think in terms of 20 years.)
5. Does it make us more attractive to our current and potential audience segments, including staff, doctors, hospitals, payers, lenders, investors, and buyers?

THE FACTS HAVE
MADE THE DECISION.
I WAS WRONG.

Alfred P. Sloan



So What's Management, Anyway?

Management in ophthalmology, or anywhere else, is quite simply *gathering information, making decisions, and taking action*. All the data in the world have no meaning unless used to help make better management decisions. A few practices make decisions without gathering information. Even more practices make decisions, but then don't act. Superior practices take all three steps. If you want to

become a better, proactive manager, work on doing a better job in whichever of these three steps are your weakest.

Another Way of Looking at Management

Management of an ophthalmic office can be looked at from many frames of reference. Here's one. The ophthalmic manager:

- measures the reality of the practice and environment (financials, volume performance figures, key ratios, competitive threats, collaborative opportunity, etc.).
- interprets the meaning of this reality.
- communicates this reality and its interpretation to the physician-owners.
- guides physicians to continuously refine their perceptions of reality and their reaction to it.
- guides physicians to continuously refine their goals, both as business owners and as professional providers (scale, profitability, service scope, individual volume performance).
- coordinates the acquisition and allocation of practice resources (time, people, expertise, technology, capital, reputation, etc.) to meet these goals.
- measures the results of this allocation, and continuously refines resource allocation as owner consensus about desired future outcomes shifts over time.

THAT'S ALL I CAN
STANDS AND I CAN'T
STANDS NO MORE.

Popeye



Hitting the Wall

In every growing organization, the ever-larger number of employees and customers, combined with complexity, causes even the best practices to gradually slow down the pace of decision making and follow-through with agreed actions. Every growing practice is periodically—and usually only temporarily—retarded by its own success. The periods during which a practice bogs down are frustrating to staff and doctors alike. If not corrected, they lead to longer lasting strategic, morale, and management problems. Here are actions that can help stimulate a breakthrough if you reach your natural limits as an organization:

- Refine your practice's management structure . . . shuffle the organizational chart.
- Hire a new administrator.
- Select a new managing partner.
- Conduct a management retreat to define a new strategic direction for the practice.
- Hire outside experts to lend a fresh perspective.
- Write a new business plan, or revise the old one.

Staff, Management, Provider and Shareholder Meetings

In a typical multiprovider practice, you should have the following meeting schedule:

Board of directors. In smaller practices, especially those run by the consensus of all partners, board meetings are frequent and relatively informal and should be held at least monthly. In larger practices, the board serves as more of a policy-setting and oversight body. An error is made when large practices (let's say with more than 12 physicians) fail to streamline their board and convert to representational governance, with majority votes for smaller issues and supermajority votes for larger issues.

Executive committee. This is typically a subset of a larger board and reports to that body, allowing more frequent, efficient sessions.

Board subcommittees (e.g., clinical affairs, compensation, finance). Meeting frequency is directed by scope of work.

Operations or management committee. In practices of every size, it's appropriate to have a group consisting of the administrator, the managing partner, and senior supervisors or managers representing every department (clinical services, ASC, optical, reception and patient accounts, marketing, etc.) gather frequently to discuss their progress with assigned projects and be kept in the loop on strategic issues. In the best practices, these department heads are often given details of the practice's finances and are responsible for a departmental budget. They should be *profit* managers, not just process managers.

IT IS ONE OF THE
MOST BEAUTIFUL
COMPENSATIONS OF
THIS LIFE THAT NO
MAN CAN SINCERELY
TRY TO HELP
ANOTHER WITHOUT
HELPING HIMSELF.

Ralph Waldo Emerson



Provider meetings. In practices where there are both owner and nonowner providers, you should arrange a regular time each month for all providers to meet to discuss care pathways, policy breeches, resource needs. . . . and to simply connect socially.

All-staff meetings. Depending on how far-flung your operations and the pace of change in your practice are, all-hands meetings should be held anywhere from monthly to quarterly to annually. Whatever the interval, they should be scheduled as deliberately as patient appointments, have a written agenda, and be largely upbeat events. You'll know you're doing it right when department managers and staff speak for more than half of the meeting time. You'll know you're doing it wrong when the administrator and physicians spend the entire meeting giving speeches.

Department meetings. All supervisors should be responsible for calling and running their own department meetings. Because few practice supervisors are professionally trained as managers, they should receive ongoing mentoring on how to run effective meetings.

Individual performance reviews. Individual staff members, including physicians, should have their performance evaluated by their supervisors at least annually. Two times a year is preferred.

IT'S CRITICAL TO
HOLD MEETINGS IN
PRACTICES. EVEN IF
YOU SPEND A LOT
OF TIME WHINING,
THE GAINS IN
COMMUNICATION
ARE VITAL.

Pete Whitted, MD



Preserving Egos During Meetings

During physician board meetings or senior management meetings, it's often useful to allow more junior physicians or staff to attend, or even present for a portion of the meeting. Rather than having such staff be "dismissed" in the middle of the larger session, it can be a little more polite to bring them in at the end of the meeting, if possible. If that's not possible, breaking the meeting into two parts, with an intermission between the open and private portions, can help assuage egos.

The Transition from Consensus to Majority Rules Governance

Group practices with a limited number of physician partners often try to make every group decision by full, unanimous consensus. This worked well before the pace and stakes of every medical or business decision started to rise.

If your group finds simple majority rule uncomfortable, a possible compromise is to divide decisions according to their scale and use simple majority and supermajority voting. Here's an example:

Minor Decisions

Approved by a simple majority of the board (e.g., 3 affirmative votes out of 5)

- Office policies and procedures
- Professional fee schedule
- Hours of operation
- Physician deployment (office schedule)
- Marketing activity
- Hire or fire support staff under level of administrator

Major Decisions

Approved by a supermajority of the board (e.g., 4 affirmative votes out of 5)

- Removal or approval of partners
- Open, acquire, or close offices
- Add physicians
- Changes to physician compensation formula
- Changes to all major office policies
- Borrow money/enter contracts/make purchases with a cost impact over \$100,000
- Major contractual relationships
- Hire or fire the administrator

The Transition from All-Hands to Representative Governance

The understandable desire of each physician-partner to have a voice in governance hits the wall at about 10 partners. Beyond this number, it's better to transition to representative governance, in which the shareholders elect

WHEN I GET A
LITTLE MONEY I BUY
BOOKS; AND IF ANY
IS LEFT I BUY FOOD
AND CLOTHES.

Erasmus



WHEN TWO
PARTNERS IN
A BUSINESS
ALWAYS AGREE,
ONE OF THEM IS
UNNECESSARY.

Anonymous



a smaller board to represent their interests. I'm in favor, in most settings, of all formal board meetings remaining open to the attendance of all shareholders.

The Transition from Shareholders Only to Outside Board Members

The next logical leap in the maturation of practice governance, beyond changing voting rules and having representative physicians, is to allow nonshareholders a chair at your board table. Candidates include nonpartner physicians and optometrists, your administrator, and outside experts (accountants, attorneys, consultants, etc.). You may not want these outside board members to have a vote, but your practice could be improved by letting them have a voice.

WITHIN NARROW
BOUNDARIES, I'M
HIGHLY FLEXIBLE.

An Anonymous Client



Make Sure You Have the Right Stuff to Succeed

Corporate planning consultant Ian Sharlit wrote, "Business failures are often preceded by personality dysfunction on the part of the executives involved. More often than we think, the root causes of many business failures lie in the executives' own traits, which are mismatched with the requirements of the business." Could you be your faltering practice's chief problem? If you can't definitively answer "no," look for improvements in this area before going any further.

A "Cooling-Off" Period for Physician Decisions

Surgeons are, by their nature, decisive in their clinical lives. This is not necessarily so in their business lives. Wise practice managers who work for equivocating surgeons (or surgeons who rush to intemperate judgment) know this and hold off making staff announcements or taking action until the physicians have come to a clearly affirmed decision. In practices with discipline gaps in this area, it may help to put physician decisions in writing and to have a 24-hour "cooling-off" period so a physician can recant any decisions he or she made too hastily.

Organizational Charts

Many practices avoid creating an organizational chart, believing it's too formal or limiting, or might hurt someone's feelings. To the contrary—the discipline of drawing this out can help even solo practices clarify reporting lines and clear up misconceptions of who is responsible for what.

The typical chart is hierarchical and looks like a pyramid, with physicians and managers toward the top and everyone else below. I've struggled with various new-fangled versions long enough to believe that "matrix" models, where everyone reports to everyone, and "upside-down" models, where everyone reports to patients, really don't fit reality. If you don't already have one, try sketching out the current organizational chart. Its appearance will speak volumes about your practice—and even more about your clarity of thinking in this important area. A great staff meeting exercise is to have everyone draw up their version of what they think the organizational chart looks like and describe it to the group . . . before you distribute and discuss the final version. Drawing out the existing and proposed chart helps both physicians and staff understand the need for change. Overly complex charts, with lines connecting almost everywhere, may indicate that the actual lines of authority are unclear. Excessive staff lined up under a single manager may indicate an overly broad span of control for any one person—even the most talented—to effectively manage. The final chart should be distributed to staff. Actual staff names and titles should appear on the chart.

MEDICINE IS A
NOBLE PROFESSION
BUT A DAMNED BAD
BUSINESS.

Benjamin Rush



Managing Partner's 10-Point Monthly Task Checklist

Pride is the first emotion of every physician who has been nominated by his or her peers to the post of medical director or managing partner. The second emotion is panic, which sets in once the physician sees how much the job entails when it's done right. Here's a generic monthly checklist for the typical setting:

1. Have two or more formal meetings with the practice administrator and review monthly financial reports, action list, graphs, and forecasts.
2. Do a quick rereading of the practice's strategic plan and ask yourself, "Are we still sticking to the plan, or is it time to revise it?"
3. Attend and participate in the regular senior managers' meetings.
4. Prepare for and conduct the monthly provider's meetings.
5. Review and take action on any open provider discipline or quality assurance matter.
6. Spend a minimum of two hours per month (in aggregate . . . just a few minutes a day) walking the halls, visiting informally with support staff, asking questions, and praising performance.
7. Do a mental scan of all external relationships (e.g., hospitals, referral sources, competitors, payers, vendors) . . . follow up on written, telephone, or face-to-face action PRN.
8. Hold a breakfast, lunch, or similar meeting with one practice department head per month and with one of the practice's providers (a separate or combined meeting as desired).
9. Read/scan one *general* management book. (Pick up several titles during a bookstore visit and get through them in the intervening months.) Read/scan a business weekly or monthly such as *Business Week, Inc.*, or *The Economist*. (Subscribe to one or more.) Distribute relevant articles to the management staff.
10. As a monthly exercise, ask yourself, "What have I done this month to understand and improve my weakest management skill, be it *gathering information, making decisions, or taking action?*"

WE DO NOT SEE
THINGS AS THEY
ARE. WE SEE THINGS
AS WE ARE.

The Talmud



Compensation for Managing Partners

In most settings, a practice's managing partner, to do the job well, must spend at least eight hours a week on practice business. His or her partners commonly expect this job to be done for free—they are wrong. The managing partner can best be compensated by a straight monthly stipend of about \$1000 to \$3000, which usually works out to a

fraction of the physician's actual value to the practice. This "honorarium" approach is satisfactory in most settings. The managing partner finds the control of leadership to be ample payback for the extra time spent on the job. And addressing the common fear that becoming managing partner will reduce personal productivity and earnings, I have never seen this happen.

A Penny for Your Thoughts

Even well-meaning practice owners can find it hard to remember to compliment their staff throughout the day. Here's a simple mnemonic. Put 10 pennies in your right lab coat pocket. As the day progresses, transfer a penny to your left pocket each time you compliment your staff. Your staff will never catch on to your trick, and their loyalty and morale will rise at absolutely no cost.

Leave Your Ego at the Door

As the long article in Appendix 1 describes, most physicians—and particularly eye surgeons—have not been selected for higher education because of their sparkling personality. Like submarine captains, they're expected to be a little brusque, a little "crisp." Read this appendix and realize that most of what has helped you accomplish so much in your life has also left you mildly handicapped. Try to be a little self-effacing, a little human. Employees do their best work for physicians who have a low ego-to-skill ratio.

Surgeons and Managers: Partnering for Practice Growth

In over 40 years of travel to thousands of practices, one overarching observation has struck me more than any other: In very few eye care businesses are the physician-owners and the management staff truly aligned. Sure, they arrive to work together at the same office each day. They write mission statements and business plans that on the surface pull everyone together. But in the daily reality of the trenches, these physicians and managers live nearly parallel work lives. They haven't tightly aligned themselves

IN A WORLD FULL
OF FUGITIVES, THE
PERSON TAKING THE
OPPOSITE DIRECTION
WILL APPEAR TO BE
RUNNING AWAY.

T.S. Eliot



into a united force to improve, grow, and develop the practice. Here are some of the most prevalent causes behind this and a few ideas to apply in your own practice setting:

- Rather than passing the practice management ball back and forth, managers and physicians too often try to carry the ball by themselves. Physicians learn too late that a key technical staffer has been fired before she could cross-train a replacement. Managers learn that their physicians have just signed off on a money-losing managed care contract when the clinic is already booked out four weeks for the next new private-pay appointment.
- More often, I see physicians acting in a vacuum without consulting their lay staff rather than the other way around. When managers hide problems from their physicians, it's usually a major issue . . . like the time I saw a manager age the payables 120 days to artificially boost profits and thereby earn a salary bonus.
- Often, managers are more than ready to be part of the practice team, but the physicians are on the sidelines. When the physicians remain disengaged from the details of their practice, even the most dedicated staff will lose focus and intensity.
- What's the biggest factor holding physicians and managers back from a deeper practice development partnership? I think the prime contributor is a lack of "strategic intimacy." Even physicians who let their managers in on all the numbers and day-to-day issues often won't let down their defenses and daydream with staff about where they would like to take the organization, much less their lives.
- Continuing the team analogy, most sporting teams have a near-term goal (win the game) and a longer-term goal (win the season and the national trophy). In contrast, although every practice knows it has to get through today's clinic session, most practices lack what one client fondly calls "a big, audacious, hairy goal." For your practice, focusing on one really tough objective may help to pull the physicians and managers together. This can be something practical and ordinary, such as developing a surgical center or reaching defined financial thresholds,

or it can be something inspired, such as funding a Third World eye clinic.

- Some of the teamwork and lack of trust between physicians and their managers can be tied to managers who are in over their head and not taking steps to improve their business skills. As the leaders of their practices, it's critical that physician-owners encourage continuing education for their managers, most of whom are very experienced and highly dedicated to the practice, but few of whom are formally trained in business.
- If we took a field trip to a typical established business organization outside of health care services, we'd observe a much tighter collaboration between owners and management. A large part of this is the mentoring that is built into the best firms from the chairman on down. If you're a physician reading this, ask yourself, "When was the last time I took one of our managers aside and really took the time to understand her position and pass along advice that was not only constructive for the problems at hand, but spoke to the manager's underlying career development in our practice?"

A Test for Physician-Manager Teamwork

The consultant's acid test for the all-too-common problem of managers and physicians not teaming up is to give a simple assignment to every physician-owner and senior manager:

Describe in 100 words or fewer the most important goals for the practice over the next three to five years.

In the comparatively few practices that *are* cohesive, managers and physicians will give the same basic set of goals. It's most often because they're meeting regularly and arm-wrestling about the best path for the practice. It's because the managers are professionally secure enough to ask questions when they're not sure about something. It's because the physicians are professionally secure enough to let down their guard, admit they need help plotting the future, and know that it's okay to share the financials with trusted staff. It's because everyone's on the same page and everyone's on the same team.

IF YOU GAZE LONG
ENOUGH INTO THE
ABYSS, THE ABYSS
GAZES ALSO INTO
YOU.

Nietzsche



Group Brainstorming— “Nominal Group Technique”

Two heads are always better than one—and more than two are even better. Try this formal approach to brainstorming, called “Nominal Group Technique,” the next time you have a problem to solve that deserves everyone’s input. This works best with five to 15 participants:

1. Formally describe and agree on the problem (e.g., “Patient waiting time is excessive from 10 AM to noon each day.”)
2. Before opening discussions, hand everyone a pad and pen and give them a brief period—no more than three to five minutes—to privately write down every possible solution to the problem that comes to mind. The moderator then calls time.
3. Go around the room and have each participant describe just *one* of his or her ideas. As each idea is described, the moderator or a scribe should summarize it on a white board or flip chart. Go around the room a second time, and a third if necessary. Then open the floor to general discussion—again writing down each new idea expressed.
4. Number each idea, read through them from the top, then ask participants to vote on the best three or five or 10 suggestions. Tally the group votes, and declare the winners. Nominal Group Technique generates far more creativity, forces everyone’s participation, and efficiently and democratically generates consensus. It works as well with senior physicians and managers as it does with the most junior support staff.

WHEN WAS THE
LAST TIME YOU DID
SOMETHING FOR THE
VERY FIRST TIME?

Anonymous



Be Willing to Take Risks

Sometimes trying something new in your practice or your life is like wearing a new shirt for the first time. You may think you’ve pulled out all the sharp straight pins, but you always seem to find the last one the hard way. Face the fear, stare down the risks and do what you are thinking about anyway.

CHAPTER 3

FINANCE, ACCOUNTING, AND PATIENT ACCOUNTS MANAGEMENT



*Thinking is the hardest work there is,
which is the probable reason why so
few people engage in it.*

HENRY FORD

Lessons for Ophthalmology from Enron

Scores of business and life lessons have emerged from the historically important Enron scandal. (This scandal came to light in 2001, after this energy company's meteoric rise, and subsequent dissolution stemming from accounting irregularities and fraud.) Some of these lessons can be directly applied to your practice. Here are three:

Lesson 1: You have to know and understand the little details, numbers, and protocols.

One senior Enron executive officer after another was trotted out before various congressional committees, mostly to take the 5th Amendment. Most of the officers who were bold enough to actually testify said something to the effect of, "I wasn't involved in those decisions." Or, "I knew generally about that accounting procedure, and it worried me, but I didn't really understand it and assumed the lawyers and accountants had signed off on it." It's essential that you, as a practice owner and as a manager, not only have access to the numbers and the operational details, but that you understand them as well.

Lesson 2: It's essential to know the big picture.

This was one core Enron failing—or perhaps it was a success because it kept the party going for just a while longer. Numerous, now-famous off-balance sheet entities with romantic *Star Wars* names were used to veil Enron's corporate debt and mask losses. The average ophthalmology practice owner may look at this and say, "Well, what does that have to do with me?" Interesting you should ask. Many successful physicians have small-scaled but still Enron-like problems. You see, these physicians have been advised—and it's not bad advice really—that they should subdivide their practices into various constituent parts to partition risk and shelter assets in the case of an adverse legal judgment. In these settings, you typically see a core practice entity that basically owns nothing. It might in turn lease equipment from an equipment company, staff from a staffing company, a building from a real estate company, and so forth. The only problem is that this risk management advice is most often given by attorneys without the

I AM INDEED RICH,
SINCE MY INCOME
IS SUPERIOR TO MY
EXPENSE AND MY
EXPENSE IS EQUAL
TO MY WISHES.

Edward Gibbon



benefit of corresponding accounting advice to unbraid the snarl of financial tracking entanglements that attend this approach.

Lesson 3: Bad enterprise models always fail . . . it's just a matter of time.

Each week, thousands of fresh new business ideas noisily spring to life in America, rosy cheeked, fully funded, with their CEOs charging hard toward dreams of wild success. In the very same week, about the same number of businesses will be smothered, voluntarily or otherwise. Obviously, most of you reading this book are working in enterprises that fall somewhere between these two benchmarks of nascence and demise. The happy truth is that eye care is an extremely difficult business to kill. You have to really, really work hard to go completely out of business as an eye surgeon. That doesn't keep some ophthalmologists from trying, however.

When you first scanned the headlines and saw the Enron news break years ago, you probably thought to yourself, "There's not much for me to learn from this." Think again. Business is business, and all businesses are fragile, living creatures. Somebody has to be their guardian, steward, and watchdog. Your wee ophthalmology business, although less fragile than the weakest of Wall Street's wobbling giants, needs your daily care, vigilance, and feeding.

MATHEMATICS HAS
GIVEN ECONOMICS
RIGOR, BUT ALAS,
ALSO MORTIS.

Robert Heilbroner



Monthly Financial Statements

In the bygone era of small, simple practices with 60% profit margins, "checkbook accounting" was sufficient—just by keeping track of the balance in your operating account, you knew enough to make most management decisions. Anyway, a 5% or 10% management mistake wasn't so critical. That era is no more. Profit margins of 40% and lower are quite normal today, and 15% to 25% urban practice profits may not be out of the ordinary in just a few years. For physician-owners especially, it's time to get intimate with the month-by-month details of your practice. Some pointers:

- You should receive a cash-basis income statement no later than the 15th of every month. An increasing number of practices generate their own statements in-house using one of the numerous user-friendly software programs now available. (Most smaller practices should avoid more powerful accounting programs such as Peachtree which are designed for more complex enterprises; more than half of all practices use QuickBooks.)
- Your monthly statement should have columns showing (a) the current month's performance, (b) year-to-date figures (with each chart-of-account line item of expense broken out as a percentage of collections), and at the least, last year's year-to-date comparison.
- Better organized and larger practices will typically do best by developing a department-by-department or overall practice budget forecast and then compare this budget to actual performance.
- Physician-owners too often skip over the financial statements and go straight to the monthly compensation worksheet. The practice's administrator or accountant should act as a tutor and provide the physicians with an external source of discipline to study the numbers every month. Some spoon-feeding can help. Consider adding a brief narrative cover sheet to the front of every monthly statement, such as:

For the 10-month period ending October 31, compared to last year, charges were up 10% but collections were down 4%, due in equal parts to larger contractual allowances and that our staff is still adjusting to the computer upgrade. Expenses were up 15%, largely due to Dr. Smith's self-insured malpractice settlement and a continued ramping up of marketing. Payroll costs have fallen somewhat as we have done a better job controlling overtime. Dr. Jones' growing plastic surgery practice is keeping ahead of our loss of patients to capitulated plans.

- If you do generate income statements in-house, have your accountant review them at least quarterly or semi-annually to provide oversight and facilitate tax planning. Many practices generate a trial statement and hand this preliminary document to their accountant for refinement (along with routine chores such as bank statement reconciliation).

EVERYONE IS
IGNORANT . . .
JUST ON DIFFERENT
SUBJECTS.

Will Rogers



Cash-Basis Accounting

Generally speaking, there are two ways to prepare profit and loss statements for your practice. Accrual-basis accounting records revenue when you charge for your services and records expenses when you receive an invoice. It's a terrific system for manufacturing and retail environments, in which the time cycle between taking delivery of raw or wholesale goods and their eventual sale as finished goods or retail products can be stretched out for months or quarters. But accrual accounting is ill suited to ambulatory health care, including eye care services. Cash-basis accounting provides the most meaningful snapshot of practice health: Revenue is recorded when collected, and expenses are counted when paid.

THERE IS NEVER
JUST ONE
COCKROACH IN
THE KITCHEN.

Warren Buffett



The First-Quarter Blahs

Novelist W. Somerset Maugham once wrote, "Money is like a sixth sense, without which you cannot make a complete use of the other five." Most ophthalmologists are reminded of this during the first few months of every year. The first-quarter profits in most practices tumble with a slew of seasonal adversities. With the onset of winter and the departure of snowbirds from northern latitudes, about half the country's eye surgeons have a drop in elderly patient volume. (Of course, this is offset in practices in the South, where the snowbirds roost.) Snow days can slaughter an entire week of patients in the toughest climates. Physician vacation time is often at a peak in the winter and includes not only legal holidays, but also vacations in the South (for some) and to the ski slopes (for the rest). Practice costs tick up a notch with year-end lease escalations, cost-of-living staff raises, increased utility costs, and vendor price hikes. Physician draws from the practice increase to catch up with underfunded tax deposits and holiday vacation spending. Medicare payments slow down as patients try to delay the cost of the new year's deductible as long as possible. Optical sales are sluggish as the buying public shakes off its holiday-spending hangovers. None of these individual hits is all that traumatic, but taken together, they can shove weak practices over the cliff and nudge even the strongest practices into a short-term deficit. For some time now, as

average profit margins have softened, these oscillations into first quarter deficits have been getting a little worse each year.

The Practice Treasury

Most countries have a treasury department and keep significant reserves—sometimes even real treasure, in the form of gold bars—to back their currency and as a store of national wealth. Most corporations of any stature also follow a strict treasury protocol, keeping an appropriate portion of their capital and borrowing power held back as a reserve against future calamity and future opportunity. In a roundabout fashion, mature eye surgery practices have a kind of “treasury.” It’s not gold bars kept in a vault but rather the personal wealth of the constituent surgeons. If the practice hits a lull, the physicians can simply forego their salaries for a few months. How much in reserves is enough? This is a complex question, with several interconnecting parts, including:

- *How fast is the practice growing, and what are your profit margins?* If profit margins are low, you have less cushion for error or a general economic slide than if your margins are high.
- *How old are you?* If you are 40 years old and have 25 years to recover from a business miscalculation, you don’t need the reserves or caution of a 60-year-old.
- *How vulnerable is your retirement portfolio?* If you’re nearing retirement age and are more than financially secure, there’s nothing wrong with taking one last, dicey business fling. The converse is also obviously true.
- *How vulnerable is your payer mix?* If you have a typical geriatric practice, the majority of your payments are as secure as the U.S. government. If you have an elective LASIK practice in a company town vulnerable to massive layoffs or depend on a single, large year-to-year capitated contract, your cash flow is far less secure.

As a general guideline, it is a good idea to have at least three months of overhead expenses readily accessible. If it costs \$45,000 per month to run your practice—pay staff, rent, utilities, etc., but not your salary—you should have at

least \$135,000 in reserve. This can take the form of recoverable accounts receivable in transit, the practice’s operating account, a line of credit, and any personal resources you have on hand.

Make Vendor Reviews Part of Your Practice’s Annual Spring Cleaning

The typical midsize practice writes about 200 checks a month to a wide range of vendors. Over the course of a year, 500 different parties may have sold you their services or products. You may believe that some of these vendors have a nonadjustable steel claw on your practice bank account, but even seemingly rigid expenses may be subject to negotiation.

Here’s an easy exercise. Assemble the practice’s most senior staff. Get out your checkbook or general ledger. For *every* vendor, fill out the following simple form:

Vendor Name	Cost Per Year	Current Rating (Superior, Acceptable, Probationary, or Terminable)	Our Ability to Eliminate or Substitute	Agreed Action
Mike’s Office Cleaning Service	\$6000	Superior—always exceeds our expectations, and no rate increase in 5 years	Many options, but no need to replace	Letter of thanks for another great year of service
First Federal Bank & Loan	\$800	Terminable—refused to increase our credit line, and many statement errors	Three other banks available within 1 mile; all have agreed to waive account fee	Interview branch managers and change banks by July 1
McLauren Advertising	\$225,000	Acceptable—sufficient for our immediate needs, but may not have the creativity if we expand our LASIK program	The best ad agency in town is already serving our competitor; we’ve gotten too big for most freelancers; the next step may be to create an in-house department	Meet with our account executive and say we’re expecting more this year or we will commence a formal agency review in the 4th quarter; review bills closely

Cost-Containment Pearls

Here are some cost-containment or service enhancement opportunities you may have overlooked. It's a useful list to bring out from time to time to remind you to work more effectively with your vendors.

- Ask companies with a discount policy for prompt payment (e.g., 2% off for payment within 10 days) to extend that same discount if you pay at the 30-day mark.
- Ask your cleaning service what discount it would provide if you had all staff members take a moment to bag their own paper waste at the end of the day or if the service cleaned the office three times a week instead of five times during the slow winter months.
- Ask ongoing, reliable vendors (e.g., radio stations you advertise with and similar small, flexible businesses) whether they can provide you with an additional discount for a longer term contract or for prepaying for a year of service. If your practice has sufficient cash or borrowing power, at current interest rates, a 10% to 15% discount for prepayment may be strongly in your favor.
- Ask the painter whether you could receive a discount if he paints not only the office, but also the homes of five staff members and physicians who have been wanting to redecorate.
- Ask your optical frame vendors what further discount you would enjoy if you bought eight frame lines instead of the current 12 and could push more business to a smaller number of companies.
- Ask your techs whether some of them would be willing to job share and take 15 hours of work off each week during the slowest times of the year.
- Ask your staff whether they would be willing to launder their own uniforms, saving \$3500 in cleaning service fees each year.
- Ask your patients whether they would be willing to use the office's courtesy telephone to call their own insurance company for approvals or to call for a taxi cab at the end of an appointment, thus saving the practice valuable staff time.

FACED WITH THE
CHOICE BETWEEN
CHANGING ONE'S
MIND OR PROVING
THAT THERE IS NO
NEED TO DO SO,
ALMOST EVERYBODY
GETS BUSY ON THE
PROOF.

*John Kenneth
Galbraith*



AN ECONOMIST
IS AN EXPERT
WHO WILL KNOW
TOMORROW
WHY THE THINGS
HE PREDICTED
YESTERDAY DIDN'T
HAPPEN TODAY.

Laurence J. Peter



- If you have a fallback position, ask the director of the open-access LASIK center you use whether you can perform your low number of cases at the center's "high-volume discount rate," preserving your mutual relationship.
- If you use a hospital's outpatient department to perform cataract surgery, ask the PR department to help you with a publicity project for free, saving you the cost of hiring a local freelance publicist.
- If you haven't checked your carrier's telephone rates against the competition's in the past year, check them now. At the very least, ask your current carrier whether it has a less costly plan for a customer like you.
- Ask the sandwich shop that caters your staff lunch every week whether it can throw in dessert for free since you're such a great customer.
- Ask your local postmaster whether there's a less costly way than a first-class stamp to mail your present volume of patient statements. Also ask whether there is a less time-consuming way.
- Ask your physicians whether they can be a little less wordy in their dictation to save transcription costs.
- Ask yourself whether you really need to send eight staff members across the country to a meeting or whether the same training goal could be accomplished by sending the two most deserving staff members, who will then serve as in-house trainers for the other six.
- Ask yourself whether an off-the-shelf accounting software package and three extra hours a month of your office manager's time could eliminate half the \$8000 annual bill you get from your accountant . . . and get you more timely financial reports in the bargain.
- Ask whether paying annual dues to multiple local, state, and national professional societies is still necessary at this point in your life.

Check Your Bank Statements for Daily Deposit Postings

Here's a simple cross-check to make sure that funds coming into the practice are being rapidly deposited. Review the deposits section of your most recent bank statement. In a larger clinic, bank deposits should be made daily and in

smaller practices, at least every other day. It's not unusual for the bank statements of otherwise well-run practices to show just one large deposit every week or two. This holdup in cash flow is easy to overcome—simply establish rules for how often you make a bank deposit

What's an Appropriate Line of Credit?

A line of credit is a prenegotiated credit facility signed with your bank to provide working and other capital for anticipated or unforeseen needs. Think of it as another kind of insurance policy, which should be “taken out” in the context of your practice's unique needs, in addition to the conventional insurance you already have. You obviously don't need a line of credit if you are independently wealthy and don't mind putting your own capital into the business. You may also not need a line of credit if you have a small practice and a lot of business continuation insurance (in the event of your temporary disability) or have an extremely large practice with many hands that can cover the monthly bills if your personal production is knocked out for a time. But for the average practice, to get through times of normal stress (payer hiccups, unexpected absences from the practice, expected bubbles of expenditure on new projects), it's appropriate to negotiate one or more lines of credit equaling not less than three months of expenses. Obviously, like a home equity loan, this should be negotiated well before you need it, tapped sparingly, and used only when other resources are unavailable.

Trust, But Check

Daily, or at least on a frequent spot-audit basis, someone in the practice should audit the appointment schedule, patient sign-in sheet, charts, superbills, and laser log and compare these to the charge ledgers. Missed charges for services provided are common and amount to tens of thousands or more in lost revenues per year in the typical practice . . . all lost profits. Most practice management systems now automate some of this audit work with missing ticket reports and the like.

Physician and Staff Computer Literacy

Every practice, regardless of size, should have two key operators for the enterprise-wide IT system (inclusive of PM or “practice management” and EHR or “electronic health record” components). These staff should each be capable of handling all routine operations, report writing, and moderate levels of troubleshooting. The more geographically remote the practice, the more important a redundancy in these skills becomes, especially if you have taken the leap to EHR. In addition, the sole owner or managing partner of smaller practices should have the ability to use the system. All managers should be comfortable with word processing and spreadsheet/graphing utilities (e.g., Microsoft Word and Excel), and most will have a need sooner or later to use presentation software (e.g. Microsoft PowerPoint). All management staff need Web access and should be comfortable performing research on the Internet.

LASIK—Should We Add Cosmetic Surgery?

On the face of it, providing cosmetic surgery should be a great way to augment cash flow for a practice. But experience shows it’s very difficult for the typical ophthalmologist to add elective plastic surgery to the practice. This is true for several reasons. First, most surgeons are uncomfortable being as “pushy” as it takes to help a patient who has come in to see better understand that you provide other services as well. Vision care deals largely with *objective*, measurable improvements. Both the physician and the patient are mutually certain that there’s been a great operative outcome. Cosmetic surgery depends on the patient’s *subjective* impression of the operation’s success. If you are not currently providing cosmetic surgery and think you might be good at the promotional aspects, start first with Botox injections. The barrier to entry is low, and you’ll learn quickly if you can deal with the patients who say, “I think we’re a-l-m-o-s-t there . . . could we try some more?”

THERE HAS
NEVER BEEN, AND
CANNOT BE, A
GOOD LIFE WITHOUT
SELF-CONTROL.

Leo Tolstoy



What About Hearing Aids?

A few vanguard—mostly large—practices have started to provide audiometric services and dispense hearing aids to their patients. As of this writing, the jury is finally coming

back in on the economic effectiveness of this service. The success factors are the same as in optical dispensing: doctor enthusiasm and advocacy is paramount, followed by the presence of a talented hearing instrument specialist, selling skills, careful recordkeeping and properly sourced retail goods. Practices with these bases covered can do quite well. It will be interesting to see if ongoing sales, year-after-year, are sustained . . . in many practice settings we observe a material drop-off in sales, which may be driven by doctor boredom, or the fact that all of the practice's core patient base have already been exposed to the new offering.

Examine Your Cataract Operative Criteria

Look at the charts of the past few dozen cataract surgeries you've performed. Write down the best corrected pre-operative visual acuity in each eye. Average the resulting numbers, omitting eyes with an acuity of 20/400 or worse. If you're an aggressive surgeon, your average figure may come out somewhat below 20/45. If you're much more conservative, your average figure may be well over 20/60. Obviously, the cash flow and profits of cataract surgeons with the lower average numbers will be more favorable . . . to a point. If you get too aggressive, you may one day find yourself working backward in the cash-flow department, refunding fees (and more) to payers for unnecessary surgery. If you feel you're too conservative because of practice stage, skill deficits, or confidence issues, it may be time to link up with a more assertive surgeon for the benefit of both your patients and your practice's economic success.

Measuring the Surgical Density of Your Practice

Nearly every surgeon wants to do more surgery and spend less time in the clinic. Unfortunately, for those physicians who would rather spend more time operating, surgical volume is directly, proportionately linked to productivity in the clinic: See more patients and you'll find more cases. You can do many things to increase your surgical yield, but none is more important than simply measuring the baseline of the surgical density of your practice today. The math is easy. With it you can assess your own, individual surgical

density or assess the surgical yield in your overall practice if you work in a group setting. Pick a reasonable time frame of at least a full month (although using data from a calendar quarter or even a full year will give you a truer average). You only need two figures:

T—Total number of patient encounters

FREEDOM IS
THE INCREASED
KNOWLEDGE OF
WHAT YOU CAN
DO WITHOUT.

Henry David Thoreau



This figure should include all paying new-patient exams and all returning-patient exams as well as unpaid post-operative visits and surgical consultations. Make sure that you do not count a patient who has an exam and a visual field or other special test as two visits. Only physician or optometrist visits count. Don't count tech-only visits.

S—Total number of major surgical cases

In a general ophthalmology setting, this used to be just cataract surgery but should also include LASIK surgery, glaucoma procedures, and plastic surgery in more diverse settings. Once these two figures are determined, the surgical density of your practice can be expressed as follows:

Surgical Density = T/S

Let's look at an example using these two numbers. Imagine a two-surgeon practice with 750 patient visits per month and 50 major surgical cases per month. The surgical yield would be $750/50 = 15$ patient visits per case—a very favorable number. Said another way, these physicians generate a major surgical case for every 15 patient visits. In the typical private cataract/general practice with which I consult, the average range is 15 to 30 patient visits per case. In extremely young and old practices, and in clinically conservative or operationally neglectful settings, the ratio can be closer to 50. A practice with a high level of optometric referral support can have a surgical density of 5 visits or fewer per surgical case. It's interesting to note that this surgical density holds up in dedicated retinal practices, too, with about one facility-based surgical case for every 25 patient visits.

Prepare for the Cash-Flow Consequences of Any Proposed Action Before You Act

Before launching any new practice initiatives, it's critical that you prepare an analysis forecasting the expected cash flows. If such analysis indicates you may be treading financial water for awhile, you must ensure, in advance, that you have access to any needed capital. Here's a common example: A two-surgeon practice hires a new subspecialist. There are immediate costs for a new professional salary, marketing, equipment, and generally setting up a new nest for the physician. Then problems hit. There's a clerical snafu or a holdup in securing a Medicare provider number, or maybe credentialing for managed care contracts is slow in coming. In situations like this, especially in a practice with a low profit margin, carrying a new associate can make it hard to make payroll for the existing physicians. The time to go to your banker to negotiate a loan or line of credit is before you need the money.

WHEN YOU GO TO
BUY, USE YOUR EYES
NOT YOUR EARS.

Czech Proverb



Remember: Health Care Is a Local Business

Don't overextend your supply lines to distant operations unless you have abundant capital and proven operational competence. For most surgeons, staking out satellite operations more than 25 miles away without planting a home-room physician in the subject market is becoming a very diseconomic business model as fees continue to erode and practice costs continue to rise. Try to have the discipline to keep remembering that success should be measured in profit per surgeon-hour (including travel time), not in cases per month.

It's Not Case Volumes But Profits That Count

Many surgeons with the highest case volumes aren't taking home the largest paychecks. And although they may be among the most driven physicians, they certainly aren't always the happiest. By the time you back out optometric comanagement fees and the marketing costs needed to

IT WASN'T UNTIL
QUITE LATE IN LIFE
THAT I DISCOVERED
HOW EASY IT IS
TO SAY, "I DON'T
KNOW."

Somerset Maugham



drive a top-tier practice, the annual income hero in your town may be someone you least suspect, especially when calculated on a profit-per-hour basis.

Filling the Seats

Here's a great pearl for physicians who still can't quite seem to get their staff to fully book out the appointment template—they have patients booked out a month, but tomorrow's calendar has 48 slots and only 43 are filled. It's deceptively simple. For every day the template is filled 100% with appointments (before no-shows peel this back), every staff member (in a small office) or selected staff (in a larger practice) will receive a \$5 to \$10 bonus. That may seem excessive, or worse, a case of bribing patients to do the job they were hired for. But do the math. Let's say it's a small 12-staff office. Five patients are gained. The average ticket might be \$150. That's \$750. Almost all of it is profit because it's incremental revenue and generates no additional fixed overhead and negligible variable overhead. The cost is 12 staff times, let's say, an \$8 bonus . . . just \$96. And the resulting morale boost alone is worth the cost. Doing this is probably the only way your techs will go to the front desk in the afternoon to ask, "Are you sure we can't fit a few more patients on the schedule for the morning?"

Choices Enhance Profits

Mediocre administrators give their subordinates or their Boards ultimatums: "We must do this!" Exceptional managers give the people they supervise, and those to whom they are subordinate, two or more equally acceptable alternatives: "I've brought three plans for us to consider today. I believe that any one of these you choose can solve the problem we've been wrestling." If, as a manager, you force yourself to come up with at least two viable solutions to problems that land on your desk, chances are you'll at least double the odds of finding the best and most profitable solution.

Central Business Offices

Mergers and acquisitions will become more common as profits are squeezed and owners look for ways to share and reduce costs. As practices merge into larger, regional

“supergroups” with a single professional corporation and uniform governance, one of the first common operational consolidation efforts is to develop a central business office (CBO). A CBO for larger groups will typically contain all patient accounting, accounts payable, payroll, financial reporting, and forecasting functions and be directed by a financially skilled administrator. Often, telephone operators, marketing, and telemarketing staff will be centralized to this facility. Here are a few observations and guidelines for success:

- In the case of a merger, although you may believe you can manage the now-joint practice with fewer business staff, bring all but the obviously unnecessary staff into the central office to start with—resist the temptation to downsize for the first several months. Your initial impressions of who might work well together are rarely correct, and natural attrition will thin the ranks soon enough. Meanwhile, the reorganization alone is enough to reduce output for a time and require that everyone be involved.
- When you do downsize staff, try to accomplish this in just one stage. Dismissing one employee every few weeks kills morale and may lead to the loss of your best staff, who mistakenly believe they may be next.
- Resist, if possible, the temptation to centralize into a neutral location off-site from the member practices. Any desired appearance of neutrality or minor saving on the cost per square foot of office space is likely to be offset by the fact that you are increasing overhead, decreasing proximity, and retarding communication.
- Carefully evaluate the cost benefit of a new, single computer system. Rather than scrapping several perfectly serviceable systems in the interest of being on one platform, it may be more cost-effective to delay centralization of patient accounting for a year or more. With the rapid advances in system features and the still-evolving state of paperless charting, a delay in your system decision could not only spare capital but also give you earlier access to the next generation of system features.
- It is inevitable that some physicians will believe (correctly or incorrectly) that their individual patient accounts are being mismanaged under the new system.

Communication and regular written reporting from the CBO manager to each physician are critical. An individual physician or practice unit should not be handed surprises. If individual physicians or office locations are generating difficulties for the CBO (e.g., incomplete superbills, poor data capture at check-in, poor preauthorization work), these problems have to be acknowledged and worked through one by one, just as in the smallest solo practice setting.

- Make sure the governance of your merged supergroup practice provides you with sufficient central authority to develop and troubleshoot a CBO. Half efforts can be disastrous, with everyone squabbling over system details and staff running back to their previous supervisors to be rescued—all the while receivables continue to soar.

THE BEST MINDS
ARE NOT IN
GOVERNMENT.
IF THEY WERE,
BUSINESS WOULD
HIRE THEM AWAY.

Ronald Reagan



HMO Versus Indemnity Economics

In fee-for-service medicine, one must concentrate on *revenue enhancement* (marketing, building surgical density) because most costs are fixed and profits soar rapidly after a minimal volume threshold is reached. In prepaid medicine, management emphasis turns to *cost containment* because your revenue for a given block of lives under contract is fixed. Most HMO-heavy practices experience a significant profit squeeze when patients and review nurses demand more services, payers demand per-member-per-month fee concessions, and inflation inexorably raises expenses.

Checklist for Selecting a New Practice Computer System

- *Do you even need an entirely new system, or will just an upgrade of your present system suffice?* Make sure that the requirement for a new system is driven by real needs (the core of which is to preserve and improve patient accounts management) and not a physician's passing fancy.
- *Do you have staff with sufficient expertise to interview vendors and make a purchasing decision?* If not, hire an appropriate expert.
- *Do you have at least one in-house key operator?* If you are upgrading to a more robust system with electronic health

records, optical inventory, and other chores beyond A/R management and scheduling, you may need a dedicated information systems director.

- *Have you factored into your transition costs staff frustrations, staff overtime, and likely cash-flow interruption?* Do you have capital reserves set aside to cover worst-case transition scenarios?
- *Are you allowing enough time to make a wise decision?* It's quite customary to study your options for several months, making site visits to existing users and involving the widest-possible cross-section of staff.
- *Are you budgeting enough?* A typical, basic small office system from a major vendor now runs \$50,000 or more.
- *Are you budgeting too much?* An overly sophisticated system will only add friction to your practice's training program and ultimately impede cash flow while wasting your technology dollars.
- *Have you seen the proposed system successfully installed and hard at work in at least two practices comparable to yours?* Have you talked firsthand with staff using the system in these practices?
- *Does your proposed system have a large enough user base?* Newer or localized systems may have just a handful of users and be dependent on a single key guru at the home office. Lose the guru, and you have to start all over again.
- *Is there sufficient customer support in the vendor's home office?* Before you buy, ask a minimum of five ophthalmic personnel who have been using the proposed system for more than a year to give you their assessment of customer support's response time, effectiveness, and patience levels. (Keep in mind that the quality of support is often based on customer size . . . what do the smallest customers say?)
- *Have you had a side-by-side live demonstration of all "finalist" systems you're contemplating?* Nothing will make a salesperson more honest and more price competitive than having peers in the same room.
- *Are electronic health record and business functions equally strong and provided by the same company?* Most vendors in this space are relatively new to EHR . . . and a few still force you to source your system from two companies.

Computer Conversion Tip

When making a conversion to a new computer system, keep the old system up and running . . . and not just to collect old accounts. Run a few trial electronic claims on the new system first. Work out the bugs. Depending on your vendor selection, these may be minimal and you can immediately plow ahead after the test runs and leave the old system far behind. But on the off chance that you have major conversion difficulties, this backup could save a lot of headaches. This may seem like commonsense advice, but many practices have ditched their old systems before their new system was properly tested and had to scramble instead of solving their conversion problems at leisure. Remember, it's not your computer . . . it's your cash flow.

Spot Check for Cash-Flow Hiccups

Every practice manager and lead partner should periodically examine the daily postings of charges and collections. Make sure that these are not excessively clustered as this may indicate staffing gaps, poor work discipline, computer glitches that aren't being reported, payer holdbacks, poor supervision, or a lack of standards.

What Problem Do We Have Today?

Think about it. There are fundamentally only two kinds of business problems.

- *Capacity problems.* The practice has more patients than capacity to see them. More physicians, staff, or facilities are needed—or the resources you have must be used more intensely or over a longer work week.
- *Volume problems.* The practice doesn't have enough business. Thus, more marketing and diversification into new niche markets are needed, or as a last resort, the practice needs to shed excess capacity.

Most growing practices move sequentially through cycles. They have excess capacity so they market or rekindle recall efforts. Then they have excess volume, so they add a physician, and the cycle starts over again.

Helping Your Billing Department

Practice billing departments are always swamped with patient calls after every batch of statements is mailed. You can reduce the traffic somewhat by adding a supplemental insert of “Frequently Asked Questions” to your bill (or printing this on the statement itself, if space permits).

Dividing Billing Office Duties

Patient accounts departments commonly divide their work into payers, with Sally handling Blue Cross, Mary handling Medicare, and so forth. Although this can foster individual expertise, it leaves the practice vulnerable to the departure of any single staff member in the billing office. Depending on the size of your practice, it may be better to divide patients along alphabetical lines. This will force cross-training and build in staff redundancy. This makes things a little harder for the supervisor and the billing staff, but it is ultimately somewhat more protective of the continuity of the practice’s cash flow.

... YOU GET WHAT
YOU NEED.

The Rolling Stones



Save Time and Costs and Increase Security with Bank Pick-up Services

Arrange, if possible, for your bank to pick up practice deposits daily rather than sending a staff member or physician to the bank. Even if a bank run only takes 20 minutes a day, you’ll save at least \$1000 a year in labor and auto costs and reduce the chances for funds diversion or robbery—not a small concern in larger markets—by arranging a bank pick-up. If yours is a larger practice, you may be able to negotiate this as a free service.

How Does Your Practice Compare to National Performance Standards?

It’s a familiar clinical process to measure patients against thousands of reference norms, such as height, weight, pulse, respiration, endothelial cells, intraocular pressure, and visual acuity. As a clinician, you have memorized (at least once) virtually all of the human machine’s normal limits. You use the most relevant norms every day. As a

practice owner or manager, you should become equally accustomed to a few critical ophthalmic business norms. Some of these can be fairly compared to national productivity standards, and some represent an *internal* standard that you can benchmark for subsequent comparison. Here are normal limits for some of the more interesting numbers. (For an expanded list, see Appendix 15.)

Labor productivity I. \$110,000 to \$200,000 or more in annual revenue (collections) per full-time equivalent, non-provider support staff member . . . this figure can be much higher in a subspecialty referral practice such as retina or cataract and somewhat lower in a pediatric setting.

Labor productivity II. 25% to 32% of annual revenue is reasonably spent on gross non-MD wages, exclusive of OD salaries in most cases . . . again, referral centers, along with rural practices, get by with less; practices in major urban centers such as New York and Chicago can spend somewhat more.

Labor productivity III. 0.8 to 1.0 tech payroll hours per patient encounter in a general practice . . . 1.1 in a refractive surgery practice . . . 1.3 in a retinal clinic . . . this figure is highly variable depending on how much work is delegated to technicians. You can have a very financially efficient practice with a large number of techs and an “unfavorable” tech payroll ratio. This is one example of many where it is better to make an ongoing internal comparison rather than trying to benchmark to some national standard.

Profitability. A 30% to 45% pretax, cash-basis profit margin (before physician salary and bonus distributions, and before depreciation) is typical in practices today. We will likely have to accommodate to a 20% to 35% range as normal for general ophthalmology practices in the years ahead. For comparison sake, it is not unusual for a large managed care contract to yield only a 5% to 15% margin on a profit-center accounting basis.

Advertising expenses. Spending 2% to 4% on marketing communications (media, creative, collateral material, outreach, holiday gifts—not including staff salaries for program

I LOVE AMERICA,
BUT I CAN'T SPEND
THE WHOLE YEAR
HERE. I CAN'T
AFFORD THE TAXES.

Mick Jagger



management, telemarketing, etc.) is average around the country. Growing practices and practices trying to hold level in competitive communities typically spend as much as 8%. Significant leadership in geriatric or vision-correction services can require in excess of 10% of total practice revenue. And if expenses are calculated just as a percentage of subspecialty collections (i.e., as a percentage of refractive surgery revenue), it is not unusual to exceed 20% of revenue in a new practice. Pricey? Absolutely . . . but still less than perfume and designer jeans makers, who can spend 50% or more of their sales on advertising.

Facility occupancy costs. It is reasonable for a practice to spend between 4% and 6% of its revenue on lease costs, routine maintenance, taxes, and utilities. This benchmark can give you an indication of the revenue base you should be aiming for to substantiate a move to a larger, more expensive office.

Overtime hours. These should be kept to 5% or less of total staff hours worked as an average, although overtime hours may reasonably climb during any one pay period to cover staff vacations, special projects, unexpected work-in-patients, etc.

Surgical yield. It is typical for a general ophthalmologist with average to moderate cataract surgical volumes to have approximately 25 or fewer patient encounters for every cataract surgery. The ratio falls to just five or 10 encounters per cataract case in higher volume centers (whether that volume is generated by optometric referrals, advertising, or a high-profile reputation).

Accounts receivable ratio. Average the past three months' gross charges. Divide this average number into your current total accounts receivable. The result in a general ophthalmology practice will typically be under 1.5. It would be realistic for this ratio to stretch upward for a workers compensation/personal injury consulting practice or for a practice overly dependent on one slow-paying HMO or with a high ratio of Medicaid patients. And it's typical for practices deeply involved with refractive surgery or other elective care to have a ratio well under 1.0.

For each benchmark, compare your practice to itself over time. Also compare the practice's performance with emerging national benchmarks. Examine your own distinct practice for ratios that would be especially meaningful. Some examples include optical or total practice revenue per square foot, RVUs per year per staff member, and in the optical shop, second pairs sold as a percentage of total sales. *Finally, remember that all the data in the world have no meaning unless they are used to help make management decisions.*

Negotiating Your Way to Higher Profits

In the words of one corporate trainer who specializes in negotiating skills, "You don't get what you deserve, you get what you negotiate." This sentiment applies more than ever to your practice today. In other business sectors, where normal profit margins can be 10% or less, shaving even a point or two from the raw costs of delivering a product or service significantly boosts profits. If you were a restaurateur or electronics manufacturer, wringing out small vendor and labor concessions could make the difference between failure and success. Here are eight pearls you can apply immediately in your practice:

- Too many people crudely think of any type of tough negotiating as "beating up" suppliers. Since your most important vendor relationships are generally long-term, any short-term efforts you make that are unfairly harsh will nearly always come back to harm you in the form of reduced service, inferior products, or second-tier support. Great negotiating is a two-way street; you need to understand where your supplier is coming from and where you are going.
- Negotiating doesn't stop after the service or product has been contracted. Ask for an extension of the 2% net 10-day terms so you can efficiently pay bills just once or twice a month. Ask vendors who don't normally extend discount terms for prompt payments to extend the terms to you as a courtesy or as a condition for doing business with you.
- Learn this by rote: "You'll have to do a little better than that for us because_____." These 12 simple

words, used as the preamble to a sincere description of your true position, can pry open even the coldest vendor's heart.

- Since staffing costs are the largest drain on most practices, look here first for opportunities to negotiate prices down. Even in today's tight labor market, you can hold the line on raises and bonuses simply by improving working conditions—and the starting point for this is to simply have any grumpy physicians in your practice be nice to people. Again, understanding where the "vendor" (in this case your staff) is coming from is the key. Pulling your senior staff or managers together for a heart-to-heart discussion of the practice's financial status and winning their approval for holding the line will mark the start of the rest of your staff accepting limits on wage growth.
- At a pace much faster than once expected, the Internet is changing the way we buy products and services. Not only are prices often lower online, the transaction costs are also lower. What's the value of 45 minutes of your time gained when you buy a business text online from Amazon.com rather than going to a brick-and-mortar vendor? The Internet has created a more rational, commodity-based market for almost everything—including ophthalmic care. Antiquities, hotel rooms and airline seats are routinely auctioned online . . . can auctioning *your* services be very far behind? It's another reason to keep down your cost of doing business.
- Cheapest is rarely best. Although it may be reasonable to get low-cost, scratchy recycled paper goods in bulk at the local warehouse, you must draw the line at false economy. In the long run, is it more profitable to buy a quality surgical instrument from a domestic supplier whose product works flawlessly for years than purchasing an inferior knockoff that will rust after a few autoclavings? What client in real legal trouble wants counsel from the cheapest attorney in town?
- Rather than focusing on one or two areas of the practice, examine *every* category for even modest reductions. In aggregate, small pricing concessions for products or services you use regularly over many years will add up to enormous bottom-line yields. Even vendors with no

AS I GROW OLDER, I
PAY LESS ATTENTION
TO WHAT MEN SAY.
I JUST WATCH WHAT
THEY DO.

Andrew Carnegie



room to move price wise may be able to add value to the overall exchange that saves costs in other dimensions—for example, a computer vendor who can be coaxed into enriching your contract with free training sessions or an extended warranty period.

- Always preserve the dignity of the person with whom you are negotiating. Unless the goods really are in sad shape, don't denigrate the quality of the wares in an effort to get a lower price. Apologize and make it your fault, not theirs, that you have to ask for a lower price. Help that person feel good about giving you a break.

Understand Your Ability to Say “No Thanks”

“Walk-away power,” as in having the power to walk away from a bad deal, is an old term for a commonsense concept. If, as a customer, you have one or more alternative vendors, the advantage is in your court. If you can buy elsewhere, you have the advantage. If you don't have to buy right away, you have the advantage. Always think in terms of what your alternatives are if the negotiations fail. Can you wait a few months and try again? At the very least, even if you only have one choice of vendors and you need delivery *now*, conduct negotiations as though you have a viable fallback position.

What's the Real Price?

Don't ever be too embarrassed to ask for a discount. The worst that can happen is that the vendor will decline. Knowing you are sensitive to costs, that vendor might unconsciously make efforts to shave charges the next time a bid is delivered. Here's a simple new habit you can start tomorrow—a core secret of the very rich—that will save you bundles both professionally and personally: *Always* ask for a better price, even in unexpected places, such as retail stores, where all the prices are marked. This is difficult, even embarrassing, for many people (including your spouse, if you really get into this). So here is some scripting to get you started:

- “I’d like to buy this, but the price is more than I’m willing to pay. Is there anything you can do to adjust the price?”
- “I have a friend who might also want to order one of these. What discount could we get by buying two?”
- “Since you can’t lower the price any further, are there accessories you can throw in?”
- “What’s the lowest price you ever sell these for?”
- “Is there a discount available for paying with cash?”
- “I’m sure I’ve seen these for a lot less. Is there anything you can do on the price for me today?”
- “I can’t tell you who, for obvious reasons, but I know that a colleague of mine buys these from your company for a lot less than you’re offering me.”
- “I’m torn between your product and your competitor’s, so now we’re just down to price. What’s the lowest you can sell this for and still make a fair profit?”
- “Is the price for this going to be coming down?”

I HAVE EYES LIKE
THOSE OF A
DEAD PIG.

Marlon Brando



Remember: You don’t get what you deserve. You get what you negotiate.

Cutting Power Costs

Energy prices are higher than historical averages and poised to head higher still. Here are tips to reduce lighting and power costs:

- Update your thermostat for a timed unit rather than keeping the temperature stable at all hours.
- Relocate work stations that need more light; group them in areas with more natural illumination, if available.
- Ask staff to turn off the lights when they are not needed.
- Install high-efficiency fluorescent or LED lights.
- If you are designing a new building or an addition, or considering taking on a larger lease, reduce space needs to the greatest possible extent.
- Color-code light switches, showing which should be on at all times, which should be on during working hours, and which should only be on for after-hours maintenance workers or security.

Put Your Money to Work

It’s a small matter, especially with interest yields in such paltry territory today, but make sure your practice checking account is interest-bearing or is swept daily to a separate money market account. For the typical midsized practice averaging \$100,000 or more in its working account, this can amount to a small income boost each year.

Graph Your Performance Results

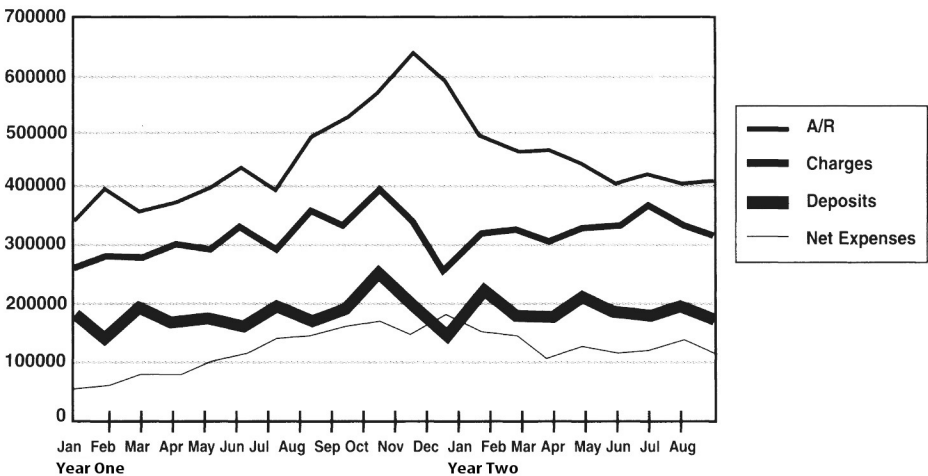
Tracking monthly surgical cases, clinic visits, charges, receivables, and a host of other volume performance data is a critical part of the regular business analysis you should perform in today’s rapidly changing environment. Some surgeons and managers can glance down columns of figures and immediately spot what’s going on. But most do a better job spotting trends when they can see the data graphically. Here’s an example of one such graph with a few observations:

ANYTHING MORE
THAN YOU NEED
IS WASTED.

John Corboy, MD
(Well, actually,
his Mum.)



- The profits of the practice are shown as the area between the bottom two curves.
- The collection ratio is shown as the relationship of the middle two curves.
- A gross impression of the efficiency of the patient accounts department can be gained by comparing the top two curves, showing charges and receivables.



- In August of Year One, accounts receivable started climbing out of all alignment with charges, peaking in November. This was due to the loss of the manager in this department, which left no one who was able to stay on top of claims submissions and collections.
- For the last three quarters of Year One, this client poured an ever-increasing amount of money into advertising. There was a mild increase in charge volume, but the profits of the practice narrowed sharply, culminating with a loss in December.
- With the reduction in allowable charges in January of Year Two, the collection ratio fell somewhat.

The Economics of Adding a Second Physician to a Solo Practice

One of the best ways for a busy, growing soloist office to improve profits is to add another physician. Unfortunately, the founding physician can be too penny-pinching, limiting the choice of associates to those at the bottom of the pack. A more generous approach can be more profitable in the long term. Compensating associate physicians is very dependent on the practice setting, but a general approach is to offer a base salary of \$150,000 to \$300,000 along with bonus compensation amounting to a percentage of excess revenue. Founders commonly overlook the fact that profit gains can often come more from overhead sharing than from passive income because so many practice expenses are fixed. Here are sample numbers to illustrate this:

Parameter	Solo/Founder Physician Before Hiring Second Physician	Two-Physician Practice
Collections	\$1,200,000	\$1,700,000
General practice expenses	\$ 600,000	\$ 700,000
Second physician salary/benefits	0	\$ 250,000
Profit available for founder	\$ 600,000	\$ 750,000

As you can see, general practice expenses rose only \$100,000; the founder’s salary (for the same personal clinical workloads and the risk of hiring a new physician) goes up \$150,000.

Health Insurance Fact Sheets

Patients show up at the front desk daily with questions about their insurance. They're often confused about what benefits they enjoy and the process they must undergo to take full advantage of these benefits. They will likely blame you and your practice rather than their carriers for oversights or coverage gaps. This all takes a toll on staff time, efficiency, and morale. Here's a partial solution: Make up simple fact sheets about the most common payers in your service area and perhaps one generic sheet to cover all the rest. Taking the time to explain, in writing, what copays, deductibles, and refraction fees are all about will have several positive benefits. It will educate patients and likely make them a little more understanding of your role. It will increase consistency and reduce the chance that an uninformed staffer will misguide a patient. It will save staff time and hassle—they can handle the more elaborate or customized questions. And it will likely lead to less resistance to paying for patient-responsible amounts at checkout.

Great Billing Advice May Be Just Down the Street

One of the least expensive and most effective sources for help with billing problems are the staff members at local eye care practices just like yours. You and Dr. Jones may compete vigorously. Although it is unlikely your marketing departments will collaborate, it's very useful to develop relationships between your patient accounts departments. It may even be helpful to formalize this with periodic group meetings to share ideas related to local carrier challenges. It's especially useful if you can network with practices that have your same computer system. One caveat: Just because Mary Jane from the neighboring practice says that something is correct does not necessarily make it so. The higher the stakes, the more you should cross-check multiple sources.

It's Not "Worth" If It's Not Put to "Work"

Billing, coding and compliance consulting firms take pains to research your practice's patterns, and write up their findings. But as the Chinese proverb says, "To know, and not to do, is not to know." Make sure that such reports don't simply sit on the administrator's desk, but that the principal findings are shared with all relevant parties on a need-to-know basis. Sometimes the content of these reports is highly sensitive, so the entire report should not simply be passed around to all hands. However, make sure that any reasonable suggestions for policy changes are the basis for rewriting your protocols and scheduling appropriate auditing and training sessions.

"Do We Have *All* Your Insurance Information?"

In every insurance department, a significant amount of rework is done chasing down blind alleys for payment. You can eliminate some of this by making sure the front desk always asks patients about their copayer status and makes copies of all insurance card changes. It's frustrating to bill the incorrect secondary payer and then have to start all over with a new payer. This points out, once again, the value of having the patient accounts and front-desk staff under a single department head so that problems in one area can be smoothly resolved in a contributing area.

Inspect What You Expect

It makes anyone nervous to have a supervisor hovering around, ready to pounce on errors. That's why it's more effective, and more humane, to let your staff know—in writing—what kind of performance you expect. Make it clear that charges for the day's services should be posted by the end of the same service day or by noon the following day, whatever your policy dictates. It's not fair to hold people accountable for occult policies and procedures. Write it down . . . train to what's written . . . then inspect at will.

THE DOCTOR WHO
HEALS FOR NOTHING
IS WORTH NOTHING.

The Talmud



Are You a Fast or Slow Technology Adopter?

Every practice likes to think of itself as leading edge, up on the latest knowledge and at the ready to provide the latest services to patients. Right? Well, like every other part of your practice, it's a question of balance. Unless you work in a setting supported by unlimited grant money, you must pick and choose as new technologies and techniques arrive. If your policy is too liberal, you could spend hundreds of thousands of dollars a year on gadgets, many with doubtful clinical application or financial rationale in your setting. Unfortunately, an increasing number of practices are sinking under the weight of a too-rapid adoption curve. But the opposite, using the same old rattletrap equipment year after year, is just as damaging to a practice, and to the quality of patient care. Ask yourself and trusted colleagues, "Are we too fast, too slow, or just right in adopting new technology?" In general, most ophthalmologists are weighted toward the former and their administrators must put a foot down around the time of the national meetings.

LEAP AND THE NET
WILL APPEAR.

John Burroughs



It's Not Your Phone, It's Your Business

In the auto-attended world we've all gritted our teeth and become accustomed to reaching a recorded message. With rising staff costs, it's not unusual for practices to succumb to the cash-flow trap of having a skeleton phone staff and resorting to auto-attendants for callers. Don't do it. Ophthalmology is best and most profitably performed with as much of the human touch as possible. For example, resorting to the false economy of automated appointment reminder calls is similarly ineffective. Practices that use automated calling for appointment reminders may have their no-show rates increase 50% to 100%. The norm in most general/suburban practices is a 5% no-show rate. In a practice seeing 50 patients a day, that's two or three patients a day. Losing an extra two or three patients by using a computer rather than having a clerk (even a very junior one) call results in \$350 or more in lost revenue for the day. A clerk can rescue this by getting the job done in 90 minutes at a cost of about \$30, including phone charges and floor space. Not a bad return on investment.

Read Provider Contracts Before Signing . . . Then Keep Checking

Don't assume you have to accept every contract that comes across your desk as it's written. If you have any kind of negotiating position (you don't really need the patients, the payment level is borderline, or the payer is notoriously late in paying), consider coming back with suggested changes to speed or increase payments or reduce paperwork. Make sure, to the extent possible, that every contract has a fee schedule attached, even though it can be changed at a whim by most payers. Periodically, ask for updated fee schedules and compare your actual payments per the EOB with this fee schedule to ensure you are still being paid per the contracted allowable amount.

Spread Payables Duties Around to Ward Off Diversion

It's not unusual, especially in smaller practices, to have one office manager or bookkeeper review vendor invoices, write the checks (even sign or stamp them), prepare the general ledger and profit and loss statements, *and* reconcile the bank statements each month. This clearly provides many opportunities for embezzlement. A physician (the same person each month for consistency) should sign all checks above trivial amounts (let's say \$250 to \$1000, depending on how you define "trivial"); the office manager can sign checks below that amount. Checks ready for signature should be attached to the relevant invoice, and the purchase agent or other person who can verify the bill should sign off on the invoice. The monthly general ledger (showing all checks as a separate line item, arranged according to your chart of accounts; for example, "utilities") should be reviewed by the physician. If the physicians see anything unusual about any vendor or see a vendor name that looks fishy, they should ask about it. Reconciliation of the bank statement to the general ledger should typically be performed by the practice's outside accountant as another safeguard against diversion.

When Should I Pay This Bill?

The answer is, “It depends.” You should certainly pay it no earlier than it is due. And you may want to stretch out payment as long as possible if your practice is in a cash-flow bind (as increasingly happens in the first quarter of the year, even in well-run practices). On the other hand, you want to secure every possible discount by paying early. Any “2% net 10-day” accounts (where you subtract 2% from the bill for paying early) should obviously be paid within the 10-day window.

Aging Your Payables

We’re all familiar with the concept of aging your receivables to have some sense of where the practice stands in terms of collecting outstanding accounts. It’s much less common to age payables in a service-sector business such as ophthalmology, in which most trade payables are paid within 10 to 45 days. But this is exactly what you should start doing if you find yourself in any financial tight spot . . . to the point of having to start stretching out vendor payments. If your payables cycle is stretching past 45 days, be proactive, and let your vendors know when payment can be expected.

Should Our Accountant Audit My Practice?

Periodic deep or even shallow auditing of the practice’s books by an outside accountant is an often overlooked area of good practice management hygiene. This need not include the full green-eyeshades treatment but should encompass just a half day snooping around once or twice a year. The key value that emerges from this review is physician peace of mind. The secondary gains include: (a) the staff knows that someone will be looking over their shoulders periodically, so their work tends to be a bit neater and any thoughts of larceny are dampened, and (b) as you grow, your accountant—by orbiting more closely—will be in a position to suggest improvements in funds flowing through the organization.

Embezzlement Proofing

Making your practice embezzlement-proof starts with selecting trustworthy staff. Trust your instincts, and back your instincts up with deep interviews with prior employers, background checks, and professional testing where indicated. Be on the lookout for staff who display an unexplained change in personal spending habits, who are reluctant to take earned vacation time, or who act oddly possessive about their work materials.

Every Financial Tool Should Agree

Your practice has a number of financial tools to measure volume performance, collections, and cash flow. You likely have an appointment module and can cross-correlate this to any missing fee slips/superbills for the day, which should in turn tie to posted charges and patient-responsible amounts received on that day. Charges, collections, and bank statements (and their reconciliation) should eventually tie in with the practice's profit and loss statement and its various operating segments. These various tools should be closed out at the same time, to the extent possible, and be in agreement. Only a few practices actually tie their disparate financial reports together in this fashion. Those that do have a better chance of spotting sloppy entries, inappropriate write-offs and out-and-out theft.

Track the Volatility of Your Average Collections, Average Charges, and Other Graphs

You may not pay particular attention to the financial details, but you can at least monitor the overall stability of your practice's financial pulse by graphing each month, for a 24-month or longer timeframe, the monthly collections and charges divided by the number of patient visits. Obviously, the average charge per patient will be more stable than the average collections per patient visit because in the latter case, you are collecting for services rendered 30 to 60 days ago or more. However, any excess swings and volatility in these graphs that are not explained by similar

OUR DOCTOR
WOULD NEVER
REALLY OPERATE
UNLESS IT WAS
NECESSARY. HE WAS
JUST THAT WAY. IF
HE DIDN'T NEED
THE MONEY HE
WOULDN'T LAY A
HAND ON YOU.

Herb Shriner



wide swings in vacation time are warning signs that can be tracked down to their source.

“Payer, May I?”

It’s a very complex variation on the children’s game, “Mother May I?” that managed care payers play with physicians and their staff. Lack of referral and treatment authorization leads to millions of untracked dollars in lost fees to ophthalmologists annually. In the hum and flow of the typical urban practice, it’s not practical, or expected, that you will win the game 100% of the time. Just like in kindergarten, you are going to lose concentration and slip up on occasion. The best remedy is to have sufficient staff and sufficient training to cover the best efforts of payers to not pay (which is of course the way they win the game.)

As with any game, you need to study and understand the rules. You must make sure that all the players in your practice know the rules. And every time you lose the game by slipping up, you need to huddle with the rest of the players on your team to know how many points you’ve just lost and run through the ways this can be prevented in the future. That’s the generic advice; the regional variations on this frustrating game are something you have to learn by experience in your own setting.

When in doubt, always check. Create a grid by payer showing what services are allowed by which providers in your practice after certain preauthorization steps are taken. Have all staff and physicians memorize the grid. Always be suspicious with payers you don’t serve often. Along the way, be sure to keep the patient (the unfortunate pawn in this game) as educated as possible. Unfortunately, unless otherwise informed, patients will blame *you*, not their carrier, for any limitations on their access to your services.

Did This Test Really Happen?

Visual field and similar testing equipment that prints out results should be checked periodically to make sure that the printed reports reflect the correct date. Failure to show the correct date during an audit could lead to some

embarrassing explanations on why the chart date conflicts with the printout date. Add this to your weekly or monthly checklist in the office.

Are You Sure?

A similar “picky detail” problem can occur with special tests that require follow-up reporting or interpretation by the ordering physician. If this reporting is absent from the chart, the relevant service cannot be billed. Develop a protocol in your office to make sure all special testing has been subsequently interpreted. This can be done by comparing the written log for the special testing equipment (or the patient accounts printout) with the contents of each subject chart. If periodic audits show you are following up 100% of the time, you can reduce the audit frequency. If your practice has an intractable problem with this, it may help to establish a routine in which all special testing printouts destined for interpretation are held back until the interpretation is completed.

UNDER CAPITALISM,
MAN EXPLOITS
MAN; UNDER
SOCIALISM, THE
REVERSE IS TRUE.

Polish Proverb

More Detail Work to Catch Billing Gaps

In the heat of battle, it's easy to forget to document special testing or treatment on the superbill. Here are a couple of quick cross-audits. First, the number of A-scans should be roughly the same as the number of cataract surgeries in any given month. Second, every unit of testing and treatment equipment should have a use log showing the date, patient name, and appropriate utilization records. When you compare the gross number of Nd:YAG laser treatments on the log for the past month with the number of Nd:YAG treatments charged out for the same time frame, the numbers should match exactly.



Differential Collection Ratios as a Marker for Billing Snafus

In a multiphysician practice, it may be revealing to look at the collection ratio by physician. Of course, there will be a variance based on practice patterns and patient mix. Pediatric ophthalmologists and LASIK surgeons in the same practice will have markedly different ratios for obvious

reasons. But for two general ophthalmologists in the same practice, the collection ratio should be essentially the same. When it's not, look for the obvious and the subtle disparities. Is one physician the sole contractor for a low-paying contract? Or does the behavior of one physician (e.g., hoarding charts after surgery; not dictating or coding the case for several weeks) explain the difference? One source of this kind of problem occurs when the patient accounts team gives the senior physician's accounts the VIP treatment because he or she signs their checks and pays less attention to the open accounts of junior physicians. Harness the natural competitive feelings within a practice to optimize everyone's revenue yield.

Options to 100% ASC Development and Ownership

What should you do if you don't have the necessary cataract case volumes, risk tolerance, or management coverage to develop your own surgical center? There are basically three options:

1. *Join in the syndication of a group ASC.* This may be an ophthalmic-only center or a multispecialty center. Your costs and risks will be much lower, but keep in mind that your returns, in percentile terms, are also likely to be lower . . . especially with a multispecialty center. Such facilities can have only a 20% to 35% profit margin, whereas the profit margin of dedicated eye ASCs is commonly 35% or more.
2. *Turn to a development/management company to carry the ball.* This allows you to own (and be responsible for) half or less of the facility and may help diffuse difficult local politics of bringing other partners into the deal.
3. *Rent facilities and staff by the day from an appropriate local facility and have the benefits of your own private space, but with no investment outlays or capital at risk.* This approach can be a potential bridge to developing your own dedicated facility (when your numbers slowly rise). With this option, there is typically no noncompete agreement in place, as there would be with options 1 and 2.

MONEY YOU DON'T
EARN IS NOT GOOD
FOR YOU.

John Corboy, MD



Basic Capitation Contract Caveats

Capitation contracting for ophthalmology and for Medicare beneficiaries continues to wax and wane depending on the market. Strong pockets of prepaid care continue to hold on in selected markets. We can forecast that health costs will continue to escalate at a double-digit pace, and some HMO-like products will find their way back onto the market and into your billing office. Here are some very basic issues and warnings related to such contracts:

- *Look carefully before leaping.* What may seem like a great way to beat the competition may end up leaving them time and the inclination to redouble efforts to get higher paying patients . . . and leaving you with the low-paying contracts.
- *Review the covered services in the contract.* Especially check to see whether you will be responsible for subspecialty care. If so, and you don't have in-house subspecialists, the cost of such care with outside providers will be subtracted from your payments. This is an easy way to "blow your cap." Try to get the HMO to pay for outside subspecialty care directly.
- *What starts as incremental income for your practice, selling unused incremental time, can turn into major time commitments that edge out better paying patients.* Make sure that any single contract (except Medicare) never exceeds 15% to 25% of your total collections.
- *It is typical for HMOs to withhold 10% to 20% of the capitation fee to cover losses that result from overutilization.* In evaluating your go/no-go with a potential contract, base your decision on the least, not the most, amount you are assured of receiving. You must also review the contract closely to ensure that you will not be obliged to cover any overutilization losses that exceed the withheld amounts.
- *Beware of accepting prepaid contracts for small beneficiary pools.* The actuarial statistics work for large pools but break down with smaller groups of patients.
- *If possible, negotiate capitation payment increases indexed to any increases in premiums charged by the HMO to employers.*

POVERTY IS NO
DISGRACE TO A
MAN, BUT IT IS
CONFOUNDINGLY
INCONVENIENT.

Sydney Smith



- *Capitation payments are made monthly, accompanied by a statement showing the number of beneficiaries.* Watch this statement for adverse trends, especially any that reduce the beneficiary pool to a size that invades the actuarial soundness of your capitation payment. Negotiate in advance if possible to be guaranteed a minimum number of assigned patients.
- *Medicare cap rates are obviously higher—often 4 to 6+ times higher than cap rates for commercial-aged patients.* This is because of the much higher utilization rates of older patients.
- *Remember that accepting your first capitation contract in a group practice obliges a close review of your group's compensation model.* Compensation directly based on utilization (RVUs, visits, surgeries) will cause physicians to increase their utilization (to get a larger share of the cap-fee pie), which decreases the profit per unit of service rendered. It's more rational to divide capitation fees based on assigned patients so that each physician's incentives (to not overtreat) are aligned with the HMO's payment methodology.

Are Multiple Fee Schedules Allowed?

If you are a typical ophthalmic practice, most of your revenue comes from Medicare. Maintaining just one fee schedule for all payers usually works well. Keep your gross charges about 50% above allowable Medicare rates, but be sure that you match or exceed the fees paid by your most generous commercial payer. If you are receiving from Medicare 100% of any of your charged fees, it may mean that Medicare's allowable fee is higher than your charge. Make sure fees are reviewed annually to keep up with changes. Patients see your fee on their explanation of benefits statement and may perceive your high fee as an attempt to overcharge Medicare. To avoid this, and to avoid large write-offs and an inflated A/R, some practices have two fee schedules—one for Medicare and one for all other carriers.

When, During a Visit, Should You Collect Copays and Deductibles?

Managers and owners of most practices have strong opinions about when copayments, deductibles, refraction fees, and any other patient-responsible amounts should be collected. Most conform with local custom, the experience of each practice, and the policy to which the patients have been habituated. At the most aggressive practices, especially those in rural markets where “tricking the physician” seems to be a community pastime, office managers get the money up front as often as they can—before the patient is allowed to see the physician. Any past-due amounts from prior visits are also collected with a vengeance. This may seem mercenary, but it is necessary in an increasing number of settings. At the other end of the spectrum are practices that collect nothing at the time of service. They end up having to chase after patients with three letters and a phone call for a \$25 copay. In the average setting, both extremes are skipped in favor of payment at the time of checkout, or capturing each patient’s credit card, an increasingly common practice

I DON’T BELIEVE IN
MATHEMATICS.

Albert Einstein



Refraction Fee Trends

A generation ago, only a few practices charged a refraction fee . . . and then it was more of a nuisance fee than a reasonable exchange for the value conveyed to the patient. That has all changed, and now a typical refraction fee is in the range of \$50—a few bold practices are now exceeding \$100. The highest-priced practices report, somewhat cynically perhaps, that “whoever is going to complain about a refraction fee is going to complain, no matter what we charge . . . so we decided to charge a premium, which offsets fee cuts a bit, pays us a fee that induces us to provide a superior level of care, and compensates us for the tongue-lashing we get from a very small number of patients. No one else seems to mind.”

Give Yourself as Many Second Chances as Possible

Most practices and most surgeons really don't try very hard to *make the sale*. The gentility of the average surgeon (and by abstraction, the management team) is not in sync with our increasingly difficult cash-flow environment in eye care. Here are just some examples:

- *Practices that let patients walk out the door with their eye-glass prescriptions but do not make a follow-up call.* When the practice does call, it learns the patient did not buy the eyeglasses at its in-house dispensary. When this happens, the practice is no longer able to offer that patient a 30-day coupon for \$25 dollars off to prove that its dispensary does the best job in town.
- *Practices that send out information to prospective LASIK patients without making a series of follow-up calls* to ask the patient to take the next step and have a consultation.
- *Surgeons who send patients home with a pat on the shoulder*, saying, "Well, Mrs. Arnold, you think about that cataract surgery and call me if you have any follow-up questions" instead of saying, "Well, Mrs. Arnold, you think about that cataract surgery and in about a week I'll have my chief medical assistant, Mary, give you a call to answer any follow-up questions. Meanwhile, here's a free DVD on cataract surgery you can share with your husband and daughter."

IT'S NOT A PROBLEM
IF YOU CAN AFFORD
TO PAY YOUR WAY
OUT OF IT.

Harvey Mackay



Aging Report Pearls

The standard vanilla-flavored aging report lumps all payers together and only has aging buckets for current, 30, 60, 90, and 120+ day accounts. Consider generating your reports by carrier so you can spot adverse trends associated with slow payers. Also, if your computer allows, consider expanding the buckets to allow 121 to 150 days as well as 151 days and over categories. As a physician-owner or administrator, you should meet with your patient accounts staff monthly. Ask about the status of individual patient line items at random. If your staff can recite from rote (or at least from the notation fields on their screens) the status

of high-balance/older open accounts, you will have some assurance they're on top of the details.

What Is a “New” Patient?

It all depends on what you're using the data for. In the world of practice marketing, a new patient is just what you would expect—a patient who has never been a customer. However, with respect to reimbursement, Medicare defines a new patient as one who has not received services from you or another physician of the same specialty within the same group practice within the past three years . . . which means you can bill for a new patient visit.

Learn in a Flash

Let's face it. Most patient-accounts work is mind-numbingly dull. If marketing is the sizzle of practice management, billing work is little more than scrubbing the frying pan, but it's obviously equally important . . . or even more so. So, how can we get physicians, techs, and others in the practice who need to know coding and reimbursement details cold up to speed? It may help to develop a set of flash cards. These can be specific to the needs of your individual practice and be prepared at a simple or more complex level depending on the skills of your staff. You can prepare a basic set for all staff and more advanced versions for staff who need a higher level of mastery.

Portable Brains

Of course, no matter how much you study coding, charting, and reimbursement, there are going to be dark corners that you never commit to memory, especially if you don't work with billing daily. Consider laminating in plastic one or more cards with a “cheat sheet” of relevant details that can be kept handy in a lab-coat pocket and refreshed periodically.

Aging Report Accuracy

Aging, or “aged trial balance” (ATB), reports should be run based on the date of service, not the date of charge posting or submission. A billing department that generates the

latter kinds of ATB report unwittingly makes it appear as though cash flow is better than it actually is. I've seen situations in which the billing managers (with some guile) rigged the reports so that the office appears to be very current in its accounts receivable management. You'll never know how polished your billing department is until you ask the right question: "Do you age by date of service, by date of charge, or by date of submission?"

Annual Amnesty Program

When a patient owes the physician a little bit of money, the patient is in trouble. When the patient owes a lot of money, it's the physician who's in trouble. The pearl that follows may not sit right with every practice, but it may be helpful in your setting: Some clinics have a soft heart, and every year they gather patients who still haven't paid their bills despite multiple demand letters. And they have not yet sent these accounts for collection (which they probably should have done much earlier). Before doing that (or in lieu of that if you're really a softie), send a last letter stating that if the patient in arrears pays just X% of the bill by December 31, the balance will be waived in the spirit of the holiday season.

CHAPTER 4

STAFF EVALUATION, TRAINING, AND SUPERVISION



*Great works are performed not by
strength but by perseverance.*

SAMUEL JOHNSON

Selecting a New Senior-Level Administrator

As the average ophthalmic practice size slowly continues to grow in America, a few practices are realizing they have outgrown their office manager. For the typical practice in this situation, months or years can be spent pondering what kind of manager is really needed and how he or she should be recruited. Here are a few guidelines for your consideration.

- Regardless of age, I steer toward maturity. When leading searches, I often expect the final candidates to be 40+ years old. Management is less a “learned” profession like medicine or law, and more a slow absorption of case histories and personal growth . . . this takes time.
- I do not have any experience-based bias for men versus women. I’ve seen terrible and wonderful on both sides of the aisle.
- Chemistry between the managing partner, the board of owners, and the new manager is *absolutely essential*. This is why it’s reasonable to trust your instincts when hiring (but to not stop there when vetting a candidate.)
- You need someone tough enough to stand up to you and simultaneously respectful enough of your ownership position to accede to your wishes gracefully when he or she doesn’t necessarily concur.
- Ideally, your practice should affirm a strategic business plan and then hire the right person to execute the plan—the reverse is more common and less effective.
- I do not put great stock in advanced degrees. Business management depends largely on integrity, a repository of case histories, abundant energy, leadership by example, self-deprecating humor, and the ability to harbor and deploy resources. An MBA or accounting degree, while helpful, is secondary. I’ve had high school dropouts run major practices effectively . . . and PhDs blow them up.
- Once you have narrowed your search by reviewing CVs and conducting brief phone interviews, credential final candidates through deeper follow-up interviews, supervisor and staff reference reports, and a review of their

DO OR DO NOT.
THERE IS NO TRY.

Yoda



writing samples. The top two or three candidates should be brought in for on-site interviews that last at least two days.

- Give candidates reasonable access to financial and volume performance data, and have them meet with a wide cross-section of staff. Candidates should present formally and verbally to the board of physicians at the end of their two-day on-site visit and should be requested to follow up with a written description of what they would do in their first year on the job.
- The finalist/s should be brought back for a final interview.

Your Administrator as an Increasingly Important Strategic Resource

The prominent difference between average and exceptional practices once resided almost solely in the skills and ambitions of the physicians. But we have now entered an era in which administrators’ abilities—and the responsibilities they are accorded—are quickly becoming a prime determinant of practice success. It makes perfect sense that this should be happening now. Over the past decade, there has been a great convergence in ophthalmology, with increasing agreement on surgical techniques and increasing documentation of the preferred care pathways. The star surgeons are no longer the only ones doing vanguard procedures . . . they have generously shared their trade secrets with colleagues. As the “product” becomes more uniform and physicians come to a degree of relative parity, the competitive advantage of one practice over another is shifting somewhat to a greater emphasis on the contributions great management can make. This trend is having knock-on effects at several levels:

- Administrator salaries are continuing to rise.
- Young physicians considering an employment offer are asking for the first time about the credentials of the practice’s management team.
- A larger percentage of managers see their work in eye care as a lifetime career.

- Physicians once brushed off the loss of their administrators . . . they now call in a panic, eager to recruit a “star” who can turn their practice around.
- Managers could once slide by just showing up for work and being affable. Today, as profits wear thin and competition grows, the low performance of an ineffective administrator stands out plainly—and must be dealt with quickly.

With this in mind, it may be time to ask, “Do we have a sufficiently strong manager to orchestrate our success?” No manager knows everything, or has equal skills in all aspects of running your business. Managers strong in finance can be appalling at staff relations and vice versa. All the same, today’s manager must have a broader skill set than at any time in the history of ophthalmology.

Most eye surgeons not only can’t see the forest for the trees, they can’t see the leaves for the cell membranes and mitochondria. A manager’s obsession with business detail must match the obsession found in ophthalmology. Great managers with this kind of obsession enjoy the trust and respect of the physicians they work with, which leads to a positive spiral of greater influence, better results, and even more respect. The opposite effect, a negative spiral, ensues when the physicians don’t trust the administrator. This results in frequent administrator turnover, low staff morale, frustrated boards, and a chronically faltering practice.

Can I Just Manage My Own Practice Without an Administrator?

Lay managers play a vital role in ophthalmic offices, large and small. Indeed, as the medical management world continues to become vastly more complex and competitive, there is an increased need today to employ a competent administrator. But there’s a reasonable counter argument, which may read like heresy in a publication dedicated in part to serving practice managers: *Not every practice needs a manager*. In fact, several practices (some quite large) seem to get along fine for years without an administrator on board. It’s nearly always impractical for smaller practices to *not*

PEOPLE ALWAYS
ASK ME, “HOW DO
YOU TEACH CORE
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ANSWER IS, YOU
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IT’S TO GET PEOPLE
WHO ALREADY
SHARE YOUR CORE
VALUES.

Jim Collins



have an office manager. In these practices, managers likely do more than supervise. They roll up their sleeves and provide direct patient care, or they handle the billing work. At the other end of the spectrum, it's similarly unrealistic to run a \$10+ million multiphysician practice without a savvy administrator. But practices between these two extremes, particularly those in the \$2 million to roughly \$4 million range, should know that it has been proven to be not only possible to get by without an administrator and adopt an "MD-as-CEO" leadership model.

Several factors must be in place for this to be successful:

- At least one physician-owner must be extremely engaged, willing to put in eight hours or more per week as the managing partner of the practice.
- There must be a second tier of high-functioning middle managers; this typically includes department heads for the technical team, optical, reception, bookkeeping, and patient accounts.
- There are frequent formal meetings and a lot of communication. It also helps if you work in a less challenging environment, with lower growth rates, little external competition, and a minimum of physician-to-physician frictions within the practice.

Several pathways lead a practice to forego an administrator. The most common, in my experience, is a series of failures in recruiting or keeping a lay manager. Such practices start out administrator-free by default, not by active choice. Other practices make an active choice to do without an administrator, or they wean themselves from having a manager as their administrator semi-retires and slowly withdraws.

The advantages of running a midsized practice without a designated administrator can be compelling:

- The organization is "flatter" because a layer of management has been removed.
- Middle managers are often happier; they enjoy directly reporting to the physician-owner rather than to an intermediate supervisor.

- Middle managers are higher functioning because they have had to learn to work more independently.
- The costs are lower and the profits higher because you can add most of a higher salary to the bottom line.

Of course, there are downsides. Many practices without a strong administrator at the helm rely more heavily on outsourcing when senior expertise is needed. Used to excess, these external resources end up costing more than one competent, multidisciplinary administrator.

In my experience, most practices that operate without an administrator do so for a finite number of years and then go back to the orthodoxy of a full-time administrator. They do this because the managing partner's enthusiasm and time availability have waned or because the practice has outgrown this administrative model. In many cases, practices that never really found the right person for this critical role eventually come across a great candidate and return to having a manager.

I START WITH THE
PREMISE THAT
THE FUNCTION OF
LEADERSHIP IS TO
PRODUCE MORE
LEADERS, NOT MORE
FOLLOWERS.

John F. Kennedy

Employee Background Checks

Unlike larger industrial employers, few practices perform formal background checks on prospective employees. Subject to input from your labor attorney, and based on state law, if you are hiring for a critical position or have become gun-shy from poor hiring choices in the past, consider engaging the services of a specialty firm that performs background checks and can help you interpret the results.



Are You Overstaffed or Understaffed?

As was touched on in Chapter 3, the productivity of your practice's nonphysician support staff can be assessed with two common ratios. The first is a simple percentile ratio derived by adding up annual lay support staff wages, payroll taxes, and benefits and dividing the resulting total figure by your practice's annual collections. In a general ophthalmology practice, the typical range falls between 25% and 32% . . . with that much of each dollar collected going back out for lay support staffing costs. It's likely your largest single cost of doing business. Too low a wage/tax/benefits ratio can indicate that you have insufficient

EXCELLENCE IS
NOT AN ACT
BUT A HABIT.

Aristotle



support in one or more areas of the practice. The result can be physicians who are held back from reaching their full efficiency or reimbursement claims that go unpaid for lack of accounting staff. With too few staffers, burnout among the remaining staff can precipitate further staff loss, leading to critical operating deficiencies, low morale, and a downward spiral for the practice.

Spending at or above the upper end of this percentile range doesn't necessarily mean the practice is healthy . . . or even sufficiently staffed. In this increasingly cost-conscious era, it's still not unusual for me to evaluate practices in which staffing costs exceed 35% of revenue. This is most commonly observed in fine, older practices with well-intentioned, long-term staff whose physicians and managers have never adjusted to the new economic climate. Walking the halls of these practices, I'll often find tech staff standing around waiting to do the physician's next bidding. *This is not their fault*, but it happens because they do not have sufficient training and supervision to simply leap in and do the next task before being asked.

The second common ratio you can use to evaluate staffing efficiency is to add up the number of support staff "full-time equivalents" or "FTEs" (a technician working 40 hours per week is 1.0 FTE; a clerk working 30 hours per week is 0.75 FTE) and divide this into the practice's annual collections. Normal limits for this ratio are \$110,000 to \$200,000+ in annual revenue per FTE in a typical general ophthalmology practice, with many variations depending on your circumstances. The figure can exceed \$250,000 in retinal settings. A too-low figure can be something you have to simply live with (as in a Medicaid-biased practice with an abundance of patients and a paucity of revenue).

It's not unusual for practices to have one ratio be within normal limits and another benchmarking ratio be outside of norms. An urban practice in Chicago or Manhattan with high regional labor costs (where tech wages can reach and exceed \$30 per hour) will commonly have excessive percentile labor costs but be within norms for annual revenue per FTE. Rural practices often experience the reverse effect.

Low wages can depress percentile costs to 20% or less, but annual revenue per FTE is held back because household income is too low to drive ancillary optical sales or elective care.

Please keep in mind that your practice's numbers (like your patient's physiologic measurements) need to be examined as a composite of many different scores, some of which are likely to be a little off in even the healthiest practices. This underscores the importance of using all comparative ratios not just as an external reference standard for how your practice compares to sister organizations, but also as an *internal* benchmark to measure the impact of your efforts to continuously improve the practice over time.

Getting Comfortable with Confrontation . . . and Honesty

I learned a long time ago that unlike soldiers, attorneys, and professional wrestlers, eye surgeons don't like confrontation. Sure, you'll confront a half gram of obsolete tissue just fine, from behind the safety of a phaco probe . . . but are you as willing to address staff members or colleagues who are acting out or underperforming? In many cases, the answer is "no." The reasons for this could fill a pop psychology text, but I believe it boils down to a few simple facts about how physicians are constructed.

Most men and women who are eye surgeons today started out wanting to please others (performing for parents and teachers) and wanting to avoid embarrassment or censure (which is why most ophthalmologists are so deeply stung when patients complain about a surgical outcome). The culture of any business is driven from the top. So, when these same physicians are unwilling to confront practice problems head-on, so are the rest of the staff members. As a result, many practices, over time, become larded with occult frustrations, hurt feelings, and a resistance to diving into controversial areas. Such practices are rife with "triangulations," where Dave talks to Sally about Bob but won't confront Bob directly. This can reach damaging proportions. At a clinic I visited some years ago, a junior physician, "Dr. Wild," was performing unnecessary surgery,

EVERYBODY IS
IGNORANT . . .
JUST ON DIFFERENT
SUBJECTS.

Will Rogers



flagrantly upcoding his exams, and being verbally abusive to patients and staff. The senior physician knew it. The office manager knew it. And so did the staff. In fact, all of these people talked about these issues behind Dr. Wild's back—but nobody confronted him directly. Not confronting issues can destroy a practice, whether the unspoken issues are major—physician impairment or sexual harassment—or there is simply a cluster of smaller issues.

Much of what really works in practices with this problem is summed up in the concept “radical honesty.” According to the Web address of the same name (www.radicalhonesty.com), radical honesty is communication that is direct, complete, open, and expressive. Radical honesty means you tell the people in your life what you've done or plan to do, what you think, and what you feel. It's the kind of authentic sharing that creates the possibility of real intimacy. The practice of radical honesty is based on the work and writings of Dr. Brad Blanton, a psychologist who found that the best way to reduce stress, make life work, and heal the past is to simply tell the truth.

THE AVERAGE DOG
IS NICER THAN THE
AVERAGE PERSON.

Andy Rooney



Post All Significant Policy Changes Before Implementing

People hate change. Even change for the better is stressful. You can reduce this stress by adding a simple rule in your practice. Whenever you have a new office policy, large or small, write it up and post it prominently for a week of open comment. Even if management has already made a firm commitment to the new policy, giving staff a voice and time to adjust to the new rule will take the edge off even the most unwelcome directives.

Hire the Pleasant . . .

Here's an old perspective from the hotel trade: “We can train anyone to do any job in this hotel, from busboy to general manager . . . but we can't train our staff how to be ‘nice.’ Being nice is the only essential skill they have to bring to the job.” Evaluating your next job applicant in this dimension isn't hard at all—it's pure gut instinct and common sense. Ask yourself at every initial interview, and ask

each candidate's references, "Is this person nice?" No matter what their other qualifications, pass up all candidates who don't pass this simple test.

... And Hire People Who Need to Work

I'd like you to put this book down for a moment and think about the best workers in your practice. Think about the people who show up on time, try hard to please you, and consistently outperform their peers. Now examine these individuals as a group. What do they have in common, beyond being your best staff? Chances are, you'll reach the conclusion that these are the people in your office who *need* to work. Single mothers with no other source of income. A mature worker who neglected saving for retirement and needs to catch up. Asking job applicants, bluntly or indirectly, why they need to work may become one of your most important applicant screening questions.

Beyond *The One-Minute Manager*

Before Sea World thankfully stopped training killer whales, management guru Ken Blanchard, whose contributions started with his now-classic book, *The One-Minute Manager*, did it again with *Whale Done*. In synch with Blanchard's easy-reading, storytelling style, *Whale Done* uses the example of training killer whales at Sea World in describing one revision of his earlier thoughts on supervision: the concept of a one-minute praise, followed by a one-minute reprimand. We're all familiar with the concept of positive and negative reinforcement. But as it turns out you can't practically use negative reinforcement with a killer whale . . . and, Blanchard says, you don't have to use negative reinforcement with your staff, either. Instead, he recommends a balance between positive reinforcement and *redirection*. An example: Negative reinforcement is when you tell your tech Ann, "Stop hurrying through your refractions. . . . you're really messing up, Ann." Redirection is saying, "Ann, I love it when the schedule allows you to slow down just a little bit and take your time with refractions. The resulting accuracy saves us time in the long run. Could you please take another look at Mrs. Raymond in room 3?" (P.S. The same tactics work with your kids at home.)

THERE ARE
ONLY 20 INCHES
BETWEEN A PAT
ON THE BACK AND
A KICK IN THE BUTT.

Anonymous
Technician "Nancy"



Building Staff Commitment

To a greater or lesser degree, every surgeon and manager I know is committed to their patients and practice. They make significant personal sacrifices on the altar of their career. You wouldn't expect anything less from a professional. But not all workers are "professional." Some people work in health care because of habit, inertia or economic need more than an upwelling of curiosity about a professional discipline or a dedication to patients. Aon Consulting, a Chicago-based human resources consulting firm, studied general staff commitment in depth. Clearly, it's more practical to hire people with a *potential* to be professionally committed to their employer and to avoid staff who are only showing up for a paycheck. But few practices enjoy a staff that's 100% "professional." How do you build career commitment in these staff? One of Aon's surveys seems to validate the common sense that, quite simply, staff members will commit to employers who in turn commit to and understand them. Employees want to work for companies that recognize the importance of their personal and family lives. Their most important practical conclusion seems to be that flexible schedules are more appreciated than most managers realize and should be constructed to fit staff needs to the greatest extent possible.

Results of Google Study on What Makes Teams Most Effective

Google has deeply studied the attributes of great teams, and among many other attributes, found the follow two key items:

- A. *First, on the good teams, members spoke in roughly the same proportion, a phenomenon the researchers referred to as "equality in distribution of conversational turn-taking." On some teams, everyone spoke during each task; on others, leadership shifted among teammates from assignment to assignment. But in each case, by the end of the day, everyone had spoken roughly the same amount. "As long as everyone got a chance to talk, the team did well," Woolley said. "But if only one person or a small group spoke all the time, the collective intelligence declined."*

- B. *Second, the good teams all had high “average social sensitivity”—a fancy way of saying they were skilled at intuiting how others felt based on their tone of voice, their expressions and other nonverbal cues. One of the easiest ways to gauge social sensitivity is to show someone photos of people’s eyes and ask him or her to describe what the people are thinking or feeling—an exam known as the Reading the Mind in the Eyes test. People on the more successful teams scored above average on the Reading the Mind in the Eyes test. They seemed to know when someone was feeling upset or left out. People on the ineffective teams, in contrast, scored below average. They seemed, as a group, to have less sensitivity toward their colleagues*

Defusing “Entitlement Issues”

People, being who they are—and more like themselves every year—means that both new and old staff will surface with a variety of “entitlement issues,” a set of unrealistic expectations about what they are entitled to in the practice. Here are the three most common issues I see in my travels:

“You guys are so lucky to have me, I should get lots of juicy benefits like I did at the hospital.”

(Your response: “Sorry, but when you work for ABC Eyecare or any small practice, you have to accept certain tradeoffs . . . remember that you joined our practice because we’re more flexible in scheduling your hours, less bureaucratic, and offer a lot more opportunity for direct patient care—all of which were things you wanted.”)

“I’m such a great employee and so valuable to you here that I should be able to hang out with the physicians, kidding around on the clinic floor, calling them by their first name in front of patients, and things like that.”

(Your response: “Sorry, but even though you are indeed very valuable to us and you’re older than half of our physicians, we can’t maintain patient and general staff admiration and support for our physicians when certain staff members act as though they’re the physicians’ buddy on the floor.”)

"I know my job, and I can work perfectly well off in a corner on my own doing my work. I don't need a supervisor, and I certainly don't need to cross-train any other staff to my job."

(Your response: "Sorry, but you're part of a team here, and every member of the team in a practice this size has to be able to function in a lot of different roles to cover for each other's absences. Everyone in this practice has a supervisor. I supervise you here in the billing department. In turn, I'm supervised by the office manager. She's supervised by the managing partner, and he's supervised by the practice board. Ultimately, we all report to our patients and the third-party payers who pay our wages.")

Performance Evaluations

An entire book could be written just on evaluating staff performance in a health care setting. If I ever get around to it, here's what I'll be sure to include:

- *Have written standards of performance.* The standards should be both generic to the practice (an employee handbook) and specific to the job (a position description, which should be edited for changes regularly).
- *Keep updated employee files.* These should include notes from each formal evaluation as well as interim reminder notes.
- *Set the evaluation dates a year in advance . . . and keep them.* A frequent complaint I hear is, "My performance review was supposed to be two months ago . . . what's happening?"
- *Make sure the evaluation is not just top-down but also bottom-up.* Find out directly from patients and coworkers what each employee and doctor has been doing better in the past year and what they need to improve.
- *If there are significant problem areas for the employee to correct, don't wait until the next formal evaluation.* Set up a progress review appointment, and give the employee a reasonable time frame in which to make improvements.

Be Comfortable with Both Individual and Group Correction of Errors

A common response by physicians and managers when they see one staff member making a mistake is to pull together the entire department and generically remind everyone present about how that mistake should be avoided in the future. Such sessions are appropriate if the error is widespread. But it's far more effective leadership to go to the singular offending party directly and appropriately redirect him or her.

THE PEOPLE IN THIS
WORLD PUT ON
A TREMENDOUS
SHOW, AND
DOCTORS HAVE A
FRONT ROW SEAT.

Augustus Hamann



Understanding Your Practice Team's Chief Complaints

Let's start off on a positive note. Most lay staff are quite happy about the work they do, and where they do it. But after conducting thousands of individual staff interviews and applying hundreds of written surveys to ophthalmic support staff over the past 30 years, I have developed a short list of what workers in eye care find the most frustrating about their jobs. Well, actually, the list isn't all that short—with some trimming, it comes to 24 key items in all. I've arranged these below, with one-half of the list more applicable to physicians and the other half more applicable to department heads and administrators.

Physician Issues

1. *Our practice lacks leadership.* Staff will sometimes back this up by saying something like, "The staff seems to care more about our practice than the physicians do."
2. *We don't understand our goals as a practice.* Your staff wants to know where the practice is heading—what your territory and service span are.
3. *We don't feel the physicians respect us, or even understand our roles here.* Members of your staff want—and deserve to be—treated as fellow adults, not children.
4. *Physicians reprimand us in front of patients and coworkers.* This common hot-button is often poorly understood by physicians. If as a physician, you're not particularly gentle when giving criticism, defer this role to supervisors.

5. *Physicians here don't acknowledge us when we are doing a good job.* The flip side of *private* reprimands should be *public* praise, evenly and fairly doled out.
6. *We only focus on what's wrong with our practice.* Physicians are trained to be critical thinkers . . . but such criticism can ooze over from clinical affairs and poison team morale.
7. *We don't treat patients as well as we should.* Staff members are often the first to wince when physicians are brusque with or dismissive of their patients . . . or when they don't take enough time to listen.
8. *Dr. Meanie, who should not be here, is allowed to stay.* In larger practices, the odds are 100% that one physician will be the least favorite. If this physician's behavior is below an acceptable baseline, he or she should improve or be removed.
9. *We don't do as well as we should in terms of staying on time in the clinic.* The most common patient complaint about your office is likely shared by your office staff. As uncomfortable as it is to be a provider in a chronically late clinic, how would you like to be the receptionist?
10. *Our practice is too mercenary. We should not be trying to collect every last dollar.* Such settings, fortunately rare, don't spring up overnight. Most physicians who are greedy get that way progressively over the years. And with every passing year, staff cynicism grows, along with the threat of whistle blower action.
11. *Our practice is too generous. The physicians are giving away our pay raises to patients who can pay.* At the other end of the continuum, it's very frustrating for staff to see their physician be excessively generous with professional courtesy or other write-offs. Yes, it's obviously the physician's privilege to discount and write off accounts at will. But if this is perceived to be done at the expense of staff payroll and benefits, the physician loses money twice . . . once from the unbilled patients and once from the staff who leave in frustration, or worse, get loose with collections because their physician doesn't seem to care.
12. *There is a disconnect between physician and staff financial success.* Our physician is more successful every year, while our incomes stagnate.

Supervisor/Administrator Issues

1. *Our practice administrator has not yet earned—or has lost—physician support.* Lay staff are almost perfect instruments in their understanding of where their administrator stands with the owners of the practice.
2. *We have grown to the size of needing middle managers, but we still don't have them.* People working in groups, by their nature, deplore a power vacuum. In a practice with more than eight to 10 staffers, it's appropriate to name department heads.
3. *The wrong people are in supervisory positions.* Department heads are usually selected for their tenure or their technical skills, not for their ability to manage other people.
4. *We don't make consistently good choices when hiring new staff.* Members of your lay staff will complain the loudest, and with every right to do so, when new staff are selected to join the practice and existing staff don't participate in the interview process.
5. *Staff who should not be here are allowed to stay.* You may be surprised to learn that your staff is tougher on their colleagues than you are as a practice manager or owner. They often know best who's pulling his or her weight and who's passing the buck.
6. *We don't put sufficient resources into staff training.* Ideally, your office should devote one hour of training time for every 79 hours of work. Ramp up training efforts for a year and you'll see marked results in efficiency, morale, and tenure.
7. *Certain staff get special treatment here.* Workloads must be evenly and fairly divided to every possible extent. And remember, perception is reality.
8. *Our supervisors overwhelm us with work . . . or . . . Our supervisors don't keep us busy enough.* This problem can be addressed from both sides. Work, to the extent possible, should be metered to the available staff, and vice versa. When there is too little work, the workforce should be trimmed or deployed to collateral duties rather than left to become demoralized because they have too much time on their hands. When there is an uncomfortably large workload, the department head

DECISIONS ABOUT
PEOPLE ARE THE
MOST IMPORTANT
AN EXECUTIVE
CAN MAKE.

Alfred P. Sloan



leading the team should be working twice as hard as everyone else to help get everyone through it.

9. *The person supervising me doesn't know my job.* Ideally, all supervisors should come up through the ranks so they understand the jobs that they oversee.
10. *We lack teamwork.* At your next group staff meeting, ask this simple question: "On a scale of 1 to 10, where 1 is low and 10 is high, what is our level of teamwork in this practice?" Let the staff vote using a secret ballot system, then tally the score. The average should be 6 or higher. *Teamwork* can be a very diffuse topic; try to get participants to the point of naming specific actions that could be taken to improve this.
11. *Communication is poor.* Staff meetings must be frequent, upbeat, and productive. For the typical three-physician practice, all-hands staff meetings should be held monthly or every six weeks, with as many physicians as possible participating. Practices with more than 20 staff members should disseminate a short, biweekly bulletin with training pearls, routine announcements, and pats on the back.
12. *We have unresolved staff-versus-staff conflicts that our managers don't resolve.* Interpersonal harmony within each department is the basis for harmony in the entire group.

Keep in mind as you review this list that no manager—and certainly no physician—can create a perfectly happy work environment out of thin air. Support staff should take a measure of the responsibility to make sure that legitimate grievances are aired calmly. It is also important that the managers and owners of the practice understand what they're doing right as overseers as well as what they need to improve.

Cross-Training Grid

To help keep track of who is trained to do what, create a simple grid sheet. In the *x*-axis, line-by-line, put all the principal skills that go into making up an ophthalmic office in all departments (e.g., refracting, history taking, TAs, filing Medicare claims, scheduling transportation, and transcription). Then, in the *y*-axis, put the names of each member of

your staff. Use three codes to fill in the resulting boxes: t = in training to do this job, k = knows this job function but does not regularly perform, and d = does this job regularly.

Teddy Roosevelt on Leadership

President Roosevelt probably had obsessive-compulsive eye surgeons in mind when he said, "The best executive is the one who has the sense to pick good men [and women] to do what he [or she] wants done, and enough self-restraint to keep from meddling with them while they do it."

Making Meetings Work

Everyone in people-intensive service organizations like medical practices laments the burden of meetings. Here are a few tips to make the best of a necessary evil:

- *Don't shy away from meetings because "the doctors don't like them."* Regular staff gatherings at the department and all-hands levels are critical to success. I'd go so far as to say that practice success is directly proportional to staff and physician meeting time per year. At a minimum, your practice should be gathering everyone (physicians and staff) at least quarterly (unless your organization is regional with scores of staff spread out over numerous satellite locations). The physicians should be meeting at least monthly. Individual departments should be meeting at least every two weeks. The administrator or office manager and lead partner should be meeting at least weekly, as should department heads.
- *Set a time limit . . . both for individual items and for the entire meeting.* Nominate a timekeeper.
- *Get closure.* Without being a slave to *Roberts Rules*, you should follow at least a limited parliamentary style, with formal motions, formal closing of discussion, and formal votes.
- *Discriminate at the outset between announcement items for information only and items that need discussion and a decision.* Cluster announcements at the beginning or end of the meeting and save prime time for the most important work.

MY DOCTOR IS
WONDERFUL.
ONCE, WHEN I
COULDN'T AFFORD
AN OPERATION,
HE TOUCHED UP
THE X-RAYS.

Joey Bishop



- *Don't use meetings as a substitute for information that could be best conveyed in writing.* (Larger practices should have a regular staff bulletin.)
- *In lieu of an agenda and minutes, consider running your meetings from an "action grid."* The grid should show in column form the agreed task, person responsible, agreed deadline, and dated progress notes. This grid keeps people accountable and instantly identifies when projects are dragging on.

WHEN PEOPLE
REACH THE HIGHEST
PERFECTION, IT IS
NOTHING SPECIAL;
IT IS THEIR NORMAL
CONDITION.

Hindu Saying



... And More Meeting Pearls

Meetings are simultaneously the worst and best part of any effort to run a better eye care organization—"worst" because few managers and physicians truly relish them, and "best" because no practice with two or more people can survive without them. In the practice performance audits I conduct, I see a direct correlation between the quality/frequency/duration of meetings and the profitability of each reviewed practice. Indeed, some of the most successful practices consciously cannibalize productive clinical hours each month to find sufficient meeting time.

- *Have a set calendar of meetings made up at least a quarter in advance.* It's best to hold most meetings midweek—with enough time at the start of the week to plan and enough time left in the week to execute.
- *Combine physicians and managers in group meetings, rather than having each half of the practice meet separately.* Large and small practices should consider an "executive committee" style of management, in which one or two physicians, along with managers from every department, meet every couple of weeks to interpret and apply board policy and organize the nuts and bolts of the practice.
- *Avoid the error of too many practice board participants.* If yours is a larger group practice, streamline your physician board to no more than seven or nine members by converting to representational governance, with each partner voting for a slate of officers pro rata to their ownership stake.
- *In smaller practices, especially those run by the consensus of all partners, board meetings tend to be frequent but relatively*

informal. These should be held at least monthly and concentrate on setting policy and covering the high points of operations oversight, rather than micromanaging.

- *In large practices, standing committees (e.g., marketing, clinical affairs, compensation and finance) can reduce larger meetings to quarterly events.* Such committees do need not more than two people in some cases.
- *Avoid the temptation to be overly democratic by having too many subcommittees and every staff member serving on a committee.* Don't create standing committees when a single individual or a brief, focused taskforce effort will do.
- *Although it should be obvious, each supervisor should be responsible for calling and running his or her own department's meetings.* In too many practices, such meetings are a command performance held for the physicians' or administrator's benefit.
- *Here are tips for the smallest meetings in your practice.* Individual staff members, including physicians, should have their performance evaluated by their supervisors at least annually—two or three times a year is preferred—as well as at the end of any probationary period. Disciplinary and termination meetings should be held at the end of the workday or week and in most cases should include a witness. Exit interviews with staff who are voluntarily separating should not only be witnessed, but in most cases be nearly as long and detailed as preemployment interviews to find out why a member of your staff is leaving.
- *Please remember that meetings are meaningless without follow-up execution.* Make sure that the minutes you keep include a system for setting and tracking deadlines and the people responsible for each project.
- *A strong practice manager is no substitute for physician involvement in all meetings.* In fact, the strongest managers demand physician participation. The frequency of meetings in the best-run practices will continue to increase in step with the expanding complexity of new regulations, higher standards for providing quality care, decreasing reimbursement, and growing competition.

Staff Members Always Have the Best Ideas

Whether you are a manager or a physician-owner, the easiest way to stay attuned to what’s going on in your practice is to meet regularly with individual employees at every level. A simple question—“If you were in charge, what would you do differently to make this a better practice for physicians, staff, and patients?”—will yield far more ideas for improvement than all the employee suggestion boxes in the world. Make these one-on-one interviews, about 15 minutes each, a regular habit . . . get around to every member of your staff at least annually (much more often in small practices.) With each successive interview, rapport will build and staff will be more candid in their comments, both during their private sessions and throughout the year. To be world class, make sure that you log and publicly display each appropriate suggestion or question in writing (without disclosing its source for sensitive items) and provide a written, public answer to each. Remember that even describing why a particular suggestion is not feasible is valuable and respectful of the person making the suggestion.

I BASE MOST OF
MY FASHION SENSE
ON WHAT DOESN'T
ITCH.

Gilda Radner



Inexpensive, Effective Staff Rewards

Not every example of exceptional staff performance deserves a financial bonus. And not every practice can afford financial perks. Create and print up a simple “Exceptional Service Citation” form and have physicians and managers hand these out liberally. The form should have a place for the giver’s and recipient’s name and a brief description of the meritorious conduct. To have greatest impact, it should be signed off by all physician-owners in the practice. One word of caution, however . . . in some settings, staff on probation or potentially targeted for dismissal could use these citations as evidence of an inappropriate termination. Make sure the doctors and management team are on the same page with who deserves recognition.

The “Blue Chip” Club

There are many ways to tangibly stimulate interdepartmental cooperation. Here’s one I particularly like:

Buy a package of poker chips, enough so that each lay member (physicians, too, if they want to join in) receives one chip. Distribute these at a staff meeting with instructions that during the course of the month, staff members are to hand their chip to a person in the practice they believe went the extra mile to help them in some way. At the end of the month, hold a drawing for a gift. (Gifts can be small items, in the range of \$5 to \$25 in value . . . more if you like.) Staff members who have been given one chip get one chance to reach for a prize. Those given two chips get two chances, and so on. Make up coupons for each prize as well as some “sorry” coupons. (Alternatively, depending on the size of your practice and your budget, all the coupons can be redeemable for a prize.) The basket of prize coupons the staff draws from should have at least the same number of coupons as there are chips.

Do this one time, or make it a periodic feature in your practice.

There’s Always One More Thing You Can Do to Boost Morale

If you’ve run out of ideas to boost morale, here’s another fun project. Encourage staff to take candid photos throughout the year . . . this can be during staff meetings, holiday parties, or warm moments with favorite patients. Collect the best shots, print them up and create a poster-size, framed montage of the year in review, to be unveiled at the annual holiday party. Do this year after year. Label each poster according to its year, and line all of them up on a wall that leads to the break room.

Staff Bonding and Teamwork of a Job Candidate Can Be Predicted

When interviewing prospective staff (and physicians), be sure to include questions about the candidate’s experience in other group settings through the course of his or her life.

Club, professional, sports, social, religious, military, and all other formal hierarchical organizations have likely molded the candidate's subsequent fit with your team. If your candidate shows a history of "not really fitting in" with other groups or has little experience adjusting to both leader and follower roles in a group, this may be a warning sign, even if their other job skills and work history are excellent.

IT'S NEVER GOING
TO BE AS BAD OR AS
GOOD AS THEY SAY
IT'S GOING TO BE.

Jack Katzen, MD



Male and Female Staff

At the risk of raising a few eyebrows, I'll venture a few observations about the in-built gender dynamics that exist in most ophthalmic offices and share some suggestions to circumvent the problems that these dynamics can create.

- Ophthalmologists are still mostly men. Support staff are still largely women. This results in a lot of locker room humor about the shortcomings and frustrations of working with the opposite sex, or working in an office whose staff is largely female. It's amazing that in today's enlightened world, staff or physicians still say, "We all get along pretty well here, considering the number of women." Practice leaders—the physicians and managers—should take every opportunity to dampen the sexism still rampant in medicine.
- A thankfully fast-shrinking minority of doctors (mostly Texans) still address their female staff and patients as "honey," "hon," "girl," "little girl," "sweetie," "babe," or "doll." These pet names, used between physicians and (approving) female staff who have worked together for years, create little problem. But in settings where it's out of hand, the administrator has to step in and impose 21st century sensibilities.
- Female surgeons in a practice, along with senior female managers, can help provide younger female staff with vital mentors and role models, but they often shrink from this role. Consider matching some staff members, especially those with a promising future in your organization, with a mentor.
- Physician-staff office affairs are at least as abundant in ophthalmology as in the general workforce. At any one time within my client base of practices, a significant number of surgeons are romantically involved with

someone on their staff. Most of these relationships are completely, humanly understandable—some are even remarkably celebrated by everyone in the practice. Less often (fortunately), they verge on harassment or worse.

Even after society and the legal profession finish redefining the ethical and legal boundary between romance and harassment, ophthalmic administrators and practice boards will still have a lot of ongoing work to do in this area. Your policy manual should contain a harassment clause written by your attorney that is scrupulously followed. But you simply can't legislate against mutually desired relationships that bloom among coworkers. The practical steps followed by management in Cupid's wake should be directed by the maturity of the parties involved, their station and function in the practice, and (most of all) your attorney's advice. Whatever your course of action, statistics show that regrets will likely outnumber happy endings. So it goes.

HE WHO CANNOT
FORGIVE OTHERS
BREAKS THE BRIDGE
OVER WHICH HE
MUST PASS HIMSELF.

George Herbert



Physicians' Spouses as Practice Employees

I once followed the crowd and was adamantly opposed to physicians' spouses working with their husbands or wives. But over the years, I have met several employed spouses who were significant exceptions to the rule. Wives who saved practices. Husbands who were terrific business managers. Helpmates in the fullest sense. Here are my suggestions today.

First, the physician's spouse should work only in a solo practice unless all partners in a group practice setting are given a chance to an ongoing secret ballot vote on continuation of the spouse's employment. Second, the spouse must be at least as capable as anyone else available for the position. Next, the role must be highly defined. The spouse should definitely *not* start out as a part-time back office assistant and then begin taking potshots at the office manager. Work should not be discussed at home, to the extent possible. The happiest spouses who work together partition their lives, not taking family squabbles to the office or

office squabbles home. Finally, physicians' spouses seem to work out best at one of two extremes: They are highly competent, full-charge administrators *or* they perform a defined role for the practice, preferably off-site, such as being the practice's accountant or attorney or handling marketing duties.

Be the Practice That Says "Yes"

One of the better practices I know has a simple orientation for all new staff. Its managers say, "It's impossible to lose your job here for making an honest mistake. We don't let people go even if they're a slow learner and they need extra time to get things right. But if we ever catch you saying 'no' to a patient—as in 'no appointment is available,' or 'no, we can't let you use the phone,' or 'no, the doctor can't speak with you'—you will be relieved from your job on the spot." The result in this practice? You hear lots of "yes, sirs," and "yes'ems" and see many smiling patients—and almost no staff turnover.

Physicians Should Remember to Praise Business Office Staff, Too

Although techs are in the hot seat all day, and some are subjected to blistering physician criticism, they also often get a measure of praise for their work. In contrast, the front office crew, billing staff and opticians sees little of the physicians except when there's a problem. Make it a point to have the physicians in your office wander through all areas of the office at least once a week, catch people doing something right, and praise them for it.

Employees May Not Mind a Cut in Hours and Pay as Much as You Think

Some years ago, the Merck Family Fund, a think tank, identified a growing desire among American workers to reduce their hours on the job. Two-thirds of the country's workforce said they would like shorter hours, and the average cut they would be willing to take was 21%. A 1995 poll showed that about a third of American workers had

voluntarily traded free time for money in the previous five years and that 60% of these “downshifters” were women. This is borne out in experience . . . when practices ask for volunteers to cut their hours modestly, numerous hands go up in many settings. Don’t assume your staff will loathe a cut in hours or that their job performance or morale will decline.

Staffing Hours Must Be Flexible

Many staffers would like to work four 10-hour days a week rather than eight hours five days a week. Although this can work well in large practices (let’s say with a 50+ staff), it’s generally poor policy unless the entire office is only open four days a week (which by itself is uneconomic). Unfortunately, some physicians naively grant this perk to their most senior staff managers, leading to especially low morale and reduced supervision. If anything, the latest trend is for some practices to be open evenings and weekends. Existing staff and new hires should be retained with the understanding that the practice’s hours and days of operation may change at any time to optimize use of facilities and increase patient convenience.

CONFIDENCE
IMPARTS A
WONDERFUL
INSPIRATION TO
ITS POSSESSOR.

John Milton



Testing Job Candidates

You should devise a standardized test for every position you need to recruit for in your practice. In addition to general skills testing for everyone, add a dexterity and memory test for techs, a practical billing protocols test for patient accounting staff, and a phone role-playing test for receptionists. Supervisor candidates can be given an “in-box” test and asked to prioritize and solve a series of hypothetical problems. Associate physician candidates can perform one or more videotaped exams (and should provide you with a videotape of surgical cases). A few practices go so far as to put candidates through a battery of psychological tests to ensure there are no gross emotional defects, and in some cases to determine whether a candidate will mesh with the composite behavior and work style of the existing team. I have had a few clients who use handwriting analysis to pick out staff, and two physicians I know have

even used a psychic. Whatever tests you use, they're cheap, if imperfect, insurance against disaster—which, with even the best screening techniques, will still strike your practice with frustrating regularity.

Observe Candidate Surgeons First-Hand

A generation ago, there was a relative abundance of candidate eye surgeons for every job posting, and you could hire a new generalist for \$100,000 or less, so candidate vetting was pretty casual. Today, generalists can start out at a base wage of \$250,000+ and are increasingly hard to recruit. Accordingly, the vetting process has become more intensive. The screening for any final candidate should include observing the doctor performing surgery in his or her own comfortable setting. In addition to simply observing surgical skills, this allows you to see how the candidate handles stress and gives you an opportunity to surreptitiously gain impressions of your potential new doctor from on-site support staff.

Let All Staff Interview All Finalist Job Candidates

It's usual for junior staff to be interviewed and hired on the spot by supervisors and office managers. But for maximum practice harmony, as well as the wisest choices, you should make sure that virtually all staff members interview and approve *all* finalist job candidates, including doctors. This is common in the corporate world. Shortly after college, I interviewed for a relatively junior staff position at the pharmaceutical giant Eli Lilly. I was elaborately scheduled for 20-minute sessions with more than 30 people, from a corporate travel clerk up to the vice-chairman. Smart people, those Lilly folks . . . I wasn't hired . . . and would have languished in this bureaucratic setting. If they can do it, you can do it.

A Staff Buddy System

Being the newest staff member of a practice can be a lonely experience . . . here's a simple solution. Match each new employee to an appropriate, experienced staff "buddy" for

his or her first three to six months and make them *both* responsible for skills transfer.

Field Trips

The richest educational setting for surgeons has always been shoulder-to-shoulder with their colleagues during a live case. The same is true of management education. Arrange senior staff field trips to appropriately advanced, noncompeting offices a couple of times a year to get ideas to improve your own practice. Ideally, a team of physicians and staff should all pile into the same van, descend on the practice together, and use the transport time to build a greater sense of teamwork and compare site visit notes.

One Supervisor, Not Two, for a Combined Reception and Patient Accounts Department

Most practices should have a single supervisor for these two areas, which are often, inappropriately divided into two cohorts. The data entry and verification work done at the reception desk markedly influences the quality and timeliness of work performed by the patient accounting staff. If your single supervisor is spending most of his or her time in the patient accounting area, as often happens, balance this out with a “team leader” at the front desk.

HE WHO KNOWS
OTHERS IS CLEVER.
HE WHO KNOWS
HIMSELF IS
ENLIGHTENED.

Lao-tse



About Wage and Salary Raises

Here's an important four-part announcement for those who hadn't noticed: (a) The fees you receive for a unit of clinical work will continue to fall in real terms in the years ahead. (b) If your practice is unable to increase worker (staff and physician) productivity, worker wages must necessarily stagnate or fall. (c) Since your practice competes with ever-more efficient, free-market industries for the same labor pool, and since we may indeed enter a new cycle of inflation, it is unlikely you will be able to hold the line on, much less reduce, staff wages. (d) *Therefore as a physician you will bear the brunt of wage concessions for the rest of your career.* This unpleasant announcement notwithstanding, let's examine a few pearls on raises:

- People work for a combination of love and money. If you don't nurture your staff, you will have to balance the equation with money. "Difficult" surgeons uniformly pay the highest salaries because they must. The most pleasant surgeons and managers create an environment in which wages can be frozen and more work piled on without complaint.
- It's well past time to wean your staff from the concept of automatic cost-of-living raises. Some years ago, the nation adjusted the way it calculates the Consumer Price Index. It turns out that the CPI, which had been used for years as the basis for cost-of-living raises, overstated the real rate of inflation, which had been at least a full point less than published figures. This may provide a modest relief in future staff demands for cost-of-living increases.
- Practices in financial trouble should consider full disclosure of their economic status to staff. Employees generally overestimate collections and underestimate expenses, resulting in wildly high calculations of how well off their physicians are. The truth can temper salary demands and generate very productive bottom-up suggestions to improve profits. (Obviously, once the lid is off this information, and if the practice turns around financially, you must be willing to share in the prosperity.)
- "Pay-for-performance" staff compensation models, with a base salary and incremental bonus based on individual or practice performance, are a logical—but largely ineffective—approach to constraining wage inflation. Most support-level, even management-level, employees simply do not want to have a portion of their income at risk.
- When a member of your staff is considering changing jobs for more money, in the vast majority of cases they will compare their current net hourly wage with the net wage of their potential new job. Only the most mature workers will weigh the fact that you offer a better health insurance package or a pension benefit to offset your lower hourly wage. Many managers and owners have discovered this practical fact and held back benefits inflation to be able to compete for staff with core, hourly wages.

- Avoid this all-too-common problem: The three physician-owners of the Smith Eye Clinic spend the entire year talking about Medicare cutbacks, competition, and rising costs as a send-up for an announcement in December that staff salaries are to be frozen next year. Then, within a week, one physician announces his month-long trip to Europe, a second drives up in her new \$90,000 automobile, and the third has his spouse stop by the office to show off her latest diamond. Make sure you walk the talk.

About Bonuses

Although it goes against all logic, bonuses don't work—at least not the common monthly fixed perks for exceeding a baseline of surgical cases or patient visits. Such programs stimulate staff performance for a month or two at most, and then everything falls back to baseline. The fixed bonus alternatives that *do* work in many practices are all short-term. They should be fun, evenly balanced throughout the office, and mildly exceed expectations. They do not have to be expensive. They should have a tangible positive impact on profits or not be given at all. Here are a few examples:

- Opticians get a \$15 bonus this month for every second pair sold to a patient.
- Each staff member gets \$100 if surgical volume in the month of October exceeds 70 cases.
- Opticians get a \$7 bonus this week for every nonreflexive coating sold.
- The administrator gets a \$10,000 bonus if the practice budget is met in three out of four quarters this year.
- The optometrist gets a \$3500 first-quarter bonus if average daily patient volume exceeds 25 visits.
- The patient transport van driver gets a \$25 cash bonus when a surprise inspection shows the vehicle is spotless and records are up to date.

Core and Contingency Workers

Most practices today still have an entire staff of employees who are paid for 40 hours per week for full-time work . . . winter and summer, Academy weeks, vacation weeks, and

“crunch” weeks. To save on benefits costs and allow flexible, seasonal staffing, consider making a gradual shift of your workforce from all-core to $\pm 50\%$ core and the balance part-time/contingency. The most efficient example I’ve seen of this was an ex-school principal, who as the administrator of a large practice was comfortable with the notion of building a large “substitute” contingency staff. Except for a few core managers, every staff member was part-time. With this approach, special efforts are needed to keep the float staff feeling part of the larger team and abreast of policy changes. It’s critical to document operations and provide training to keep part-time skills sharp. It is difficult in most settings to ask existing full-time employees to severely reduce their hours. The best of these staff may need to be grandfathered as full-time workers while you apply the flex schedule as a hiring criterion for new staff.

Staffing for Growth Versus Steady State

Physicians with growing practices often fall into the mistake of comparing their staffing levels unfavorably with those of colleagues whose practices have reached a plateau. A growing practice’s staff—like a growing kid’s shoes—should be chronically about one size too big. Everyone will still be training . . . procedures keep changing with growth . . . and the stress of building an organization keeps everyone a little below full productivity.

Staff Policy Manuals

It’s a mark of good business practice to have a simple employee policy manual that lays out performance and behavior expectations for all staff. These documents, running about 30 pages, are available in boilerplate form from your attorney or a generous colleague . . . you need one even if you only have a couple of employees. A few of my ophthalmic clients, having been stung because they didn’t adhere to the policies in their employee manuals, have abandoned the manuals altogether—to their regret. Keep your manual up to date and have your attorney review it periodically. Pay particular attention to following the rules you’ve established regarding disciplinary action and termination. (In most states, an employee can be terminated

“at will”; your attorney may recommend stipulating this in your handbook.)

Practice Operations Manuals and Job Descriptions

Fewer than 5% of the offices I visit initially have a written “how-to” guide for their practice. Yet many of the same practices may have only one or two key staff members who know critical functions in the practice. The best practices have the discipline to blueprint every last detail of how their organization operates. It’s a wonderful training manual, and perhaps as important, it gives the physicians a control document verifying a baseline of expected performance. A comprehensive manual may run 200 pages or more and take a year to complete. At the very least, all members of your staff should have a regularly updated, written description of their job responsibilities.

For the clinical/technical department, where each staff member’s skill set is rather long and each skill needs to be performed precisely, consider a simple hybrid between an operations manual and a job description. Give each tech a notebook containing a single-page description of each task (from simple tasks, such as how to escort a patient, to complex tasks, such as refraction). Use this notebook as the syllabus for regular in-service sessions. You can even run the department like a nursing school and have supervisors and physicians sign off on each new task in the tech’s notebook when he or she masters the skill. By dividing these tasks into three or four levels of complexity and value to the practice, you create a rational basis for wage administration (e.g., a Tech II makes \$13.25 to \$15.75 per hour depending on tenure, while a Tech IV makes \$16.50 to \$21.50 per hour).

Staff Photo Albums

Once a practice exceeds 20 or 30 support staff, keeping track of who’s who starts to become a challenge. Old staff begin to feel a little lost in the system, while it can take new staff weeks or months just to figure out who does what. In larger practices, it’s common for physicians to know the

names of only a few key support staff, which inhibits the desired behavior of physicians actively greeting and praising each staff member by name throughout the day.

To improve, pick two or three staff to develop a practice photo album. This can be maintained on your intranet or a simple, staff-accessible Word-for-Windows file on the practice shared drive. Take photos of every staff member, write down names, positions held in the practice, and special skills. In casual settings, you can put more personal information such as hobbies or a favorite recipe for chili.

Name Tags

Nearly every practice makes name tags available to their staff . . . few practices enforce that they be worn. Name tags should always be worn as a courtesy to patients, new staff, and forgetful physicians. Staff are on best behavior with patients when they know they can be identified by name in the event of service complaints. It is preferable for the tags to display the person's first name only; this will help head off potential harassment by patients. It's a nice touch to include a job title and years of service to the practice.

Initiating New Staff Members

Too few surgeons and too few senior staff members—at the peak of their careers and accustomed to the daily miracles they perform—convey the emotional kick of eye care to new staff members. Consider bringing new staff into your practice by having them blindfolded for an hour and escorted around the office by a staff guide. Then, have them talk to a few patients who have had surgery. Take them to the ASC to see a procedure or two. Then, on their toughest days at the front desk or in the insurance office, they'll know that what they're doing really does make a difference.

Heading Off Rivalries and Jealousies Between Satellite Offices

From time to time, a client will build an especially lavish satellite office that puts all the practice's other locations to shame. Once this new unit is staffed, a natural rivalry

is established between the “fresh/new” and “tired/old” offices. Some of this must be lived with. The rest, especially when the rivalry shifts from friendly to mean, should be headed off. The simplest and fastest way to do this is to rotate staff between two or more offices. This helps build teamwork and disseminates to each location the strategies and techniques that are working best system wide.

Uniforms

In my experience, one of the most frustrating and acrimonious staff meeting topics is the simple matter of uniforms. Here’s a solution: Put every staff member, from junior clerk to senior physician, in scrubs, all of the same color, with clean white athletic shoes. All staff who have direct patient contact can add waist-length white lab coats. Provider’s lab coats should be embroidered with their name and the name of the practice. The “scrub solution” has numerous advantages. The uniformity of this highly professional look builds staff cohesion and presents a united front to patients. You’ll have no more staff confrontations over inappropriate street attire. You won’t have to wince at the physician’s latest Father’s Day tie. (By the way, ties—except for those poor souls practicing in Boston and NYC—should be eliminated. They restrict cerebral blood flow, waste time and money, and are notorious disease vectors with no place in a health care setting.) Scrubs are cheap, come in a rainbow of colors, and are easy to clean. Athletic shoes are extremely comfortable for clinical staff who are on their feet all day long. Best of all, you’ll look more like a *surgical* practice, which may boost patient confidence and increase surgical conversions.

IF MEN CAN RUN
THE WORLD, WHY
CAN’T THEY STOP
WEARING NECKTIES?
HOW INTELLIGENT IS
IT TO START THE DAY
BY TYING A LITTLE
NOOSE AROUND
YOUR NECK?

Linda Ellerbee



Ensuring a Match Between Manager and Practice

Most practices have at least slowly increased in service, revenue, size, and enterprise complexity over the years. A few have spiraled downward, either by design (as when a physician decides to slow down) or by neglect. Whatever the direction of change in your practice, it’s unlikely the practice administrator who was a *perfect* fit when he or she was hired is still as well-matched today.

The skills set of your practice manager or administrator should be in line with the needs of your practice today, as well as with anticipated future needs. Let's say your practice's profit margins have been thinning for the past few years. The dip from 45% to 35% profits might have been barely noticed. But now the margins are approaching just 30%, the staff is overdue for another pay raise, and your aging office is ready for a facelift. You clearly have a *financial* problem. And you may need a new administrator or manager, with core skills that line up with your most pressing kinds of problems.

Seven Administrator Warning Signs

Here are seven warning signs, by no means a complete list, that your ophthalmic practice manager may be in trouble:

1. *Your manager lacks a sufficiently broad skills set.* No manager is a complete package. The clichés are true: Strength in finance and accounting is classically antithetical to good human resource development skills. A manager with outstanding sales and marketing skills can be befuddled when looking at the bottom line. And outstanding strategic thinkers often overlook day-to-day operations. But to the extent possible, your manager should have balanced skills, and perhaps more important, the ability (and humility) to know when to call on outside expertise.
2. *Your manager is not sufficiently committed to his or her career.* It's ordinary for a practice manager to spend 45+ hours per week on the job, even in smaller practices. They should be among the first to arrive and among the last to leave. It's rarely helpful for a manager to work part-time and be routinely absent one or more days per week, unless the rest of the management team (e.g., the head tech, optical manager, patient accounts manager) is extremely high-functioning and can work autonomously.
3. *Your manager has burned bridges with staff or physicians.* Let's face it. Even the smallest practice is an emotionally and politically charged environment. Even a superior manager who starts out with 100 points may slowly have his or her leadership capacity diminished by the

corrosive barbs of competing staff members or physicians. Enough judgment errors, and a harsh physician board may lose sufficient confidence in an administrator to let him or her work independently and do the job.

4. *Your manager has simply lost interest.* Talented managers need stimulation. If you have a mundane, no-growth practice, your manager may not have enough to do. Finding a special project or leasing your manager out to referring optometrists as a consultant may perk up your manager. Make sure your practice has objective performance benchmarks a manager can strive to reach to relieve boredom.
5. *Your manager is in over his or her head.* The signals from a drowning manager are often overlooked. Competence can and should be measured. Are deadlines made, written down, and kept? Is your manager in command of myriad details? Inasmuch as written and verbal skills are at the heart of management, does your manager have the communication skills (including *listening*) to be able to run the practice? To be blunt, is your manager smart enough for the job?
6. *Your manager fails to delegate.* Physicians are too quick to applaud superhero managers who take on every detail of every project. One practice I served took more than a year to recover from its loss of a manager who failed to delegate. Authority and responsibility should be sufficiently distributed throughout the practice so that no one person is “mission critical.”
7. *Your manager fails to groom an eventual replacement.* As vital as an administrator is to your organization, it’s critical that this manager work to continuously groom an understudy. Mentoring a junior manager in training is understandably skipped by insecure managers and relished by strong, secure managers.

Terminate or Remediate?

It’s quite common for physician-owners to wring their hands and delay making a decision about their faltering manager. Whatever you may say about the perfectionist tendencies of ophthalmologists, at the core they have a soft heart and an aversion to conflict, which can drag out

the “What are we going to do with Frances?!?” decision for several years. When doing administrative remediation and recruitment work for clients, one of the first questions I ask them is, “How long has your current manager’s performance been unsatisfactory?” The answer commonly exceeds a year.

The strongest practices don’t make any fewer senior management hiring blunders, but they do make their mistakes faster and are willing to fix or cut an underperforming manager. It may be perceived as kindness to give “Frances” yet another try, but at the same time you may have 10, 20, or more staff members and their families (not to mention your own!) depending on optimal performance at the top. It’s lax leadership to put 10 or 20 careers in jeopardy just to avoid one confrontation. And such confrontation needn’t lead to termination.

It may be that your now underperforming manager was elevated to the position just a little too soon. Find an honorable way for this manager to step back into a more junior role for a few quarters or years. If your practice has grown rapidly, outpacing the career development pace of your relatively junior office manager, the easiest solution may be to bring in a more seasoned administrator and let that individual determine the best slot for your outpaced manager.

Perhaps your manager is not performing satisfactorily simply because there are no performance guidelines. The basics should include a position description, a written set of operational enhancement goals for the next year, and specific financial targets for the practice. If your administrator doesn’t have a roadmap and directions from the physicians, he or she is likely to drive your practice to an unintended destination.

The New Super Managers

Regulatory and financial management complexity is increasing rapidly. This, combined with the senior administrative talent required to manage larger scale organizations in an era of extreme change, makes it harder and more expensive to find, recruit, and compensate practice managers. Merged

practices often seek a neutral, more senior administrator to handle their larger, politically tender organizations. Skilled ophthalmic practice administrators in practices with more than one or two surgeons are now commonly being bid up to six-figure salaries, and the lead time for a successful search is lengthening. Talented “executive directors” and “CEOs” working in \$20+ million practices commonly earn as much as the average ophthalmologist in America.

The Rising Cost of Quality Managers

When it's time for a new manager, the typical small (two-to-five-doctor) group practice is exchanging a \$75,000 per year office manager for a \$125,000 per year administrator. This should feel as threatening to the underperforming manager as it feels encouraging to strong managers. For practices, there is an increasing mandate to secure competent management staff because practices in a competitive market are no longer just competing physician-to-physician, but also manager-to-manager, for dominance. Managers must be given the time and dollar resources to attend national meetings, take field trips to other successful practices, and purchase study materials. This, combined with higher base salaries and an increasing trend toward bonus compensation—and even equity participation by superior managers, is driving up costs for practices. I believe this will continue to contribute to a trend of the aggregation of some smaller practices into larger practices—organizations that can collectively afford exceptional management talent.

The Change in Administrator Skills Set

Every one of us has a unique set of innate and learned abilities—the common phrase in the corporate world is “skills set.” For the most fortunate of us, our skills set matches our job responsibilities. Which brings us to our next pearl. Starting several years ago, a subtle and now stronger shift in the most valuable skills set for ophthalmic administration occurred. Let's simply divide it into the ideal “Era 1” and “Era 2” managers:

Era 1. For most mature practices today, this era is remembered fondly. Two-thousand-dollar cataracts. Sixty-percent

profit margins. Every marketing effort seemed to work well, and even if it didn't, there was always more money in the budget to try again. The toughest part of management was holding it all together. Racehorse surgeons and large staff cohorts needed a combination den mother, marketing guru, staff psychologist, and armed courier to run the deposits. Many managers rose through the ranks and did a splendid job despite little formal education. The most successful holdover managers from this era have learned the numbers side of the business on the job. Others, equally successful today, have filled in their weak spots with a staff accountant, strong billing supervision, or outside advisors.

Era 2. As full fee-for-service care has yielded to reduced fees and capitated care in vanguard markets, and as Medicare allowables have softened everywhere, the primary skills required have turned to areas of accounting, finance, and patient accounts management. CPAs and business majors with medical experience, especially those with solid leadership skills, have seen their salaries bid up in recent years. It's too often a true cliché that these "number crunchers" lack a full complement of creative, strategic, and personnel management skills. Like their Era 1 colleagues, the best managers today strive to fill in their gaps with complementary colleagues and advisors.

The C Word: "Compassion"

We ordinarily think of health care workers as a fairly humane bunch. Yet I've seen some pretty mean things in my travels. Physicians who all but slap their patients to evoke compliance, and supervisors who cruelly treat their subordinates. Human compassion comes in an amazingly wide spectrum. We are a species, as a Texas tragedy pointed out, that can chain a live man to the back of a pickup truck and drag him down country roads until he dies. Yet the very same human species is capable of inordinate compassion: Witness the practice of Buddhist builders, who sift the worms and bugs from every shovel of dirt lest they take a life by accident. This is a business text, to be sure. But there is a bottom-line cost when you, or any single member of your staff, are being uncompassionate. Examine your own heart and your own behaviors. If a patient is having trouble

getting up from her chair or through the front door, do you rush to assist her or stand by impatiently? When a new staff member is trying her best, but out of nervousness is still not getting something you just showed her 10 minutes ago, does your temper flare? If so, your bottom line is suffering along with the people around you.

Think You Know It All?

Jim Crupi, a consultant to the likes of Coca Cola and AT&T, has never worked in eye care, as far as I know. But he could have had the typical, harried practice manager or physician in mind when he said this:

The day of the know-everything manager is over. Not only do they not know everything, everyone knows they don't know everything. In the old days you were a manager because you had the knowledge and you had the power based on that knowledge. People weren't going to make decisions unless you said so. All that has changed. The object now is to take the brilliance of the ideas of the people who work with you and focus them . . . to affect the direction of the business, to affect growth, and to affect strategic issues.

CHAPTER 5

MANAGING PHYSICIANS



*A man is about as happy as he
makes up his mind to be.*

ABRAHAM LINCOLN

The “University Problem”

I started my health care administration career at a private research center in La Jolla, The Salk Institute, where Nobel Laureates abounded and deep thoughts were thought. These ivory towers were an exciting place to have a first real job, but the experience left me with extremely poor work habits that took years to break. The moment-by-moment work intensity and business common sense of the real world is simply lacking in most of academia. (Not that teaching centers don't have their own brand of intensity, but it is on a different cycle from the rest of the working world.) I've had several opportunities since to apply this personal experience to my consulting work, both with university eye departments and with academic physicians and managers who have joined the real world. Here are some impressions and recommendations:

- Although there are splendid individual exceptions, many who transfer from academia have a difficult time adjusting to the steady, high level of work intensity found in private practice. It's critical that employers screening both lay and physician applicants look for clues of a strong work ethic. The most reliable clue I've found is the age at which the applicant started working. Those who delivered newspapers or set up a babysitting service in their early teens usually have the right stuff.
- The academic world thrives on and rewards a personality I'd term “argumentative individuality,” while most of the private practice world, and business in general, thrives on “collaborative consensus.” Even the typical university building floor plan, with an inner physician's office and an outer, defensive personal assistant's office, can chop your department into individual turf rather than creating a group playing field.
- I'm convinced that a few university eye departments must require that their members undergo a “commonsensectomy” before coming on board. What else would explain 15% staff pay raises when the department is losing money . . . elaborate standing committees to solve minor problems best left to staff in the trenches . . . waiting lists for surgery when the professor takes his extended summer holiday? The key difference

is obviously in the reward structure of university departments versus private practice. When your private practice employs a university physician, manager, or support staff member, make sure you provide a clear and ongoing orientation to the bottom line—both personally and for the entire practice organization. With a little coaching, most make the transition nicely. (And if you head an academic department, please consider taking a mini-sabbatical to a private practice for a week to gather a few pearls about commonsense thinking, rapid decision making, and “doing it today” that could turn your department around.)

NOTHING WILTS
FASTER THAN
LAURELS RESTED
UPON.

Robert Frost



Associate and Partner Recruitment

Finding an excellent partner-track physician for your practice has always been critical, difficult work in all but the most attractive urban markets. However, with shrinking residency slots and growing baby boomer demands for care, the typical \$20,000 (and up) fees charged by search firms are looking like a bargain, especially in rural settings. Augment the work of your professional recruiter with AAO listings, national journal ads, and state-based or regional colleague networking. Ask pharma detail representatives for leads. Consider a letter-writing campaign to all eye surgeons licensed in your state. And don't let the added cost for this diminish the resources you put into vetting candidates, and paying your attorney to ensure that employment and partnership terms are well conceived and protective of your practice's interests.

Interviewing Prospective Physicians

Interviewing a physician is a little like talking to a patient about a prospective surgical option. It's essential that you show confidence . . . be positive . . . speak largely of a glowing future, with appropriate candor about any downsides. But you are better off not disclosing the practice's full array of warts until the candidate has provisionally signaled he or she is willing to actually join the practice. Remember that you *are* leading the conversation. It's wonderful to disclose your true feelings about the practice, but using your candidate as a visiting psychologist and baring your soul

about your dissatisfactions won't attract top physicians. Discussing your unhappiness with past associates is poor form, especially in the first conversation. It's a little like talking to your dinner companion on the first date about how your old spouse didn't work out.

Strategies for Hiring and Managing Subspecialists

As a teenager, I apprenticed for three years with a master falconer who taught me how to train and hunt with birds of prey. Learning this ancient art taught me more about how to help clients manage their subspecialty providers than any training since. I learned the critical difference between training social animals such as canines (with a mix of positive and negative reinforcement) and solo animals such as predators (which *only* respond to positive reinforcement). And I learned three secrets: Never rush . . . Never lose patience . . . And never, never stare directly into a predator's eyes. At the risk of excess anthropomorphism, subspecialists—and particularly retinologists—are the high-strung, raptorial falcons of the profession. They need to be coaxed gently to perform at their best. General ophthalmologists are the happy dogs of eye care, at least *comparatively* easy to hire, train, and manage. Here's a recap of how I've applied these lessons to subspecialist management:

- *Make sure you have enough referral business to internally support a subspecialist.* If you have just two or three average generalists in your current group, the only way you will likely be able to support a new retinal surgeon or glaucoma specialist is with external referrals, which competing generalists may be reluctant to supply, or by having your new physician pursue a mixed subspecialty/general practice.
- *Make sure that you have sufficient control not just over practice capacity, but volume as well.* If your practice is spending \$225,000 this year to hire a corneal surgeon to start a new LASIK practice, you may also need to spend several times that amount on promotion.

PHYSICIANS, OF
ALL MEN, ARE THE
MOST HAPPY. THE
WORLD PROCLAIMS
WHATEVER GOOD
SUCCESS THEY HAVE,
AND THE EARTH
COVERS WHATEVER
FAULTS THEY
COMMIT.

Francis Quarles



- *Make sure your practice has high enough profit margins to support a subspecialist, or be willing to bend your compensation model.* There's a catch-22 seen with many multi-subspecialty practices in that retinologists and others unfavorably compare their normal retina-only overhead (40% or less) with the ordinarily higher overhead of a larger mixed group practice (50% or more).
- *Beyond the base cost of hiring a new physician, be prepared to make significant investments in equipment, facilities, and staffing.* Spell out to any potential candidates what the budget will be for technology and personnel.
- *Draw out your candidates on their expectations.* Are they expecting an open checkbook every year, or do they understand the concept of applying a cost-benefit analysis to every capital expenditure?
- *Understand that there is a bell-shaped, normal distribution, a "quality continuum," from the worst to the best physicians, in any subspecialty.* It should be obvious that your practice wouldn't want to hire from the bottom of the pack, nor from the very tip-top, in most cases—such physicians are often too high strung and better off running their own practices.
- *Credential deeply.* This can be difficult with newly minted, fellowship-trained subspecialists, whose only job history is in an academic setting. Getting a professor's recommendation is a little like asking an assembly line worker if you should buy his or her car—it's only natural that the maker's pride will eclipse objectivity.
- *Look for clues that suggest teamwork and a good work ethic.* Did the candidate play team sports? Is he or she a joiner or a loner? Is the social history stable? Has the candidate floated through the academic years on the strength of external goading or been self-directed?
- *Trust your staff's opinion about the fitness of all final candidates.* Before you make a hire, make sure your potential new physician has met with virtually every member of your staff.
- *Have sufficient face-to-face time with any candidate before offering him or her a position.* Share several meals together. Meet the spouse. Take a long walk and discuss the goals you each have.

- *Be specific about your expectations regarding volume performance goals, help with continuing staff education, community outreach, local volunteer work, and the like.*
- *Once a hire has been made and a contract signed, match your new physician to a partner-level physician in the practice. The selected partner should act as the new physician “sponsor,” ensuring that all is going well by holding regular meetings and preparing a formal, written career development plan.*
- *If your new physician is on track for partnership, begin the financial and practice management tutorials early on. Err on the side of overdisclosing the financial status of the practice.*
- *Finally, make sure your practice has sufficient leadership. Better still, have two leaders: a strong medical director/managing partner and a strong administrator. Most subspecialists have reached their rarified heights by being more diligent, persevering, and competitive than their peers. Like all highly evolved predators, they will intuit, test, and attempt to overthrow any perceived weaknesses in management.*

PRACTICE IS THE
BEST OF ALL
INSTRUCTIONS.

Aristotle



Managing Employee Optometrists in Your Practice

If you’re like the typical ophthalmologist reading this, you’ll see 100 to 200 patients in clinic this week. Unless you’re in an obscure subspecialty niche, or very old-school, chances are you could delegate about a third or more of those patients to an optometrist on your staff. Yet, only about one-half of the new client practices I serve employ optometrists. If your practice has more patients than professional capacity, you might consider optometric staffing to ease the crunch. There are both advantages and disadvantages to hiring an optometrist instead of a fellow ophthalmologist. These are summarized in the following table.

OPTOMETRIST	OPHTHALMOLOGIST
Fairly easily recruited; expect a 45- to 120-day recruitment cycle.	Can be extremely difficult to recruit quality individuals, especially in recent years; expect a 120- to 180-plus-day recruitment cycle.
Lower base salaries to start, in the range of \$110,000 to \$130,000 for higher-level doctors.	Higher base salaries in the range of \$150,000 to \$300,000+. Subspecialist base salaries can range to \$350,000+.
Potentially much lower income generating capacity and payer panel access limitations; practice profit augmentation comes from freeing surgeons to take on more patients with a higher income yield.	Potentially much greater ability to generate direct income for the practice.
Potentially significant source of revenue from optical dispensing, if allowed to develop their own primary care practice.	Limited optical sales augmentation in many settings.
Limited succession-planning ability; an optometrist can only take over a narrow scope of a retiring surgeon's practice.	A professional succession event is relatively easy and seamless.
In most state jurisdictions, optometrists can only be business partners with physicians through a labyrinth of shell organizations.	Physicians can readily partner with other physicians, facilitating institutional growth and integrity.
Even highly skilled ODs are generally content being permanent associates rather than partners in the practice; this can be important for surgeon-owners who would prefer to not dilute their ownership position or who desire passive profits.	The best ophthalmologists desire partnership positions, which leads to inevitable issues of profit and control dilution for existing partners; it is somewhat harder to build an organization generating passive income for the founders.
Professional boundaries, authority, and reporting lines are generally clear; optometrists readily defer medical and management decisions to physician owners.	Struggles for authority and autonomy by junior physicians are far more common; in the best of settings, this results in a stronger organization, but it can also destroy practice harmony.

Partnership Trends in Mixed MD (DO) and Optometrist Practices

In my experience, fewer than 5% of optometrists working today in private ophthalmology practices are partners or partner-track. I believe this figure will grow, and that it should appropriately grow. There are several reasons for this. Some ODs make significant partner-worthy contributions, either in clinical or business terms. And given the difficulty of finding partner-track associate physicians

(which is gumming up succession planning) some periretirement MDs are looking to ODs to help take over their practices. Most state's regulations still prohibit optometric ownership of an MD practice, but this is slowly yielding. While almost all MDs recruited into private practice are on a pre-ordained partner track, and almost all ODs are not, this is only because the limited number of young MD recruits have the upper hand in negotiations. It's mostly about supply and demand. If ophthalmology residencies were as abundant as optometric training slots, then most MDs would become durable associates.

"What Can an Optometrist Do in My Practice?"

Optometrists can fill several different, sometimes overlapping roles. Here are the most common:

- *Refractionist or supertech.* A few surgeons use optometrists as refractionists only. In my view, this is a vast underutilization of resources. In the most efficient practices, technicians (and technology) do the refracting, and patients have to see only one doctor during a visit—an optometrist or ophthalmologist—based on their needs.
- *Clinical support staffing director.* Once a practice has more than three or four technicians, it's wise to select a supervisor for this group. In the absence of an appropriate lay staffer for this important job, an optometrist can be a fine choice.
- *Technician training director.* Optometrists often have more time and patience than physicians to elevate technical staffing competency and can add real value as the practice's resident "professor."
- *Comanagement center director.* Practices dependent on optometric referrals are often concerned that adding an optometrist to the staff will inhibit referrals. The reverse is actually the case. Higher volume comanagement centers learned long ago that hiring an optometrist as the administrator or senior director of the practice (with duties split between outreach and direct patient care) is actually better for the bottom line.

THE IDEAL DOCTOR
IS PATIENT.

Robert Haven
Schauffler



- *Separate/autonomous practitioner within your practice.* Practices with a diversified service base that includes dispensing and primary care should be delegating all appropriate patients to an optometric provider rather than tying up surgeon time.
- *Chief or “homeroom” clinician in a satellite office.* A hub-and-spoke practice with one core office and numerous satellites can be an extremely viable business model—or an absolute economic disaster. I’ve found through the years that the most important success factors include having a resident physician who is in the practice daily, providing patient and staff continuity. In my experience, an optometrist can fill this role at low cost and with great loyalty to the home office.

Optometrist Position Descriptions

Hiring a new optometrist (or properly managing the doctors you have) should start with a position description. This should include the following sample elements:

- *Scope of practice.* The practice’s optometrists will practice to the highest levels permitted by state practice regulations and payer stipulations and within the boundaries set by the medical director.
- *Supervision.* Optometrists will report to the medical director of the practice (or can report to the optometric director, a chief OD selected in larger practices, who in turn reports to the medical director).
- *Practice volume.* The practice optometrist will see a mix of postoperative surgical patients, routine patients, and treatment follow-up cases. Depending on patient mix, the optometrist is expected to see between 20 and 50+ patients per day with two or three exam rooms, and one or more dedicated technicians.
- *Location of practice.* The practice’s optometrists, like all professional staff, may be called on to see patients in various locations throughout the service region and have the flexibility to provide care occasionally in less-than-optimal settings.
- *Days and hours worked.* Full-time optometrists are expected to work no fewer than 40 hours per week and may be called on to work additional hours to fulfill all

professional duties. To optimize use of the practice's office facilities, optometrists may be required to conduct early morning, evening, and weekend clinics.

- *Practice emergency call responsibilities.* Subject to hospital regulations, community standards, skill level, and practice policy, practice optometrists will share call with ophthalmologists.
- *Staff education.* Optometrists will share staff education duties with the practice's surgeons.
- *Meetings and assistance with management projects.* Optometrists will participate in various practice management committees and may be called on to lead various initiatives and projects for the practice. Associate providers in the practice are expected to devote no fewer than four hours per month to such duties.
- *Community service and promotion.* All professional staff are expected to give no fewer than three talks in the community per year, which will be scheduled by the practice administrator. Staff optometrists are strongly urged, especially in their initial years of getting established, to join a community service organization such as Lions or Rotary.
- *Outreach to fellow optometrists.* If the practice seeks optometric referrals from providers in the community, staff optometrists may be called on to help in this area.

MAMA ALWAYS SAID,
"LIFE IS LIKE A BOX
OF CHOCOLATES.
YOU NEVER KNOW
WHAT YOU'RE
GONNA GET."

Forrest Gump



Finding an Optometrist to Work in Your Practice

As with eye surgeons, not all optometrists are created equal. And half are below average. It's a broad but true generalization that younger ODs are better trained and equipped to step into a busy ophthalmic practice. Sparky doctors, both in intelligence and energy, can see more patients than dull docs. Recruiting a high-quality optometrist is generally much easier than finding a top-flight ophthalmologist. Journal ads and letters to doctors in the state or region will almost always yield a pool of acceptable candidates in short order. It pays to aim for a higher quality doctor; small increments in compensation can yield large benefits in productivity and ease of management. Here's a sample ad with all the right buzz words:

INDIANA. Leading regional, rural practice, vicinity Indianapolis, now seeks an Optometric Director for our referral center. Significant clinical volume and diversity, great learning environment, great staff support. Family-oriented community, a diversity of outdoor recreation, and easy access to international airport. Please send your resume including salary requirements to Smith Eye Center, 125 Swallow Road, Smithville, IN 33333, or to smitheyecenter1@gte.net. All submissions will be handled in strict confidence.

Once your new doctor is on board, use the sample position description outlined above to set and manage highly specific performance standards. When I'm called on to untangle OD performance snarls, the first thing I address are the basics of the practice's written expectations for the doctor. More often than not, when there's a problem, such documents are absent. In addition, ongoing management of your practice's optometrists should include all-hands doctors meetings at least once a month. Nothing can reduce optometric morale and performance faster than being left out of meetings and feeling professionally marginalized.

As for the future, optometric training seems to be improving, as is the average quality of students entering optometry school. And, at least legally, the optometric scope of practice is widening. I predict that before too many years pass, it will be legal in a majority of states for MDs and ODs to directly partner, which should usher in a significant increase of OD-MD comingling, including merger/consolidation between practices.

Associate Physicians and Side Businesses

Many midcareer surgeons change jobs and bring along with them related or unrelated business interests (e.g., expert witness skills, consulting, and product development). To avoid misunderstandings, make sure that the employment contract stipulates that the associate will apply 100% of his or her professional efforts to the practice. Any side business interests should be pursued only upon prior written approval from the employer.

Physician Compensation

Of all the arguments and issues that arise among physicians working together, it would be natural to expect that the most interesting—and heated—is in the area of compensation. There is clearly no one, simple algorithm or formula to guide practices. What works perfectly in one setting can be found profoundly lacking in another, often for reasons that are not initially apparent. Here's a rundown on my current thinking:

- Equal-split compensation works well with small groups of physicians who are very close in their production levels and potentials and who are compatible partners, working in an environment of stasis. I think there must be at least one practice in America that is still using this traditional method and is happy with it. For all the rest, equal split doesn't work.
- A modified equal split stipulates a hold-back of profits for periodic distribution at board discretion. (This could be applied to contingency funding needs, staff rewards, unequal physician rewards for exceptional performance, or other contributions.)
- A pure "eat-what-you-kill" approach has physician payroll allocated to an index of personal production (this can be based on visits, charges, collections, or RVUs) . . . and tends to lead to competition rather than the increased collaboration desired in all settings.
- A modified eat-what-you-kill approach divides costs into those that are for general benefit and those that are in support of individual physicians. Sometimes this is arbitrarily set; for example, 50% of expenses are divided equally and 50% pro rata to production. In other settings, costs are more closely allocated on a line-item basis. The rent and office manager's salary are divided equally, for example, but tech costs are split according to patient volume. This is one of the more common arrangements and provides an incentive for physicians to work hard and to work full-time. (If they work part-time, their base overhead is disproportionately high.)
- Taken just a bit further, this approach can be turned into a microallocation approach to sharing expenses; with

ALL THEM
SURGEONS—THEY'RE
HIGHWAY ROBBERS.
WHY DO YOU THINK
THEY WEAR MASKS
WHEN THEY WORK
ON YOU?

Archie Bunker



microallocation, physicians precisely account for the portions of the facility, staff, and supplies that they consume. This is labor intensive but can be the fairest way to divide costs . . . and save partnerships where doctors are unwilling to agree on a fair way to approximately divide costs.

- You can be more complex and have a three-way compensation formula, with part of each physician's compensation as base salary, part production-based (e.g., \$X/RVU or Y% of collections), and part paid as a group dividend, pro rata to the physician's percentile ownership of the business.
- But, my favored approach is to divide a minority of available profits (e.g. 10%, 20%, or 30%) pro rata to ownership and the balance pro rata to individual collections. I have observed this approach being used over long time periods with the greatest degree of partner harmony and the lowest frequency of compensation squabbles.

Small nuances and variations on the above abound. Some practices use a point system, in which the number of years worked in the practice translates into a larger share of the pie. Some practices have a deferred compensation plan so that dollars are withheld and paid at a later time; the goal is to lock in a physician who might otherwise leave. Partner physicians who go to less than full-time (however that is defined in the shareholder agreements) or who stop operating are often given a separate associates-style compensation formula and sell their partnership shares and voting rights back to the group. Most comp models should provide a rational linkage to capitated managed care reimbursement, charity work, call coverage, internal cross-referral of surgery, and cross-coverage of post-ops.

Typical Salary/Benefits Package for Your New General Ophthalmologist

Base compensation. \$150,000 to \$350,000 (Note: This can range somewhat lower in highly competitive markets such as Chicago or San Francisco and higher for exceptional candidates in less-attractive markets.)

Bonus compensation. At the end of each full quarter, half-year or year worked, for collections above two to four times base salary, a bonus of 15% to 40% of such excess collections is paid. Premature termination by the associate without cause or by the employer with cause will result in forfeiture of any outstanding bonus amounts for the subject quarter.

Benefits. Malpractice insurance including one-half to full tail coverage on departure in the second or subsequent years; three to four weeks of combined education/vacation/sick leave in the first year, five to six weeks in the second year; \$3000 to \$5000 educational fees/materials allowance; all reasonable/receipted practice promotion and outreach expenses reimbursed; health insurance benefits per current staff policy (although full family coverage is an increasingly common recruitment incentive); ability to take any other reasonable professional expenses out as pretax draws against salary, as long as such pre-tax draws are approved as tax-qualified by the practice's accounting firm. It is typical for all pre-hire interview travel and reasonable moving costs to be paid by the employer. Some or all of this may be paid back to the employer out of the associate's terminal compensation in the case of the associate's early voluntary departure or termination with cause.

Noncompete Clauses

It is wise, but not always typical, for physician employers to seek a noncompete clause conforming with the most stringent application of local case law. The converse is obviously true for job applicants, who would prefer a free hand to leave and compete. This winds up being highly variable depending on local customs and each party's negotiating skills and advisory team. Obviously, all patient charts and patient lists should remain the property of the employer. A noncompete period of six to 24 months is common, and the geographic range depends on the market, as well as on case law. In urban markets, where patients come from a relatively short distance, a five-mile radius may be all that's necessary to protect the practice's interests. In rural markets, it may be both appropriate and legally possible to increase this to a 50-mile radius or more. Using liquidated

THE SECRET TO
GETTING ALONG
IN THIS BUSINESS
IS TO NOT MAKE
EVERYONE MAD AT
THE SAME TIME.

John Weems



damages clauses can be a practical way to put teeth in an associate's contract. Under these, a departing physician is under contract to pay an agreed sum or percentage of future earnings if he or she competes with a former employer. A noncompete is nearly impossible to enforce in some states, in California for example, unless the physician is a partner (which has led to some physicians arranging small equity stakes for new associates from day one to help increase the theoretical enforceability of a noncompete clause).

The Rural Practice Expansion Problem

Rural ophthalmologists work in an environment with a very favorable population-to-provider ratio. It's not unusual to find an underserved community with 10 times the patient base per surgeon as in urban markets. But if you are a solo rural surgeon who is ready to expand by adding one or more physicians, you face a serious risk not encountered to the same degree by your city colleagues. If your associate leaves you and sets up his or her own practice across the street, your patient base can be extremely vulnerable. In contrast, one more ophthalmologist added to Chicago or Denver to compete with his or her ex-employer would hardly be noticed. Here are some points to consider to protect your favorable turf:

- Pick the right associate . . . firing a physician would be more disruptive to your practice and more visible in your rural community than would be the case in the city.
- Make sure the associate's employment agreement contains the strictest possible noncompete recitals.
- As important, be sure your associate knows you intend to enforce this document if necessary.
- Make sure the hospital is on your side. It's not unusual for departing associate surgeons to run to the local hospital for support in developing a competing practice.
- Brace yourself for the possibility that a departing associate will prevail in establishing a competing practice, despite your noncompete agreement. The greatest harm you will suffer will be to your ego and your peace of mind. It's a wretched experience to have in your midst a rival that *you* created—try to normalize relations as

best you can. If you do get into a promotional contest with your ex-associate, chances are you'll both benefit by raising consumer awareness and increasing the utilization of eye care services. Rest easy. Experience shows that departing associates only retain a fraction of their former patients.

NO SNOWFLAKE
IN AN AVALANCHE
EVER FEELS
RESPONSIBLE.

Stanislaw Jerzy Lec



The Practice Administrator as Referee

An important part of practice management—whether by lay managers or physician managing partners—is given over to mediating conflicts within multigenerational practices and helping everyone find a common mission and common tactics. Weaving these conflicting individual interests into a harmonious group practice has become far more difficult. The natural tendency may be to go and hide in separate corners, but the key to success is mixing it up and a lot of communication. Fostering this communication is one of the administration's most important jobs.

Relations Between Dr. Young and Dr. Old . . . Dispute Mediation Pearls

Management of the associate's career is obviously not just the associate's responsibility. Both permanent employees and partner-track associates have to work happily and hard within their organization's hierarchy. But ultimately, when the relationship between junior and senior declines, it should be up to the senior party to put things right. Here is a list of success factors in associate-physician management for Dr. Young and Dr. Old (and their managers) to discuss:

Leadership by the managing physician. The lead physician has a responsibility to nurture all of his or her clinical colleagues.

Meetings. Hold at least monthly, meetings of all providers. Compare notes on interesting cases, share pearls, provide further training, and most of all, develop rapport to a level that allows everyone to feel comfortable enough to address personal or professional problems early on, before they blow out of proportion.

HAPPINESS? THAT'S
NOTHING MORE
THAN GOOD HEALTH
AND A POOR
MEMORY.

Albert Schweitzer



Reciprocal chart review. This is not just Dr. Old checking up on Dr. Young. Dr. Old should ask his or her younger colleagues for advice from time to time to help build the associates' confidence.

Involvement. Participate with the practice's management team and in meaningful assignments; lend a voice (if not a vote) in key practice decisions.

Positive feedback. Even the most confident young physicians respond, as we all do, to positive feedback. Reread *The One-Minute Manager* and *Whale Done*, both by Ken Blanchard, and apply the lessons in these books to all corrective messages.

Outside mediation. When internal communication between professionals breaks down, having a mutually trusted, outside professional mediate can often be the fastest and most ego-sparing solution. Resources for help include management consultants, professional mediators, and existing advisors to the practice, such as your practice's attorney. I call an industrial psychologist in as co-counsel to help me in the most challenging client situations.

Keeping Physician Workload, Compensation, and Other Squabbles from Killing Your Group Practice

In any group ophthalmology practice, there are myriad partner issues to resolve. These include compensation, minimum workloads, and staffing. Most are nailed down at least generally in the written shareholder or partner agreement that everyone signs when they become an owner in a group practice. However, even a few months after the contract ink has dried, it's typical for questions and arguments to erupt. It's unlikely that every contingency will be covered in your original documents, and it's incumbent on every large-practice administrator to secure a periodic legal audit to make sure the old contracts are still suitable to changing times and circumstances. Partner issues most often break out because of just one disaffected or misbehaving partner or a small, like-thinking cluster of individuals in a larger practice. Even in

the strongest and most convivial settings, it's common for one or more of the following issues to fester:

- *How much of the practice should we each own?* There is no one formula for success. There are happy, stable practices that split the pie up evenly and equally happy practices with one majority owner and several junior partners. The argument for equality is more often visceral than financial. It just somehow *seems* and *feels* more fair.
- *How should decisions be made?* Few new partnership or corporate documents initially cover decision making in sufficient detail and require that the group fine-tune the rules over the years. Mature, amended agreements should contain sufficient detail on how decisions are made to allow for unambiguous group and individual action.
- *If we develop a new building, optical shop, or ASC, should we all own it?* As a guiding principle, I generally urge sharing all practice business opportunities with all partners, even if some partners are not as involved as others. For example, if a multi-subspecialty group practice has a pediatric ophthalmologist who will make scant use of a new ASC, this physician should still have an opportunity to buy into the unit, at least at some junior level.
- *What's the best formula for how we get paid, and how often should we review it?* Every system under the sun—from pure equal split, to pure “eat-what-you-kill,” and everything in between—has its proponents and detractors. There are literally hundreds if not thousands of models. Depending on the individual practice, at one moment in time, one methodology is usually better and fairer than the others. But check the same practice in a year and the odds are great that something will have changed so that the adopted system is now less fair. That's why it's important for larger and more dynamic practices to formally review their compensation formula at least annually.
- *How are new patients assigned to each of us? What are the boundaries, if any, on our personal scope of care?* I didn't think much about this topic until many years ago, when I heard that one physician in a group practice was paying off the front desk staff to steer surgical patients his

WASTE OF TIME
IS THE MOST
EXTRAVAGANT OF
ALL EXPENSE.

Theophrastus



way. Your practice should have formal, written rules for receptionist and phone staff on how to assign patients.

- *How should subspecialty practice resources such as marketing, staff, and technology be apportioned, when not all doctors use these resources?* Since at least the advent of refractive surgery, internal practice battles have raged over who is going to get the largest ad budget, the best staff, and the latest technology. Obviously direct costs such as a laser facility should be directly charged to the doctors performing this service, but more general expenses like LASIK surgical counseling (which has a cognate in cataract surgery) and advertising costs (which provide a degree of general visibility and benefit to the entire practice), need to be discussed and thoughtfully apportioned.
- *How hard must we each work—and how much time can we take off?* Patient assignment is not the only things partners compete over; at the other end of the spectrum, they can end up competing for time off, especially if the compensation methodology has a bias toward an equal split of profits. Since ophthalmology is a fixed-cost business, it's critical that individual productivity is both sustained and predictable. A partner who takes unannounced vacations or insists that the practice staff make up for his unpredictable peaks and valleys is costing his partners hundreds or thousands of dollars a day.
- *How far should one partner's personal collections be allowed to fall before the physician must revert to being an associate?* This question is the flip side of the question at the start of an associate's career; that is, how high must an associate's production rise before he or she can "make partner"? There is no easy answer to these two related questions. Even after employees/associates have been in the practice for two or three years—the most common pre-partner trial period—they may lack the productivity to support not only their own salary, but also their buy-in. As a *very* broad generalization, the math works out this way: Once an associate rises above (or a partner falls below) personal collections equivalent to 50% of the average of the total group, a transition in status is indicated. A figure of 60% or 70% could just as readily be used if you want partners to cluster more tightly in their production.

Avoid These Physician-Driven Practice Efficiency Killers

On the most hectic, late-week clinic afternoons, every manager and practice owner laments the human factor that trips up the best intentions for an efficient flow of patients. As you begin work to develop a more efficient practice, it helps if you vanquish the large and small “efficiency killers” found in every organization. Some are occult; others are out in plain sight. Physicians are the most visible culprits and are their own largest source of inefficiency in most practices. The most immediate improvements are truly at the provider’s command. Consider the simple, obvious dimension of practice efficiency: At what time does the physician arrive at the office? In the overwhelming majority of cases, a clinic with excessive patient waiting time can be remarkably improved simply by having physicians arrive 10 minutes or more before the time of the first scheduled patient appointment. Staff members appreciate when physicians arrive a bit early. They like spending just a few extra minutes with the physician and having the benefit of his or her leadership. Starting the day *ahead* of schedule makes it harder to get *behind* as the session proceeds along. Once your clinic is in session, stay on the floor and resist the temptation to wander off for a chat with your administrator, friendly rep, or stock broker.

A few physicians have no problem arriving at the clinic and sticking around, but they *do* find it difficult moving from one room to the next because they socialize with patients too much. This can grind the clinic down to a crawl. How much social time is too much? That’s entirely up to you, obviously. But consider the hard costs. The typical surgeon, with, let’s say, \$400,000 in annual overhead, has about 75,600 clinic minutes per year to see patients in the office. (That’s 48 weeks, times 3.5 clinic days per week, times 7.5 hours per day, times 60 minutes per hour.) The result is that it costs \$5.29 *per minute* for you to sit and socialize with patients when you could be starting the next encounter.

Some physicians arrive on time, stay on time, and stay on the clinical task at hand, but their efficiency is stunted by insufficient delegation to optometrists, techs, and other staff. Others lose time and efficiency doing more for patients than is obliged by third-party payers or needed to give the patient excellent service and a great experience in the clinic. Remember that the reimbursement world we are moving toward is a little like the world of modern commercial airline service, where for all but your “1st Class” passengers, you will be rewarded for providing a *sufficiency* of services rather than an abundance.

BEHIND EVERY
GREAT MAN IS A
WOMAN ROLLING
HER EYES.

Jim Carrey



Finally, some physician inefficiencies are the result of poor physical or mental conditioning, a tempo dulled by substance abuse or simply a lack of sleep. The most efficient physicians maintain disciplined dietary and exercise regimens. If your practice is measurably inefficient in volume or economic terms, or simply *feels* a little pallid, look first to the core of the practice—to the physicians—and then work outward from there.

What Is a Partnership? What Kind Do You Have?

In an average year, I spend hundreds of hours constructing, deconstructing, and patching up physician-to-physician partnerships. At the surface are scores of hot-button issues that make partnerships so difficult to make and keep happy. But at deeper levels, there is perhaps just one core attribute—the degree of partner equality. Not that *inequality* is bad. Extremely strong business partnerships (and for that matter, other kinds of partnerships such as marriage) exist where both sides agree who is going to lead and who is going to follow. But the most extraordinary environments for surgeons to work in are often those where equality prevails.

What is a partner, really? Here's a dictionary definition that's suitable for most competitive ophthalmic environments: “A partner is one of two or more people who play together in a game against an opposing side.” Ophthalmic partnerships fall into two broad and profoundly different categories.

Unequal Partnerships

Surprise! This is the most common form of partnership, in eye care and elsewhere. Even if partners are legally and economically equal, they are rarely equal in actuality. An examination of the typical ophthalmology practice reveals a rank order of leaders and followers. The hierarchy is most commonly along lines of tenure (who came first), economic production (who collects the most), or natural leadership (who by raw personality is granted the most authority). In these kinds of partnerships, decisions and resource allocations are lopsided. The senior physicians get the choice midweek, morning hours in the practice's surgical center; the junior physicians get Friday afternoons. The seniors get their pick of the best technicians; the juniors by default run the tech training program. The seniors are excused from call sharing; the juniors are excused from a sound night's sleep. Not a bad arrangement . . . if you're a senior. As long as everyone gets to rise through the ranks and agrees to this approach ahead of time, unequal partnerships can work just fine.

Equal Partnerships

In these rare partnerships, physicians most often (but not always) have equal shares in the practice and all of its subsidiaries, such as optical shops, buildings, and surgical facilities. Both younger and older physician partners have an essentially equal voice in management; more decisions are made by consensus rather than by formal vote. Perhaps the most important contribution to harmony is that everyone in an equal partnership setting gets an equal share of resources. Marketing dollars are split equally among the various subspecialists. Everyone gets to rotate through the most productive satellite offices. Every physician gets a turn at being the managing partner. Perhaps most important, all partners rise or fall with the total success of the total organization.

Whether partners are equal or unequal, the biggest factor in success and harmony is mutual agreement about the development path of the practice. Partnerships are hardest to maintain when the partners have no large goals in

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DESTRUCTION.

Krishnamurti



common. I have found that the physicians who are most angry are those with partners who don't share their goals, or far worse, hold them back from accomplishing their dreams. The best kind of partner is someone with whom you can accomplish things that you can't accomplish alone.

Seven Rules for Getting Along with Your Practice Partner

Benjamin Franklin once said, "Keep your eyes wide open before marriage, and half shut afterwards." He could have just as readily been giving advice to partnering eye surgeons, who today have a disharmony and divorce rate that nearly matches that of the ordinary kind of matrimony. Strained relationships can exist even in the most congenial practices. In some cases, significant time must be spent getting one back on track. Following is a simple how-to list of recommendations that may help you reverse partner discord, or even better, stay out of trouble in the first place.

Partnership Rules

1. *Don't compare your "deal"* (your hours, wage, call schedule, case mix, burden of scout work, etc.) with your partners' deals and get burned up because Joe gets more cataract cases than you get, or Mary makes more than you do, or the practice's senior partner is now off call rotation. Instead, it's a lot easier on your nerves to compare your present situation as a partner with what life would be like as a soloist. Junior partners can be steamed because they don't have the same high surgical loads or incomes as the senior physicians. My advice to them is this: "Wait. If you have the right talent, your turn will come. Imagine you were off on your own . . . how many fewer cases would you be doing then? How much more overhead would you have to cover all alone? Who would you talk to about difficult cases?"
2. *Accept that all partnerships are flawed because all people are flawed.* Even the coziest partnerships have a 5% grief and regret factor. Nobody I know in this business is holding hands with their partners, singing hymns around the campfire. Indeed, being an affable partner

is something that many eye surgeons struggle with their entire career; it's their "adapted" personality, not their natural state. The ophthalmic personality is not often given to playing well in groups. On top of that, ophthalmology is now an increasingly disciplined business. Resources are tapering. Profit margins are shrinking. There are more excuses to pick a fight. You have to redouble efforts to admit your own flaws and accept the flaws in your partners.

3. *Fighting and conflict are good to a point.* Although this is true, you need to understand and respect your partner's willingness to confront and his or her natural conflict-resolution pace. If you're the kind of person who blows off immediate steam at the first provocation but quickly settles down, you can get into trouble having a partner who quietly, gradually reaches the boiling point. If your style is to talk everything out in the open and your partner is more obtuse, you're both going to be frustrated. Discuss your differences and then respect them. Of course, this is more easily said than done. If you're running into chronic strife over differences like these, it may help to have all partners (and the administrator and department heads if appropriate) tested with one of the common personality inventories. Then, have a trained professional discuss the results and the implications to you as a group. It's worth the time commitment—you may just be a few hours away from making your work environment a lot more pleasant.
4. *When there's strife, as difficult as it may be, look in the mirror first and ask yourself, "Is it me? Am I causing this?"* Ask for and defer to the opinion of a few trusted coaches. I took this particular pearl to heart when my son Graham was a teen and I learned I was being, in his words, a "butthead" on some issue. In your practice life, you may feel close enough to your administrator, chief tech, or semiretired senior partner to take them aside and find out whether you're being a butthead, too. If so, don't worry; you're part of a big, big club with lots of fellow eye surgeons (and management consultants) as members.

WE MUST LAUGH
AT MAN TO AVOID
CRYING FOR HIM.

Napoleon Bonaparte



5. *Don't use the administrator or other lay staff as the referee for physician-to-physician conflict resolution.* If you're an office manager and your physicians are in a fight, your first instinct may be to dive in and break up the rumble. You should resist this in most cases. As any police officer can tell you, some of the most dangerous calls are seemingly minor domestic quarrels. Like an unwary cop, you can get yourself gut-shot if, as an office manager, you try to resolve partner conflicts that have heated beyond a certain point. Even if you succeed in lowering tensions, at least one of the partners will likely perceive you're taking sides against them; their resentment will be durable, and you can lose the ability to lead in other areas of the practice in the future. It's far more appropriate for the managing partner or an outside party to handle and solve difficult situations. Managing partners can be rotated out. An outside vendor can be dismissed and replaced with two phone calls. But losing a valued administrator can set your practice back for years.
6. *There's no such thing as a 50–50 partnership.* Perfect equality is as much a myth as Santa Claus, another idealistic archetype that serves a valuable social purpose to keep naïve believers temporarily in line. Somebody in your practice is the smartest. Somebody is the dumbest. Somebody is the best with financial details. Somebody is the most skilled surgeon. Chances are, nobody is the best at everything. The TEAM acronym, "Together Everyone Achieves More," only works if you harness everyone's unique strengths and simultaneously acknowledge that not everyone is going to get a perfectly fair, perfectly even deal. This year you might make less, but your partner finally gets lanes two and three equipped just the way she wants them. Next year, you can get your LASIK marketing program tuned up while your partner takes a mild pay cut for you in turn. To be a happy partner, your favorite expression must become, "I can live with that." Not every partner problem has a solution. Living with a modicum of small inequalities is obligatory.
7. *Don't be shy about calling 911.* You need to know when partner discord has lasted longer or plunged deeper

than is healthy. There are all kinds of outside parties you can draw on, depending on what's at issue. A purely financial argument might be best solved by your accountant. An ethical issue can be addressed by a professional ethicist. Interpersonal frictions may yield to an industrial psychologist. Practice management consultants typically provide help with multidisciplinary issues, as when both practice governance and financial integrity have fallen off.

I hope that by using the ideas above, you and your partners will be able to stop well short of divorce. With any luck, it may be as easy as ceasing to look so hard for what's wrong and focus instead on what's right about your partnership. Accentuate the positives. As Ben Franklin might have said, were he an ophthalmologist, "Enter a partnership with crystalline vision, and thereafter work hard to develop a progressive case of macular degeneration."

Rescuing Poor Relationships Between Physicians

When conflicts arise that are beyond the skill level of the partners or administrator to resolve, hire outside professional management assistance, ideally someone who has a history with the practice—a trusted attorney, accountant, or consultant. By talking round-robin to partners, staff, and the associate physician, it may be possible to rescue a relationship that was slipping toward divorce. The cost of professional help to salvage a failing relationship is always much lower than the cost of starting all over again with a new search, especially when the loss of even a single, critical specialist's cash flow can lead a wobbly practice to economic disaster.

Physician Management Style: Striking a Balance Between Dr. Marshmallow and Dr. Terror

Physicians young and old often ask, "How tough should I be with my staff?" Consider America's marsupial, the humble opossum. Biologists know that "playing possum" is not

FOR ONE WHO
HAS CONQUERED
THE MIND, THE
MIND IS THE BEST
OF FRIENDS. BUT
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FAILED TO DO SO,
HIS VERY MIND WILL
BE HIS GREATEST
ENEMY.

Bhagavad-Gita



THE MAN WHO
CAN'T DANCE
THINKS THE BAND
IS NO GOOD.

Polish Proverb



some coy act. The animals actually *pass out* from sheer terror. Does your staff look similarly dazed when you approach them? Or are you ophthalmology's answer to Rodney Dangerfield, so meek that you get no respect? Either extreme is bad for business. Too rough, and your staff will flinch when you come around the corner, avoid taking chances, and hide all their mistakes from you. Too easy, and staff will neither respect your leadership position nor respond to your requests. Getting the staff "pucker factor" just right is an art often practiced but rarely mastered. Milquetoast physicians go through life wondering why they're chronically dissed. The most successful physician managers are naturals whose supervisory skills are so adroit they verge on manipulation . . . management poetry in motion.

Curing Tardy Physicians

In most cases, physicians who are chronically late getting to clinic (and always on time for surgery and most other engagements) are probably signaling that they don't like that portion of their work. As a result, the clinic runs late for the rest of the morning. The lost productivity and poor example for staff are worth reversing, even in the toughest cases. This is a rather common problem, occurring with at least one physician in about 25% of the practices with which I work. Here are a few approaches to a cure:

- *Since procrastination is most often an aversion to clinical drudgery, try to make the clinic more enjoyable.* This might include delegating more testing to technical staff or adding just one more medical assistant so that the physician is never under-supported. It might mean rearranging the schedule so that the day starts with a series of brief, gratifying post-op visits. Hiring an optometrist or medical ophthalmologist for routine care may help relieve the boredom. Ultimately, a brief course of counseling may help the clinician put the boring part of the job in context.
- *Sheer burnout from an excessively busy schedule has to be addressed in many settings.* This can be done by reducing duties or finding ways to mediate the stress of a full day (e.g., sleep better, diet, and exercise).

- *Document the lost productivity and profits.* This includes staff time waiting for the physician, disgruntled patients who walk out and don't refer others to the practice, and loss of the incremental time needed to convert surgical candidates.
- *It rarely works to simply move the clinic back an hour or two.* If the physicians are 15 minutes late for their 8 AM clinic, they will probably be 15 minutes late for their 9 AM clinic.
- *If the tardy physician is an employed associate rather than a partner, you can get a little tougher.* Try the ordinary incremental discipline (verbal warning, written warning, economic sanction, probation, termination) you use with support staff.
- *Peer pressure from colleagues rarely works unless they make a concerted group effort to intervene.* Individual pestering and teasing can have adverse, rebound consequences.
- *Put all physicians and senior salaried staff, along with hourly staff, on a time clock.* Some physicians really don't believe they arrive late.
- *Some physicians arrive to the clinic on time but are difficult to pry out of their office.* These physicians will wait until five patients have been worked up before getting out on the floor. In these cases, start the clinical day with a back-office huddle, a three-minute standup meeting led by the physician, before patients are even shown back. Then, after the huddle, the physician stays on the floor instead of going back to his or her office.
- *In a few tough cases in which the physicians have been late to everything, gotten lost on the phone, and socialized with patients who shared the same interests, I've hired a human clock.* This employee's unusual job includes making sure the physician gets up in the morning and out the door, serving as gatekeeper for calls and drug rep visits, and even standing chair-side to move the physician along. The resulting increase in productivity has far exceeded the cost of the hire in most cases. And if you're looking for justification, this practical solution is really no different than the personal secretary commonly hired by senior corporate executives.

THE GREAT CREATIVE
INDIVIDUAL IS
CAPABLE OF MORE
WISDOM AND
VIRTUE THAN
COLLECTIVE MAN
EVER CAN BE.

John Stuart Mill



OBSTACLES ARE
THOSE FRIGHTFUL
THINGS YOU SEE
WHEN YOU TAKE
YOUR EYES OFF
YOUR GOAL.

Henry Ford



Your Physician Recruitment Decisions Will Change Lives

I once coached an eager young South American surgeon through the process of joining a fine, established group practice here in the States. When the assignment was over, I sat back and realized how the subtle ebb and flow of introductions, negotiations, and decisions—on both sides of the table—finally resulted in life-changing events for everyone involved. For the young surgeon, at stake were a new professional context and financial opportunities that were better or worse than he might find elsewhere. For this physician's spouse and children, at stake were not only what they would find in a new community, but also what they would experience in a new country. And for the hiring practice, their decision will bring reverberations for the next 20 years or more. In some cases, with a few twists and turns, the fit between physician and practice is almost a foregone conclusion. But in most cases, the subtle romance that takes place between a candidate physician and the hiring practice is fraught with blind alleys, unintended slights, and misunderstandings. The most benign statement or action by one side or the other can make or break the deal.

Recruiting Tips for Employers and Their Physician Candidates

Here are great suggestions to help employers in the delicate recruitment dance, courtesy of Lauren Simon and Amelia Rogoff of The Eye Group (available at www.theeyegroup.com).

- *Be sure to have a formal "visit plan" for any prospective candidates.* Before the visit, make sure the candidate has a specific itinerary so he or she knows what to expect and what clothes to bring.
- *Allow some free time and "freshen-up" time in the schedule.* Visits tend to be stressful, hectic, and tiring even when time zones are not being crossed.
- *Distribute a CV or bio and a schedule of events to all participants in the recruitment process.* This will ensure there are no surprises and that the practice's staff and physicians can arrange their schedules.

- *If the candidate (with or without family) arrives by plane, he or she should be met by the senior physician or a staff member who is very familiar with the area.* This person can identify points of interest on the way to the candidate's accommodations. The route taken should be as attractive as possible as first impressions are lasting. The candidate should receive a visit itinerary and all appropriate background information on the practice and the community that was not sent in advance. Remember: You may love living in Smithville, and you've long since gotten over the stench of the pulp mill or the eyesore of a boarded-up factory, but your candidate is seeing your beloved hometown for the first time.
- *You don't need to put your candidates up at the Ritz, but neither should you choose a Motel 6.* An itinerary, a welcoming card, and a hospitality basket should be placed in the candidate's room.
- *On the candidate's first day, include a tour of the main office facility and nearby satellite offices or surgical center.* Individual and small group meetings with a cross-section of senior staff are helpful because the candidate learns more about the practice, it's a nice message to staff members that their opinion counts, and your lay staff's first impressions are a highly effective screen for poor candidates. A haughty, young physician who turns off your technical staff will do the same or worse with patients.
- *Individual (or group) meetings should be arranged with associate and partner physicians in the group.*
- *Ideally, you will have prepared in advance a brief sanitized version of your practice's strategic plan, and will have answers ready for how you intend to grow Dr. New's business once she arrives.*
- *A first-day's schedule for the candidate's spouse should include a personalized tour of the city.* Special attention should be paid to individual interests—career opportunities, schools, housing, clubs, cultural opportunities, and recreational facilities. A driving tour with an enthusiastic real estate agent can help nudge things along.
- *Evening social events should be in keeping with your group's natural leanings.* If you have a straight-laced, formal practice, be sure to entertain that way. If you maintain a frat house environment, take your candidate out for a night

on the town. Wherever your group lies on the spectrum, show your candidate who you really are.

- *The second day should include a deeper tour of the area for the physician and spouse, and older children, if they've come along.* If younger children are in tow, offer competent sitting services at any point in the visit.
- *A wrap-up session should be formally planned.* If it's been a successful visit for all concerned and your candidate still appears to be a great match, a simple agreement letter or proposal can be presented at this point. However, given the time and resources it takes to interview a candidate on site, you may want to cover, at least verbally, the housekeeping details of a prospective offer in advance, before arranging an on-site visit. There's no sense spending hundreds or thousands of dollars for an in-person interview if the fundamental terms—salary, opportunity for partnership, buy-in methodology, noncompete issues—have not been discussed and agreed to in principle by both sides.

Here's a somewhat shorter list of suggestions for candidates who have been invited for an interview:

- *Be appropriately attired and groomed.* This should go without saying, but you will increase your odds of being hired if your appearance fits the expectations of your potential employer, and, ultimately, of your employer's patients.
- *Be enthusiastic and keep an open mind.* Even if you feel the practice opportunity or market might not be the right fit, put your best foot forward.
- *Be courteous and friendly.* Be this way not only to the physicians in the practice but to technical, administrative, and clerical staff as well.
- *Be punctual.* Arrive a few minutes early to every meeting—from the start of the day to evening cocktails at the managing partner's house. When traffic or other circumstances beyond your control have you running late, call ahead and apologize.
- *Be curious.* Have a list of questions ready about the practice opportunity. Don't just ask questions that center on "what's in this for me?"

- *After the visit, always send a thank-you note.* Bringing you in for a visit is very costly and time consuming. Show your appreciation, even if you and the job are not a match.

Successfully Adding a New Doctor to Your Practice

1. *First, ask, "Do we really require another doctor?"* Ask this in the context of the needs of your practice and the needs of the overall community. For example, your practice may be on the verge of being able to support a new surgeon, but if your service area has markedly fewer citizens per private practice ophthalmologist than the national average (now about 20,000) or a remarkably younger population than the country-at-large, it may be appropriate to hold off on hiring.
2. *Forecast the post-hire financials.* This most common hiring error is not so much the result of choosing the wrong candidates as lacking the financial and clinical volume performance data to substantiate a new hire in the first place.
3. *Make sure you're adding the right kind of doctor.* Should you add an OD or MD? Surgical or medical? Generalist or subspecialist? A permanent associate or partner-track? Sometimes the choice is clear, such as when you have a subspecialty niche to fill or need a physician to take over for you in the near term. At other times, your choice is somewhat more complex. Seek out someone with a complementary skills set who can add a new service line to the practice and who won't crowd your pet patient-care interests.
4. *Clarify your long-term goals in advance of hiring.* In an effort to sell a prospective associate, it's easy—and human nature—to omit the details of where you really want to take the practice in the future. But one of the real success factors as you and your new colleague work together will be how much your respective dreams for the practice overlap.
5. *Share the true details of your job position and your practice.* To the extent possible, lay out both the wonders and the warts of what you are offering. Let candidates know

YOU NEED THAT
LIKE A PIG NEEDS A
SIDESADDLE. THAT'S
ABOUT AS HANDY
AS GLOVES ON A
CHICKEN.

*Texas Backcountry
Idiom*



whether there are occult partner tensions or wobbly managed care contracts, or if the candidate will have to build his or her own practice rather than find one ready-made.

6. *Don't be proud . . . get help if you need it.* In the most attractive, coastal markets, finding someone to join your practice may take nothing more than sifting through this month's unsolicited applications. But in most of the rest of the country, it remains a seller's market for talented doctors. In secondary markets in the interior of the country, most practices find it necessary to be either very lucky or very patient, or to hire the services of a recruiting firm.
7. *Deeply credential your candidates.* Once your recruiting efforts have paid off and you've got one or more solid prospects in contention, how should you select the final candidate? First, trust your instincts. Second, conduct 360-degree interviews, allowing each candidate to meet with all or nearly all of your practice staff. Lay staff members are uncanny in their ability to sniff out "Dr. Turnoff," who won't be successful in building his own following or who won't work out with the rest of the practice team.
8. *Write an employment contract that makes both parties equally unhappy.* Whether your new associate is a physician or optometrist, partner-track or durable, develop an employment contract spelling out responsibilities, authorities, and expectations.
9. *Start early with licensing, credentialing, and related chores.* Once you have selected a new associate to join your practice, one person should be in charge of overseeing the housekeeping details of his or her introduction to the community. Inattention to these details can result in many months of delays in cash flow.
10. *Set realistic expectations.* Nothing is more dispiriting to a new associate in your practice than the perception that his or her personal practice is faltering. It's important to manage the expectations of new associates.
11. *Go overboard in introducing your new doctor to the community.* Remember that "welcome to our practice" advertising serves two purposes: the practical, immediate purpose of gaining new patients and the secondary

gain of showing your new doctor that you really are exerting best efforts on his or her behalf.

12. *Actively lead and coach your new associate's performance.* New associates in your practice should have one, clearly defined supervisor. In nearly all cases, this supervisor should be the medical director or managing partner of the practice. This supervisor should review the associate doctor's charts, observe clinic and surgery, and meet regularly with the associate for at least the first year of employment.
13. *If you've made a hiring mistake, fix it quickly.* It's not terribly reassuring to remember that about half the doctors you hire simply won't work out. When you begin to feel you've hired the wrong person, reach a conclusion as soon as possible and cut your losses.

Consider Hiring Midcareer Physicians Instead of New Grads

Physicians who assume that new grads make the best candidates for new associates and future partners miss out on some of the best physicians available today. This assumption may have been correct a few decades ago, when anyone over 35 looking for a job was likely a washout from another position. Today's medical-economic realities mean that numerous high-quality physicians are now searching for a new job, through no fault of their own. Even before recent labor force changes, there were good reasons to consider hiring a midcareer associate. With notable exceptions, new grads are largely untried. They have been sheltered from business affairs, and they have been groomed to expect that the world will orbit around them. In contrast, midcareer physicians generally have more realistic expectations, fewer entitlement issues, and can be better team players. Most important, vetting experienced candidates is easier; they have a longer career history that you can investigate.

LIFE MUST BE
LIVED FORWARD,
BUT CAN ONLY
BE UNDERSTOOD
BACKWARD.

Soren Kierkegaard



What Does Your Employed Associate Physician Really Want?

Among the many great mysteries of the ophthalmic world, one the most enduring is summarized in the question,

THE GEM CANNOT
BE POLISHED
WITHOUT FRICTION
NOR THE PERSON
PERFECTED
WITHOUT TRIALS.

Chinese Proverb



“What does my associate physician want anyway?!?” A significant portion of my client phone calls and e-mails revolve around this topic. What’s left after you feel you’ve given your first born the moon, the sun, and the stars and your employee physician is still not happy? There’s no easy answer, especially when an overly tight senior physician is the employer of an overly grabby junior physician. Here’s a brief digest of the most common complaints I hear from junior associates, along with a few ideas to help their employers and practice managers.

- *All physicians, whether permanently tabbed as associates or on a partner track, want respect.* They want lay support staff to be responsive to reasonable requests. They want to hear their employer say during a staff meeting, “Now I want you all to realize that in the eyes of our patients and the eyes of our staff, Dr. Smith is my colleague and equal in this practice.”
- *As an owner, foster a group spirit and talk about the “team.”* Be an “us” practice, not a “me” practice in all communication—at staff meetings, in speaking with patients, and in marketing materials.
- *It’s in marketing coverage that some of the worst conflicts arise, not only interpersonally, but in a very practical business sense.* If your practice advertises, using one physician’s name as the name of the practice, such as “Michaelson Eye Center,” works better than a generic name such as “Western Eye Center.” And we also have learned that using one physician spokesperson as the public guarantor of quality works better than a parade of different faces. If your practice can overcome the ego strains, stick to one person in the ads. If the associates insist on their 15 minutes of fame, use a group shot and point out the fact that your taking a team approach is one factor distinguishing your service.
- *The best-quality associates want to get involved with decision making and with special projects they can call their own.* Allow associates to sit in on nonsensitive portions of your practice’s partner meetings. Give them a voice, even if they don’t have a vote.
- *Physicians who have not yet made partner, along with younger partners, are often exquisitely sensitive about how new patients are assigned in the practice, especially if the*

compensation methodology leans toward top-line production. There should be a written protocol for scheduling new patients, and the front desk or appointment clerks should be checked periodically so that the very human tendency to please the senior partner by feeding him or her patients is not biasing the system.

- *Most associates (and partners, too) detest being clinically pigeon-holed and kept from areas of practice that they enjoy.* As a general principle, unless an associate has been hired with the expressed agreement that he will stick to defined practice areas, it works best if every physician is permitted to provide whatever care he or she is trained to perform well.
- *Even the most junior physicians will commonly—and understandably—complain if they are forced to report solely to a lay manager in the practice or answer to a clinician or paraprofessional they deem to be of lower status.* I ordinarily construct the organizational charts of my clients to have dual reporting lines so that physicians report to a medical director or managing partner for clinical affairs and to the practice administrator for business matters.
- *It's not unusual for physicians—even permanent employees—to react adversely when the partner physicians are using staff and other practice resources for personal purposes.* I'm speaking of the common practice of a senior physician sending someone out for personal errands or over to his or her home for childcare or housekeeping duties. This rarely works in a group practice.
- *Partner-track associates obviously want an equity stake in the practice, but owners and associates are rarely on the same page regarding a fair percentage.* Owners can be too parsimonious, offering just 5% or 10%, even if their associate is now doing nearly half the work. It's best if ownership is equal, or at least roughly proportional, to production.
- *I find more often, it's the associates who are overreaching.* It's not unusual to speak with an associate who perhaps generates just 15% of the practice's revenue but expects to be granted a full 50% equity position.
- *Believe it or not, associate physicians want clear boundaries.* A common complaint I hear from associates the practice's about to terminate is, "I never knew I was expected to do that. Why didn't somebody tell me?" Every new associate should be given a written summary of your

minimum performance expectations. This list may reasonably be quite different for partner-track associates, who should *cheerfully and skillfully* take on extra work in such areas as staff training, community outreach, and quality assurance review.

Doctors, Back Up Your Manager

Remember grammar school, or perhaps high school, and those deliciously cruel days when you had a substitute teacher? Almost without active coordination, the entire class worked as a team to undercut the substitute's authority. It can be the same way in your practice if one or more physicians undercut the authority of your administrator. The manager of your practice has to be the "real teacher," not the "substitute."

A STAR ON THE
MOVIE SET IS LIKE A
TIME BOMB. THAT
BOMB HAS GOT
TO GET DEFUSED
SO THAT PEOPLE
CAN APPROACH IT
WITHOUT FEAR.

Jack Nicholson



Take Your Charm Pills Every Morning

Many great practices with technically great surgeons bite the dust because the surgeons just were not very charming to patients (or staff.) In other, thankfully fewer, cases, technically lackluster surgeons and practices offer so-so care to the public but still have high volumes because the physicians are charming. There are obvious cash-flow advantages to being "nice," even if you have to fake it. If you can't turn it around and be completely nice, at least work on "not making everyone mad at you at the same time," as wise old Mississippi administrator John Weems once told me.

Cures for Physician Burnout

A little boy in the first grade goes to his mother and asks, "How come dad comes home, spends just a few minutes playing with me, has dinner with us, and then goes to his study to work the rest of the night on that briefcase of papers he always brings home? How come he doesn't spend more time with us?"

Mom gets down on one knee and gently says, "Your father is a busy eye surgeon. All day long he's helping lots of people see better. He has a lot of people counting on him . . . so many people that even when he's finished his office work, he still

has much more left to do. That's why we only get to see him a short time each evening."

The little boy rolls this around in his head for a moment, applying what he knows of his innocent grammar school world, and with enthusiasm says, "Mom, I've got it! If dad's having such a hard time keeping up, why don't they just put him in the slow group?"

Why not, indeed?

Unfortunately, very few ophthalmic surgeons *voluntarily* put themselves in the "slow group," even when burnout looms. As a business coach to some of the country's most ambitious surgeons, I look for early signs of burnout, just like an athletic coach looks for early signs of physical injury. There's no point in increasing a surgeon's patient volumes or decreasing an athlete's marathon times if the result is an achiever who can no longer perform at all. Every surgeon has a different reaction to stress. Some of the country's highest volume surgeons get "crispy" only at 300 or more major cases per month. At the other end of the scale, some anxiety-prone surgeons are like twitchy concert musicians who can only go on stage if they are medicated for the stress induced by having to perform. Here are several ideas to forestall or reverse burnout in your own setting:

- *Use diet and physical conditioning to offset mental and physical exhaustion.* Paradoxically, regular physical activity—anything from long walks to formally supervised gym workouts—can be both treatment and prophylaxis for burnout. That's why some of the nation's busiest surgeons are extremely physically fit.
- *Increase delegation.* You don't personally have to do everything. Have your optometrist or senior tech take first call, with you available for standby. If you're in solo practice, take on a junior partner or recruit an administrator with enough sophistication to take the business worries off your plate.
- *Decrease your cost of living.* As the old saying goes, "When your outgo exceeds your income, your upkeep becomes your downfall." Many surgeons slip unconsciously into a

pattern of increasing the cost of their lifestyle just slightly faster than their hard work can keep up. The stress of excess debt and a spouse asking when the family's second home can be redecorated—on top of an already stressful practice—can put even the most burnout-resistant physician over the top.

- *Reengineer or eliminate the unnecessary. Not everything needs to be done.* If you have an ASC and you're burdened by residual hospital duties, draw back to courtesy status if this is politically feasible. Are you writing letters when a quick call, or better yet an e-mail message, will do? Shift gears and communicate in the most streamlined way possible. If you dictate at the end of the day, shift to dictating in front of the patient at the end of the encounter—it takes less time (since you're already oriented right then to the case), and it's working smarter because you save steps in discussing the treatment plan with the patient.
- *Learn to say "no" to responsibilities that don't make a proportional contribution to your business.* You might want to still chair an annual vision-screening program in your community but then decline speaking once again during career day at the local high school. Any of the recent books on simplifying your life may help you commit to an less committed lifestyle.
- *Establish boundaries.* Are you like the physician in the story above, with a satchel of paperwork to plow through each night? Consider setting boundaries. Even small steps, like "I do not EVER work Wednesday evenings, which are reserved for family night," can be remarkably liberating. Use your appointment calendar not only to be disciplined about when you're available to see patients, but also to be disciplined about when you're not available at all.
- *Change the duration and periodicity of time off.* The typical eye surgeon takes about six weeks off a year. Half or more of this is commonly spent at national meetings. Granted, the meeting locations are often posh, but such meetings are hardly a break from the office. Indeed, by the time you factor in the added stress of modern travel, worries about leaving the office uncovered, and the anxiety that arises when you hear how many LASIK cases

your old roommate Charlie is now doing, you will likely return home more stressed than when you left.

- *Put yourself permanently in the slow group.* We can learn a lot from surgeons who, as they enter their 50s and 60s and become financially independent, start working a schedule that pleases them. Surprisingly, they rarely quit. Instead, they transition to four-day weeks. They refer the toughest cases. They develop deeper relationships with a few pet patients and favorite staff members. If you're in your 30s or 40s, taking this approach early may grind the sharp edge off the least pleasant dimensions of your practice.

What's in It for . . . E-V-E-R-Y-B-O-D-Y?

When developing, you must align the incentives for all stakeholders in your practice. Fair enough: As a surgeon-owner, it's reasonable for you to ask first, "What's in it for me?" But immediately after this you should also ask, "What do my partners get? What do my staff get? What does the physician whose practice I merge with get?" If the incentives are markedly unbalanced, your plan may be destined to failure.

Making Equity Buy-Backs More Equitable

Partners in a group practice generally have buy-sell agreements stipulating how much a departing partner is paid for his or her buyout upon departure. This typically stipulates a payment for at least the physician's accounts receivable and fair share of the tangible equipment. It may also include a buyout for the goodwill value of the practice. Because there is always a concern that a productive physician who leaves suddenly will leave behind partners who are unable to take full advantage of that part of the practice they're taking back, it's best to include a side recital in such contracts. This recital stipulates that a departing partner gets a full measure of payment if he or she leaves with sufficient notice (let's say a year or more, which is more than adequate to forecast retirement plans). But if the partner leaves after giving shorter notice, he or she receives only partial payment.

THE FIRST
ATTRIBUTE OF
A SURGEON IS
AN INSATIABLE
CURIOSITY.

Russell John Howard



IF A CLUTTERED
DESK IS THE SIGN OF
A CLUTTERED MIND,
THEN WHAT ARE WE
TO THINK OF AN
EMPTY DESK?

Albert Einstein



When Everything Goes Wrong: Practice Divorce

The survival rate for physician-to-physician unions seems to be about the same as for married spouses in America. About half the time, things just don't work out. That's why in most situations, there should be a two-year or longer associate-employee status for even the strongest partner candidate. Like other business partnerships, practices rarely split up for purely financial reasons, although finances are often used as a scapegoat. Instead, the breakdown is generally over control issues, which should be clarified at the outset of employment. Here are a few recommendations for both parties to a professional divorce, directed at the issues that arise when a younger physician voluntarily or forcibly leaves an established practice:

- *Realize that both parties have made a mistake.* In even the most malignant cases, at the very least the "wronged" party has made an error in judgment by hiring Dr. Young or joining Dr. Old.
- *Be honorable.* Live up to your contractual obligations. If you signed a noncompete agreement, even if it isn't technically enforceable in your state, don't compete. Likewise, don't copy charts, withhold compensation, make disparaging remarks, or spread rumors.
- *Seek legal advice early on, and draw up a specific separation agreement if appropriate.* If possible, do this before emotions escalate and communications break down.
- *Help each other get on with your respective business.* In an ideal world, the departing associate or partner should give adequate notice, assist with recruiting efforts, and help orient the replacement. The enduring employer should actively help the departing doctor seek a new position, write fair and factual reference letters, and provide both economic and moral support to the released doctor—who in today's harsher environment is generally less prepared for change and far less advantaged than the employer.

CHAPTER 6

MARKETING AND DEVELOPMENT



*From running I've learned
that pain is nothing compared to
the emptiness of quitting.*

BY A 15-YEAR-OLD ATHLETE IN A
SCHOOL ESSAY, "WHAT I'VE LEARNED"

“Marketing” Defined

The definition of *marketing* I like best is, “*Establishing and maintaining an exchange relationship.*” Too often, the most aggressive practices forget the “maintaining” part of marketing. Remember that nothing makes a poor product fail faster than great advertising. That’s partly why many formerly thriving, marketing-oriented cataract and refractive surgery practices have failed. Getting a new patient to enter your practice is more difficult and expensive than ever, which is why greater attention must now be given to patient satisfaction and retention.

Establishing a Practice “War Room”

Marketing warfare is an accepted fact in corporate America. One of the first things I ask exceptionally competitive clients to do is post a large-scale map of their entire service area in their administrator’s or managing partner’s office, or the board room. They then add pins to designate all their offices, prospective new offices, competing ophthalmic providers, potential consolidation targets, hospitals, and large clinics. For each office, they pull the location of the last 100 new patients to enter the practice and put a pin or dot on the map for them, too. This serves as a useful visual aid for consolidation discussions and a reminder to all partners of the agreed development goals.

All Marketing Should Start Internally with a “Zero Defects” Recall Protocol

It can take \$500 or more in media advertising to generate a single new patient for your practice. By comparison, internal promotion is cheap and effective, advances public health, and is a good defense against malpractice claims. Here’s a starter list of several internal promotion ideas. There are scores of additional opportunities, many of which will be unique to your practice setting. The *breadth* of what you do is far less important than *100% follow-through* on these most critical items:

- *All patients, unless they are from out of town or being returned to their referring doctor, should be given a recall*

MEDICINE SHOULD
BE PRACTICED
AS A FORM OF
FRIENDSHIP.

Leon Bernard



or return visit interval—not “PRNd.” This return interval should be plainly noted in the chart and on the superbill and used without fail by the front desk to establish a return appointment (up to 12 months out) or trigger a recall notice. Each of these steps is subject to breakdown and should be audited regularly.

- *Patients who need to make an appointment but are unsure of their schedule when they check out should be called within 48 hours if they don’t call first to make an appointment.*
- *Standard recall intervals should be established in writing for various categories of patients and memorized by all physicians and staff.* Staff should feel free to question the physician on what seems to be an excessively long recall interval.
- *All no-show patients should be called within one hour and worked in on the same day if possible.* Call all patients one or two days before their exam. If your no-show rate is over 5% (common in pediatric and other Medicaid-based practices), consider making more than one call and even considering a no-show charge.
- *Establish a recall program, and make sure to follow up.* Only about 40% of patients respond to a first recall card. In about half the practices I visit, no follow-up attempt of any kind is made. In the rest of the practices, the norm is to send additional cards—this is only partially effective. Instead, it’s best to call nonresponders: “Hello, Mrs. Evans? This is Judy in Dr. Briant’s office, your eye doctor. About a month ago we sent you a recall notice, and we didn’t hear back from you. Dr. Briant asked me to call—he was concerned that you keep regular appointments because of your diabetes.”
- *Ask all patients for referrals at every visit.* Your leave-taking from the exam room should end with a simple script along the lines of, “Please tell your friends about the importance of regular eyecare,” and handing out three of your cards.
- *Install small signs throughout the office to encourage referrals.*
- *Like the smartest large practices do, hire a separate, full-time “continuity-of-care coordinator” to monitor recall, phone patients who have been lost to follow-up, and contact surgical fence-sitters.* In smaller practices, split these jobs up among your staff, but audit for follow-through.

- *If your practice has lagged behind in continuity of care, you may have some rehab work to do.* Check a few dozen charts of patients who are one to four years out since their last visit. With current technology this is easy: simply run a report for patients above a given age or with appropriate pathologies who have not been in for an excess period. In practices with paper records, it's not unusual to find thousands of dollars in lost patient service opportunities per linear foot of patient charts. It is best to outsource the hard work of calling these missing patients back into your office to somebody not on your regular staff. In most busy offices, harried staff understandably have little incentive to pack more visits into an already full schedule.

Better Practice Fitness in the Long Run

Studies show that jogging increases your lifespan, but by little more than the time you've spent jogging. In the same way, many forms of practice marketing may have little more than a one-for-one return on investment in raw dollar terms: A dollar spent on marketing yields an incremental dollar of revenue. However, like a regular running program, consistent marketing can create a greater level of corporate fitness because it builds incrementally on a base of patients who refer family and friends to the practice. Spurring this secondary alumni referral is the greatest gain from most ophthalmic marketing programs.

THERE ARE COSTS
AND RISKS TO
A PROGRAM OF
ACTION, BUT THEY
ARE FAR LESS THAN
THE LONG RANGE
RISKS AND COSTS
OF COMFORTABLE
INACTION.

John F. Kennedy

Welcome-to-the-Office Letters

The staccato of modern life has eliminated many of the social graces, including letter writing. So it's a pretty big thing when a patient new to your practice receives a welcoming letter from the treating physician. There is obviously no way to calculate the cost-benefit ratio of such letters, but the cost is small and the activity can be largely automated. See the sample letter on the next page.



Mr. David Hamilton
7139 Ames Street
San Diego, CA 92117

Welcome to Our Office!

Dear Mr. Hamilton,

We appreciate your selection of our office to serve your eye-care needs. Your regard and trust is important to us. We'll try to keep it by always providing you with personal, sincere, and professional care.

Our office is dedicated to serving our patients with the utmost quality and compassion. Every decision and every action we make is aimed toward this goal. As you're about to experience at your first appointment, we will strive to provide you with a level of care and concern that rises above what you have experienced in other settings.

All members of our staff have been trained to not just do their individual job, but to communicate their concern and their sensitivity in a pleasant and professional way, while functioning as a member of a team striving for excellence.

Thank you for the privilege of allowing us to become your eyecare provider for your first appointment at 3:15 PM on June 15, and hopefully for many years to come.

Sincerely,

Mark Krossman, MD

Mark Krossman, MD

Icing on the Patient Encounter Cake

A few select practices send follow-up letters to their patients after the first visit (or even after every visit), thanking them for coming. The letter includes a customized or standard paragraph abstracting how the visit went:

As we have discussed, you have the early signs of cataract formation in your eye. I don't believe this is appreciably affecting your vision. But together, in the months and years ahead, let's monitor these cataract changes. I can assure you that when the time comes, we will be able to treat your cataracts using the latest methods.

HE WHO WOULD
FLY ONE DAY MUST
FIRST LEARN TO
STAND AND WALK
AND RUN AND
CLIMB; ONE CANNOT
FLY INTO FLYING.

Friedrich Nietzsche



Your Physicians Are Your Practice's Product—Show Them Off

This pearl is overlooked by a majority of eye care advertisers: Make sure a physician-as-spokesperson is included with all ads. Patients want to see and hear what they're buying. A physician's photo with a brief bio as a caption should be included with all print ads. Radio and TV should showcase the physician as "star" of the practice. Doing this can double response rates—which should overcome any resistance you have to appearing in your own ads on the grounds that doing so is undignified.

Elevating Your Practice's Graphic Design Standards

Can your practice's graphic design work pass this test? Take one copy of all your print ads, your stationery, your brochures, and signage. Mount them on the wall, and step back 30 feet. Does everything look like it comes from the same company? To develop a more cohesive branded look, have your graphic artist prepare a standards summary that describes the colors, sizes, and fonts you use; the relationship of graphic elements; and the person in your practice who will approve everything going forward. Depending on how important style is to your practice (vital for refractive surgery advertisers, less so for established geriatric practices), schedule the replacement of any materials that don't fit your new standards.

Exterior Signs: A Great Marketing Value

It's astounding: Practices that think nothing of spending \$300,000 a year on media advertising will shy away from a \$30,000 expenditure on their building sign . . . even though the cost-per-reach is a lot less than media advertising over time. Since you are unlikely to get a second chance to get it right, here are a few simple guidelines: Your sign should be as large, as high, and as close to the street as local code will allow. It may be worth attempting to get a variance on restrictive signage regulations inasmuch as you *do* serve the visually handicapped. It should be backlit at night. Look at and photograph other signage. What stands out? Red, yellow, and black are the most common colors. A changeable area (like a digital theater marquee) can announce optical sales and educational seminars and increase customer interest.

Brochure Tips

Many practices still have a general brochure describing their services. Here are a few content and production tips if you're creating or revising yours:

- Use a four-inch by nine-inch format so it can be mailed out in a #10 envelope.
- Use photos liberally . . . keep the design simple and clean, with lots of white space.
- A local freelance graphic artist should be able to turn-key the job, and the final production should come in at under \$1.50 a copy for the first 5000 copies printed; much less after that.
- Don't skimp on quality—it should match the quality of your facility and people.
- Use individual tip-in sheets for all doctors and satellite location maps so the brochure doesn't have to be reprinted as frequently.

Distribute *very* liberally, including, if you're comfortable, handing a copy to every happy departing patient with the words, "Please pass this on if you know someone who's been needing eyecare."

AAO Brochures

The American Academy of Ophthalmology produces simple, effective patient education brochures. Although they are a little costly on a unit basis, they are a great solution for smaller practices that lack the resources to customize their own materials. As a secondary benefit, physicians gain a certain “halo effect” of enhanced credibility with patients through their association with a national society. These and other brochures should be personalized with a stamp or sticker and spread throughout the office—check-in, check-out, the primary and secondary waiting rooms, and every exam lane.

I THINK WE SHOULD
JUMP ON THIS LIKE
WHITE ON RICE.

Matt Wesson, MD



Patient Newsletters

Patient newsletters were once among the most effective and common advertising tools. Since then, most practices have cut back or eliminated their publishing activity. That’s a mistake in some settings. As ophthalmology increasingly migrates toward primary eye care and dispensing, maintaining a longitudinal relationship with the entire family of patients is important. Newsletters can help stimulate alumni referral, remind patients to keep making their appointments, and influence their decision when neighbors try to get them to switch brands. Consider reinstating a patient newsletter, with a few modifications to the way things were once done. Keep your mailing list clean—eliminate inactive patients and duplicate addresses to reduce production and mailing costs. Produce a smaller/simpler piece in-house to save time and graphic design costs. Something closer to a bulletin—even an open letter on letterhead—may get more readership attention than an overly large and lavish piece. Mail your publication three times a year rather than four to six, as was once done. Consider specialized publications for key audiences that may need special treatment—a brief monthly bulletin on vision correction to refractive surgery fence-sitters, a quarterly senior-vision newsletter, an office management tips flyer (or faxed or e-mailed memo) sent out periodically to optometry practices.

Improving New-Patient Sourcing Studies

Marketing-oriented practices spend significant sums of money on promotion but pay little attention to measuring the return on investment from their efforts. Patient referral reports from most computer systems will indeed show patient counts, charges, and similar data by referral source. But this simplistic approach has two chief weaknesses. First, it relies on accurate information input by the front desk, which for “referral source” is commonly an afterthought. Second, such reporting shows the breakdown for all patient visits or charges for that month only. It doesn’t show the long-term value of a newly captured patient.

Unfortunately, the solution is fairly laborious and requires physician input. However, the results warrant this effort, which can be done on an ongoing basis or with periodic spot sampling. Here’s how:

- *After a new patient completes an information and history form, make a spare copy and clip it to the outside of any paperwork accompanying the patient throughout their exam. Ideally, the question on the form about the referral source should be, “How did you hear about our practice?” rather than, “Who referred you to our practice?” The latter question makes some patients think they need a physician referral or third-party payer authorization, and this can be confusing.*
- *During initial testing and history taking, the workup tech should verify and refine information about the referral source. If the patient wrote “a friend,” try to get a specific name (and make sure to write a follow-up thank-you note). If the patient wrote “radio” or “newspaper,” try to get the name of the station or publication. The tech should enter these specifics on the spare copy of the information form.*
- *After the physician sees the patient, he or she should write a dollar amount in the upper right hand corner of the spare copy of the information form corresponding with his or her best estimate of the total collections to be expected from this patient in the next three years. If you are uncomfortable specifying an amount, classify patients into I, II, III, etc.,*

THE PRIVILEGE OF
A LIFETIME IS BEING
WHO YOU ARE.

Joseph Campbell



categories, with estimated collection ranges for each classification.

- *Ask all providers in a multiphysician practice to make consistent estimates of the value of each new patient. This is a critical step.*
- *At the end of the reporting period (which might be a typical week if you are sampling data or a month if you perform regular reports), collate the data. Show in column form the specific referral source (including specific doctor names), the number of referred patients, and the value of these patients.*
- *Over time, compare the value of these referrals to the amount spent to generate them. For example, you may find that from the \$8000 per month you spend on print ads, you yield \$32,000 in estimated future revenue . . . a fairly typical, and acceptable, four-times return on investment. You will also be able to draw conclusions about which doctors send what kind of patients. (An OD whom you thought was a great source of patients may be sending only nonsurgical cases to you.)*
- *Repeat the study with whatever frequency makes sense. A conservative practice with little external promotion may conduct nothing more than a one-time benchmark study out of curiosity. A practice with significant advertising outlays should probably perform this study monthly to better meter and apportion marketing investments.*

Patient Satisfaction Survey Protocol

Aside from objective clinical and surgical outcomes, patient satisfaction should be the core “product” of your practice. But few practices evaluate customer satisfaction in any depth. Most stop at periodic written surveys and call the job done. Written surveys with pointed questions provide a way to ascertain how patients feel about specific things; for example, to identify what portion of your patients feel that waiting time is appropriate versus excessive. However, written surveys have several shortcomings, the biggest of which is an adverse selection of respondents; only your raving fans and your biggest detractors tend to respond. In addition, written surveys don’t allow patients to elaborate on their feelings and can’t draw out creative suggestions for

your operational problems. Telephone surveys are much better if you want a deeper understanding of your practice's ability to satisfy patients. A "laddering" survey (think: "I'm climbing down a ladder into this patient's mind") will allow you to explore in depth how you're doing. Here's the protocol:

Depending on how serious you are about the study, select between five and 20 patients at random per provider per month who were seen in the past month. Select a surveyor to place the calls; this can be the practice administrator, marketing director, or an outside party . . . it shouldn't be someone who is likely to be overly attached to the outcome of the study, for example a physician's spouse or a technician. Call each patient and start with the following introduction: "Hello, this is Mary from Dr. Bill Smith's office, your eye doctor. Each month we select at random a few patients we've recently served to find out what kind of a job we're doing as a practice. I'll only need about five to 10 minutes of your time if you can help us out." With the patient's approval, you can then pursue a line of questioning about his or her global experience with the clinic:

- How easy was it to make an appointment?
- Did we provide you with a reminder call?
- Was it easy finding the office and getting a place to park?
- Describe your experience checking in at the front desk.
- Were you seen on time, or did you feel your wait was excessive?
- Do you believe the technician, the staff member who first examined you, did a good job?
- How did your time with the doctor go? Did she answer all your questions? Did she address your chief concerns?
- At checkout time, were you clear about when you should next come back for an appointment? Did the fees seem fair and reasonable?
- Is there anything else we could have done more of, less of, or differently to make your total experience better?

THE EDSSEL IS
HERE TO STAY.

Henry Ford



With a cooperative patient and an adroit interviewer, these sessions can last 15 to 20 minutes or longer. Write down each patient's responses, and collate the results monthly.

Implement obvious improvements. Discuss material failings, privately in most cases, with the relevant parties. For example, take a technician aside and tell him that patients are mentioning he's too abrupt sometimes. Repeat the survey monthly or quarterly for each provider.

Patient Focus Groups

There is no faster way to gain an impression of your total eye care product you offer than to hold a formal discussion session with eight to 12 patients who share something in common (e.g., all are three-month cataract post-ops or refractive surgery advertising leads who have not gone forward with surgery). It's typical to compensate the participants with a small check or a gift certificate to a local mall. You need a quiet board-style room, refreshments, a moderator, and a video camera and operator. (Or you can simply audio record the meeting.) First, go around the table with a few warm-up questions. Then get to the tough questions about what your practice needs to do better. Patients typically take up to 45 minutes to warm up and give you their true feelings, so be patient and do more listening than talking.

Publicity Hints

Trying to generate favorable stories in the lay press is frustrating for most practices because they lack media contacts, scale, or newsworthiness. Here are a few ideas to get the most possible attention:

- *There are two basic kinds of stories for you to try to generate: news and features. "News" means hard news—you've found a cure or you're the first in the state to perform a new procedure. If you have done something truly newsworthy, hire a local professional to get the word out as far and wide as possible. "Features" are softer pieces—human interest stories, by and large . . . "At 68 years old, Mr. Schwartz has just received his pilot's license thanks to cataract surgery." Feature stories, unless they are so interesting that they are nearly newsworthy, are generally worked up for a single media outlet.*

- *In larger markets, with major media outlets, any effort to generate press interest (for example, in your practice's PIOL advances and superior outcomes) will likely stimulate multi-source stories.* This means your positive comments will be balanced with negative comments from other sources. Try to head this off by including in your interview comments that anticipate the negative input of others.
- *Be an opportunist.* When you treat a member of the working press in your practice, ask him or her if you can follow up with a few questions after the exam . . . network to the right medical or other reporter . . . find out what he or she might be interested in covering.
- *The advertising and editorial departments of most credible media outlets are completely separate.* Unless you are in a small-town environment, don't expect your ad dollars to buy media attention or shield you from negative publicity.
- *In most cases, you should avoid "advertorial" opportunities—articles written about your practice for special health care or senior sections of the newspaper.* The return on investment is very poor. The same goes for monthly senior newspapers, free weekly shoppers, and the "special" package deals that radio stations use to snooker unsophisticated physicians into buying ads during the late-late-late show. As a starting point, always ask yourself, "Has this been proven to work in some other practice first?" If yes, get the references. If not, walk away.
- *Negative news sells better than positive news.* What starts as a professional warning to seniors about the sun's harmful rays can be a backdoor to discussing advances in cataract surgery.
- *Your hospital likely has an experienced publicist who speaks to the local press every week.* Enlist that person's assistance. Most hospital publicists get little cooperation from physicians, and your willingness to simply be available may generate large returns.
- *Make sure to reprint any print media stories about your practice and to hand them out to patients and referral sources.* Frame multiple copies—one for each office location and one for each physician, staff member, and patient mentioned in the article. Make dubs of all electronic media coverage.

- *Publicity has its limits as a promotional tool and cannot be relied on to carry the entire burden for developing new patients.* It is best used to stimulate market interest in advance of or concurrent with launching paid advertising.

The Role of Social Media in Your Practice's Promotion Mix

As Wikipedia has defined it, "Social media are computer-mediated technologies that facilitate the creation and sharing of information, ideas, career interests and other forms of expression via virtual communities and networks. A common thread running through all definitions of social media is a blending of technology and social interaction for the co-creation of value." Seen through the lens of business communication, social media is just another communication channel—like newspapers, radio and TV—to reach a target audience. Social media, once the province of younger audience segments only, reaches all age groups today. Unless you are lucky enough to employ a precocious 15-year-old, it's best to leave the development and implementation of a social media strategy to a specialist firm such as www.page1solutions.com.

Welcome Patients' Family Members and Friends

You should always have your appointment staff encourage patients to bring their family members and friends to office visits and have them join the patient back in the exam room. You'll multiply the number of people exposed to your practice, and if the patient is a surgical candidate, friends and family will likely be involved anyway. Senior patients can be told to bring any senior friends or neighbors who would like to get a free eye screening. P.S. When a spry 88-year-old patient is accompanied by her daughter, be sure to present your assessment and plan to *both* mother and daughter.

WE DON'T LIKE
THEIR SOUND.

*Dick Rowe
(of Decca Records,
rejecting the Beatles
in 1962)*



Securing Optometric Referrals

Independent and chain optometry practices control the distribution of eye care to the majority of commercial-aged patients (i.e.: adults below age 65) and an important percentage of seniors. Surgeons have been tapping into this distribution channel for decades. The historic, grudging acceptance of referrals from optometrists has shifted in the past decade to relatively high levels of camaraderie, as both Os have come to realize the practical and patient-care benefits of working together. The most economically effective surgical practitioners now work closely with optometry, either by encouraging referrals from external doctors or employing a large cohort of optometric providers who represent a feeder source for surgical care.

“My Mother Has Cataracts” Secret Shopper Survey

The first step in assessing and potentially expanding optometric referral relationships is to develop a benchmark of where their referrals are currently going. Have a staff member (whose voice is unlikely to be recognized and whose phone is blocked from caller ID system access) call every optometric office in your service area with the following script: “My mother lives in California and she’s just been diagnosed with cataracts . . . she’s going to be visiting us this summer, and she would like to get a second opinion—who would you recommend I have her see?” Responses from the optometrists’ receptionists fairly accurately reflect referral patterns from each office. Use the resulting information and your own internal new-patient sourcing statistics to assess your ability to establish or expand a referral network.

Additional Optometry Outreach Pearls

Your practice should review referrals monthly and use any doctor’s drop in referral volume or surgical density as a signal to reconstitute the relationship. An early, direct call from the ophthalmologist to the optometrist asking what’s gone wrong is generally the best approach. The above “My mother . . .” survey, performed as an initial baseline, should

be repeated semiannually or annually to identify emerging trends. An optometric director is a core success factor in higher volume referral centers and has been the “secret weapon” of corporate comanagement centers. Hiring a highly experienced center director is expensive—\$150,000 and up in many cases—but could be the critical gap in your program. Excess dependency on a single lay staff member or optometric director for outreach can leave a practice highly vulnerable . . . it’s critical for physician-principals to maintain a minimum threshold of direct personal contact with “key accounts.”

Adding Value to Your OD Relationships

Staff-to-staff outreach can be an effective adjunct to physician-to-physician contact. Provide a billing helpline, develop a tech training workshop, and hold a periodic open house for staff. The proliferation of competing CE programs for optometrists is making these programs somewhat less effective as an outreach tool in some urban settings. Consider more personalized, in-office mini-fellowships and drop-in “lunch and learns” for staff. Provide your optometric and primary physician colleagues with referral pads indicating the patient’s name, consultation sought, appointment scheduling information, and a map showing how to get to your office. Consider a private, priority OD hotline, and designate one staffer as a chief contact. Identify each OD’s preferred follow-up communication (e.g., a call versus a letter versus an e-mail).

FORTUNE FAVORS
THE AUDACIOUS.

Erasmus

Moving Beyond Optometric Comanagement to Partnership

Some of the most advanced practices—including practices that were the first to comanage with optometrists—are making a transition from purely informal and voluntary referrals to deeper business relationships. Jointly ventured marketing and part-time facility leases are now common. But these arm’s-length relationships still do little to truly secure the distribution channel. Full economic integration of optometry and ophthalmology—via merger or acquisition—is the emerging trend, and I predict that this



will be the ultimate eye care industry endpoint. If your surgical competitors enjoy all of the voluntary optometric referrals in your area, your best strategic move may be to buy up or merge with their patient referral sources. It can be difficult for comanaging practices to take the first step toward merger lest they appear to be in competition with their referral sources. However, if your practice is dependent on OD referrals, it may be critical for you to secure this distribution channel, even at the risk of losing some referrals.

Don't Neglect Outreach to Primary Care Physicians

Few general ophthalmologists exert much effort to develop strong referral ties to primary care physicians for practical reasons: They represent less than 5% of the dollar referral volume in the typical practice. However, in anticipation of the potentially growing influence of PCPs in selecting specialty panels (subject to the direction taken by future health reform), the smartest ophthalmologists are reconnecting with their physician colleagues through a variety of tactics including casual social contact, participation on hospital committees, greater attention to following up consults over the phone, sending periodic reprints on the intersect between ophthalmic disease and general medicine, annual grand-rounds workshops, and holiday gifts.

Own Your Patient Base

Do your patients feel a sense of belonging—even “membership”—in your practice? You can foster this with between-visit phone calls, newsletters, support groups, and a call from the physician to say “thanks” for referring a new patient. Laminate a discarded sample of the patient’s IOL or the patient’s Rx and your card into a single unit for his or her wallet. Have this card be good for a courtesy discount in your optical shop. Get your staff accustomed to saying things like, “You’re a real VIP here in our practice—I’m sure I can get a more convenient appointment for you!”

Harvesting Patient Data

You spend tens of thousands of dollars every year on computer systems and data entry. Make sure you are harvesting as much value as you can from this precious investment. It's called "data mining." Scan for patients lost to follow-up. Find patients who have had one cataract procedure but no fellow-eye surgery and no appointment on the books, or cataract surgery but no Nd:YAG laser treatment. Determine the geographic and demographic distribution of your refractive surgery patients, and redirect your advertising messages accordingly. In short, squeeze more value out of what you've already paid for.

Naming Your Practice

What should you name your practice? Here are a few guidelines. Your name should describe what you do . . . "Smith Eye Clinic" is obviously better than "Smith Clinic." It should have no more than three words, four at the most, if possible . . . "Smith Eye Associates of the Southwest" is a little cumbersome. Avoid using a geographic identifier if this is overused in your service area, like "Cumberland Eyecare." Avoid a name that boxes you in geographically or in the services you provide. If you live in a twin-cities area, don't name your practice after just one city. If you are going to offer total eye care, don't name your practice "The Eye Surgery Center."

Should You Name the Practice After Yourself?

A personalized practice name can be extremely effective. Dr. Smith, his staff, and patients will likely have more pride going to "Smith Eye Care" than something more generic. However, what happens when Dr. Smith tries to take on an associate? Unless the second physician is very subordinate, he or she can become understandably demoralized laboring in the founder's shadow. If you can overcome this hurdle, a proper name is the most memorable for branding purposes. For a cogent and to-the-point read on the subject, buy a copy of *Selling the Invisible* by Harry Beckwith.

If you're hung up about using your own name, name the practice after its long-ago founder, the first eye doctor in the region, or a random but unique and brandable proper name.

Transitioning to a New Name

If you are broadening your locations or scope of care, part of your marketing and development work may involve a name change. Transition the name as carefully as possible, but do so briskly. If your old name is "Seattle Eye Surgeons" and you are adding optometrists, transition to "Seattle Eyecare." In most cases, don't waste money buying ads announcing the name change unless it is part of a larger change, such as a new location or added services.

More Practice Name Advice

Advertising under a separate, subspecialty DBA ("doing business as"), for example, "The Jones Cataract Institute," can increase responses compared to advertising as "The Jones Eye Center." (The word *institute* is effective, even if it's used by a smaller solo practice. But expect some ribbing when the name goes up on your 1500-square-foot office.) Don't name your practice based on a surgical modality, but feel free to name your practice based on a presenting condition. The ongoing fashion to name practices "LASIK" this or that is ineffective. As new methods emerge, your name must endure. I'd choose "Iowa Vision Correction Center" over "Iowa Laser Treatment Center," even if "laser" does sound a little more hip today.

Cross-Border Malpractice Exposure

If your practice is located near a state border and you use broadcast advertising or cross-border screenings to draw out-of-state patients to your practice, check with your insurance carrier to make sure you are covered in the event of a malpractice claim by such patients.

Thirty-Minute TV Ads

Infomercials—long TV ads combining education with hard sell—have become a popular vehicle to promote cataract and refractive surgery. Production costs are generally shared among numerous practices on a syndication basis, and for \$10,000 to \$20,000, the clients get a semicustomized product that's better than they could produce on their own. The resulting video can be aired as well as distributed as a patient education DVD. It can even be shown in the reception area. Now for the downside. This production cost represents a significant commitment for smaller practices; if this marketing approach doesn't work in your location—and there's no sure bet it will—you may throw good money after bad trying to get a response rather than cutting your losses. Past experience shows that in most locations, the cost per lead (the cost to generate a single qualified call) is the same for shorter spots as it is for longer infomercials. The *critical* disadvantage of infomercial advertising is that your patient leads are compressed into a much shorter time frame. This puts a burden on the fulfillment staff in most practices, which in turn means that screening and surgical conversion rates can be lower. In summary, infomercials should be a supplemental, not primary, tactic in most settings.

MY TASTES ARE
SIMPLE. I AM
EASILY SATISFIED
BY THE BEST.

Winston Churchill



Homegrown Vision Care Plans

Chances are that developing a vision care benefit plan is best left to organizations larger than your own—just make sure you have a role as a provider in such organizations. The exception is if you (a) operate in a more rural community, (b) operate with mostly smaller employers who have little in the way of vision care benefits, or (c) provide primary care or have a network of comanaging optometrists. If this is the case, your local employers may be receptive to your providing a plan competing with VSP and the rest. Here are the basic steps:

- *Survey the employers.* Find out what they have, what they want, what discounts they expect, and for what they would be willing to pay. (Programs can range from free

discount cards handed out to beneficiaries to company-sponsored benefits.)

- *Survey the providers.* If you are doing this with multiple independent optometry practices, find out what fee and product concessions the practices are willing to make. Unless you are all in one practice entity, you should avoid any discussions that could be construed as price fixing.
- *Make sure you will not be cannibalizing your own patient base.* If you and your colleagues already “own” a rural market, there is no point in discounting to the entire base. Realize that some degree of cannibalization will occur anyway. If you go forward, some established patients will be getting a discount. It’s vital that your optometric colleagues understand and accept this in advance.
- *Develop the program, including benefit or discount parameters, employer fees if any, educational materials, membership cards, company lists, and contact names.*
- *Hire a representative (full or part time), and get member cards in the hands of employees and their families.* Start with larger employers, both for the sake of sales efficiency and to develop a degree of momentum and credibility for your product.
- *Measure the results.* Find out what’s working . . . correct what’s not.

Guest Relations

If you have a high-throughput practice that tends to generate patient confusion about “where do I go next,?” and you want to soften the “clinic” atmosphere, consider a volunteer or paid concierge staffer, at least for peak periods. This staff member, who sits at a desk in the waiting room, can offer refreshments, tell patients how their appointment time slot is coming along, spruce up the reading materials, and intercede with irate patients. At the very least, peak traffic times should mean that a front-desk receptionist makes a periodic tour through the waiting room to smooth over any problems.

Office Signs That Stimulate Referrals

Because patient-to-patient referrals are the most important source of new patients in most general practices, it is crucial to do everything possible to encourage referrals. One way is to post a sign or two, with wording along the following lines: "Please tell your friends about the importance of regular eyecare."

Upscale Sponsorships

If your practice depends on a large cross-section of professional referrals or has a better educated, upscale patient base, consider sponsorships on PBS radio. The cost is relatively low, the audience premium, and the cause great.

What the Best Marketers Have Always Known

Controversy sells. No, you're not like a film star who can increase ticket sales by being arrested. And as much as you would like to, you can't run political-style ads about your surgical competition: "Did you know that Dr. Reynolds broke his right hand in high school football, and his board scores were among the lowest in the nation?" (Actually, this would probably work.) However, you can play the outer edge of this strategy even in ophthalmic advertising. Consider ads that say, "You may not need cataract surgery," and offer second opinions.

Ophthalmic Advertising: Micro and Macro Seasonality

Beer commercials run on Friday and Saturday because that's when beer is purchased. Office supplies are advertised on billboards heading into the city (because people place their orders during the work day), while weekend travel getaways are advertised on billboards heading out of the city (because that's a purchase you might discuss with your spouse over dinner). The same common sense is applicable to ophthalmic advertising. If you graph your practice's monthly new-patient volume, you'll likely find two broad

"humps," one in the spring and another in the fall. In most settings, you should stop advertising (or markedly reduce your budget) between November 15 and January 15 and during the summer lull. In addition, health care customers are far more responsive Sunday through Wednesday . . . go dark Thursday through Saturday. Most radio responses for refractive surgery surface from the morning drive time to mid-afternoon . . . so go dark after 3 PM if you are trying to spare your budget.

Web Pages

Ages ago, sometime between the Jurassic and Cretaceous, I wrote in the first edition of this book,

WE WILL EITHER
FIND A WAY OR
MAKE ONE.

Hannibal



"I spend several hours a week online. However, with apologies to all the vendors trying to sell you a Web site, I don't think this is likely to be a very productive advertising outlet for you for the foreseeable future. The audience is small. Many are younger than optimal refractive surgery patients—Generation X-ers do the most surfing, while late 30- and 40-somethings are among the least active on the Net. And while some of these boomers may skew upscale (good for vision-correction surgery), they tend to be highly circumspect in making a surgical commitment."

What a difference a few decades make. We now spend more than 10 hours a day looking at a screen. A Web site is obviously obligatory for all ophthalmic practices. The typical client reports that 15% or more of the practice's leads now come from the Web. There are do-it-yourself site-building tools, and in most markets, you can find a local freelance Web designer who will get you up and rolling for a couple thousand bucks. Sophisticated sites and active management run several times this starter price. Clients of mine find good results and service from the developers at www.page1solutions.com.

Senior Sensitivity Training

A great activity for a staff meeting is to sensitize your employees to the physical difficulties faced by your older patients. (You'll need a few common drugstore supplies in advance.) Pair off your staff two by two. In each pair, one

will be the facilitator, one will be the subject. The subjects should all wear glasses, if possible. Have each facilitator “age” each subject by:

- Wrapping their elbows and knees with elastic Ace bandages to limit flexibility
- Putting cotton in their ears to muffle sounds
- Smearing water-soluble K-Y jelly on their glasses to limit vision

Let the newly aged subjects walk around the office and interact with one another for a few minutes. Have everyone sit down, and hold a discussion session on their impressions. Try to arrive at some practical ideas suggested by this exercise (e.g., talking louder, escorting at the patient’s slower pace, replacing stairs with ramps, and limiting the number of times patients are moved).

TO ME, OLD AGE IS
ALWAYS 10 YEARS
OLDER THAN I AM.

John Burroughs



Diagnose the LASIK Marketing Choke Points in Your Practice with a Simple Flowchart

The best LASIK marketing in the world can go to waste if internal systems are not in place to follow up with surgical candidates. One of the better diagnostic tools is to draw a flowchart of how patients migrate through your practice, from first call to last postoperative visit. As you draw each arrow, for example from seminar to surgical consultation, write down the time lag as well as the percentage of patients who pass from one stage to the next (e.g., “50% of seminar attendees who are potential candidates book a subsequent complete consult, but they have to wait an average of 15 days for an appointment”).

The Advertising “Guns” to “Bullets” Ratio

Imagine an army supply depot full of guns and no bullets—or full of bullets, but no guns. Both are equally under-equipped, right? The same is true of naive practices and the apportionment of their advertising budgets. Think of the media budget (the money used to buy clicks on the Web or print space or air time) as the “guns.” Think of the creativity and production work that goes into the ads

themselves as the “bullets.” Some practices spend almost nothing on creative services, so their marketing bullets barely dribble out of the gun. Even if they spend a lot on media, all they end up with is a pile of bullets at their feet and few new patients. At the other extreme, some practices spend 50% or more of their budget on creativity and then have little left to buy the media guns needed to shoot the bullets. The right balance in the typical ophthalmic setting is to spend about 80% of your global ad budget on media and 20% on creating the ads you will place.

Refractive Surgery Is Marketing-Driven

In the early years of a LASIK practice, it's essential to invest heavily in paid advertising. Early on, expect to pay out in the range of 20% to 35% or more of your desired refractive surgery revenues in advertising. After a few years, this figure can drop to 10%. Of course, this estimate breaks down if your aspirations are low and the market is large—you may not have sufficient revenue to support a threshold level of marketing in your service area. Another way of estimating an efficient monthly refractive surgery media budget is to multiply your total regional population by two to three cents . . . that's \$20,000 to \$30,000 per month in a market with one million people. If the required budget that emerges from these calculations exceeds your commitment level, you may be forced to abandon refractive surgery, focus on optometrists as a referral source, or be a part-time surgeon for a corporate LASIK center.

LASIK Marketing Cost Allocation

What you spend your LASIK budget on is dependent on several factors, most of which should be tested in your individual market and practice. For example, there is no pat answer to the question, “What works better, the Web, radio or newspaper ads?” It depends on the cost of these outlets in your setting, how they are being used, and what the competition is doing. With any significant level of commitment, the first dollars must be spent on one or more people to run the marketing department, traffic the calls, handle fulfillment, and drive appropriate surgical conversions.

Significant LASIK Practice Development Requires a Market of 350,000 or More People

In the 2009/2010 time frame, surgeons performed about 800,000 cases per year, down sharply from about 1.4 million cases in 2000. Thus, today we only have about 1% of myopic people coming forward each year to have refractive surgery. With the usual splitting up of the pie among competing surgeons, any market with a total drawing population smaller than about 350,000 doesn't have enough case volume to go around far enough to pay for new technology upgrades. This is exacerbated in markets with a much higher senior population (where eye surgeons should logically concentrate on geriatric eye care, anyway) and in secondary markets adjacent to urban hubs, which can bleed off a disproportionate number of patients who believe big-city doctors might be superior (and where price competition is more likely to break out). If you practice in a small market, this should not dissuade you from operating on a few cases a month in a co-op or mobile laser center . . . just be realistic about how far LASIK will go in offsetting falling third-party payments in small markets. If you seek a high-volume LASIK practice or would like to substantially shift from a cataract practice into refractive surgery, it would be best to move to, or at least satellite in, a larger urban center with a one million or greater population base.

THERE ARE SIX
STEPS IN A TYPICAL
CORPORATE
PROJECT:
ENTHUSIASM,
DISILLUSIONMENT,
PANIC, SEARCH
FOR THE GUILTY,
PUNISHMENT FOR
THE INNOCENT,
AND FINALLY,
PRAISE FOR THE
NONPARTICIPANTS.

B.C. Forbes



. . . Major Metro Markets Have Daunting Entry Barriers

At the other extreme of market scale, breaking into the country's largest cities (e.g., New York, Chicago, Dallas, and Los Angeles) requires an extremely long development cycle (to allow optometric and patient alumni referrals to build) or seven-figure annual advertising budgets.

Small Markets Have a Faster Alumni Referral Cycle . . .

Rural physicians already know they can't go to the mall or enjoy a restaurant meal without saying hello to several

patients. For better or worse, your reputation in a small community gets around a lot faster than in the big city, where even the most successful eye surgeons are pretty anonymous. Seen in a positive light, this can accelerate the pace of patient-to-patient referrals in small markets. Also, patient testimonial ads in a community where everyone knows one another are somewhat more effective. Educational seminars are better attended in small markets, and with more accessible/less adversarial reporters, generating local publicity is easier.

... Larger Markets Allow Greater Patient-Source Diversity

It's important to have a diverse source of patients so that the loss of any one referral channel isn't fatal. Urban markets allow this greater diversity because they have a much larger pool of professional referral sources, an ample pool of large employers to approach for a LASIK courtesy discount program, and niche media for ad placement.

THE QUIETER YOU
BECOME, THE MORE
YOU CAN HEAR.

Ram Dass



Large LASIK Practices in Midsize Markets Enjoy the Best of Both Worlds

Perhaps markets with drawing populations of around 750,000 are the best environments for refractive surgery practice development. Marketing costs are reasonable, and the addition of a few more competitors can be readily absorbed. These markets are large enough to have a significant, affluent population base. Perhaps most important, if fees fall and profit margins dip significantly, it will be important to have a large overall patient volume (on the order of 1000+ eyes per year) to support high fixed facility costs, pay for promotion, and invest in new technology. The math of fee-based competition goes sharply against small and even mid-range players.

LASIK Money-Back Guarantees?

In 1996, *The New York Times* broke a story about a heretofore unheard of practice in medicine: Fertility clinics were starting to provide limited money-back guarantees to would-be parents. It's taken some time for ophthalmology

to catch up, but we've now seen ads making the same guarantee for LASIK outcomes: "20/20 or Your Money Back." Before dismissing this out-of-hand as an outrage, consider the big picture. First, such guarantees don't promise a particular outcome. They simply reflect to the customer that the surgeon is willing to share the financial risk with the patient. Indeed, it could be argued that such risk sharing might make a surgeon more cautious in case selection and more careful in performing LASIK. Second, from a strictly business perspective, it makes perfect sense. If two equally well-trained surgeons with comparable equipment, experience, and fees are competing head-to-head, a money-back guarantee warranty is a powerful incentive that can tip the patient's purchasing decision. If reading this makes you interested in considering such guarantees in your promotion, speak first with your attorney and malpractice insurance carrier representatives for guidance. This one is not for the fainthearted.

Harvesting Lost Refractive Surgery Cases

Most prospective refractive surgery patients who are referred by their friends or respond to your ads will not go forward with surgery, at least immediately. Most will be surgical fence-sitters. These fence-sitters represent an underworked resource in most practices, which lack the staffing, supervision, or sales moxie to efficiently convert appropriate cases to surgery. Here are three must-do activities:

- *Make sure all prospective patients are followed up by phone.* It's amazing, but most practices still mail out information kits without a follow-up call to answer questions and to encourage an office visit for a free screening or consultation. Additional follow-up calls should be made beyond the first call. This requires some sensitivity and judgment; there's a fine line between staying close to a prospective patient and harassment.
- *Days, weeks, or months after the initial response from the lead has failed to result in a surgical conversion (again, based on staff judgment about where the individual is in the decision process), explore more deeply the most common point of resistance—cost—and start doing a bit of price negotiation, if acceptable to the surgeon. A simple, direct question—*

DON'T BELIEVE
ANYTHING YOU
THINK.

Wayne Dyer, PhD



THE REAL VOYAGE
OF DISCOVERY
CONSISTS NOT
IN SEEKING NEW
LANDSCAPES, BUT IN
HAVING NEW EYES.

Marcel Proust



What would make LASIK affordable for you?”—may give you a surprising answer. The patient may simply need to make two payments, get a courtesy 10% discount, or have the down payment waived for financing. Set up negotiation parameters for staff, with a price and terms floor. This approach works especially well if staff members are given incentives for cases converted, although this is a sensitive ethical issue best decided within each practice.

- *Once or twice a year, consider having a private “refractive surgery sale,” with a 10% to 25% discount for continued fence-sitters.* The upside of this tactic is that you will likely generate more volume and thus perform surgery on patients who would otherwise never convert. Because most practice costs are fixed within a wide volume range, the incremental cases are highly profitable, even after a discount. (It’s like airlines selling their unsold capacity at a steep discount.) The downside is that you may condition a portion of your market to expect discounting.

College Towns Are Good for Business, But the Rust Belt Is Better

It obviously helps to promote your services in a community with higher educational achievement . . . but not too high. Although higher education corresponds nicely with income, it also makes for a population that responds less well to general consumer advertising. The ideal environment can be found in the nation’s residual (albeit fast-shrinking) manufacturing hubs, where both union and nonunion wages are high and higher disposable income levels coexist with greater advertising responsiveness. It’s interesting to observe even today, in the once vibrant (now forlorn) manufacturing centers of the Midwest, that geriatrically-oriented practices continue to do quite well.

Where You Practice Will Influence Your LASIK Fees

Although there will always be room in most markets for one physician to be the very best and most expensive LASIK surgeon, only a small percentage of patients will seek out

the very best irrespective of cost. Large markets will support a larger absolute number of premium providers. Everyone else will deliver adequate quality at affordable prices. As natural economic laws catch up with the LASIK market, most patients will be cared for by surgeons sacrificing per-case profit for market share. A few developers have moved forward in larger markets with LASIK clinics positioned as the low-fee alternative, while others have staked out a premium position. Both will likely survive.

A Few Competitors Help Business; Too Many LASIK Surgeons Harm

Most larger (let's say 750,000+ population) markets will support two large LASIK practices along with one or two secondary players. These top-tier providers typically control nearly all of the market. Every additional provider establishing a new LASIK practice has to exert extreme energy and extreme patience or find an unoccupied niche to enjoy a viable practice. As the me-too, low-volume LASIK providers are increasingly dropping out of the market, those who remain in today's tougher environment are settling into a sustainable volume of business. The laws of gravity and economics prevail once again.

LASIK Marketing Costs Are Proportional to Market Size

More than any other factor, it's the *size* of a market that determines the cost of refractive surgery advertising. Refractive marketing experience shows that a full, effective "dose" of media buys (for LASIK, this means largely radio and print and a Web presence) is in the range of \$15 to \$30 per 1000 total population per month. Thus, the annual media budget in Chicago could easily exceed \$1 million to elicit the same percentile market response as spending \$300,000 in Omaha or \$180,000 in Colorado Springs. For large-market practices in the early years of marketing that are still developing a brand and jockeying for position, each test campaign can be extremely costly.

IF A EQUALS
SUCCESS, THEN THE
FORMULA IS:
 $A = X + Y + Z \dots$
WHERE X IS WORK,
Y IS PLAY, AND
Z IS KEEPING YOUR
MOUTH SHUT.

Albert Einstein



CHAPTER 7

GENERAL OPERATIONS ENHANCEMENT



*There is little that I try out in today's car which
has not already been tried out in the past—
and discarded before its real possibilities were
fully ascertained. It is consequentially
not so much inventions which are needed
as conscientious elaboration.*

ENZO FERRARI

Think in Terms of “Operational Integrity”

A well-run practice is one with a high degree of “operational integrity.” I’m not referring to morality or ethics, but to adherence and follow-through with agreed upon operational standards. The first step is put your practice’s operating standards in writing, with as many specifics as possible. Don’t just say, “Medicare claims will be filed in a timely manner.” Say instead, “Medicare claims will be filed within 48 hours of services being rendered.” Operational integrity is boosted when training is high and staff turnover is low. Integrity is higher when protocols are simple—having different protocols for different physicians or different office locations magnifies errors.

Eight Ways to Slow or Cut Costs Without Pruning Customer Service

It would be nice to have it all. But when that’s not possible, you have to settle for what’s truly important. In health care, that means great clinical outcomes and happy patients. Unfortunately, everything else comes in third place. Here are eight actions you can take to enhance profitability, sustainability—even survivability—without sacrificing quality care or customer satisfaction:

1. *Save on housekeeping.* If you have to cut back on outside, after-hours services, ask staff to pitch in with ongoing tidying efforts throughout the day (and make sure somebody is designated to patrol the office to ensure that the new habits stick). If you have to truly economize, spruce up the waiting/reception/dispensing area, letting the rest of the practice housekeeping slide a bit. Remove excess clutter, 20-year-old artificial plants, and other dust-collectors.
2. *Replace one overtaxed staff member with full benefits and overtime, with two part-time, job-sharing, low-benefit staff members.* You will reduce labor costs and gain more flexibility to handle your busy season, and be able to trim hours during the slow months. You may also help reduce your vulnerability to the loss of one key staff member. This is especially useful if you have a smaller practice. Let’s say you have one billing clerk. Reducing

this clerk's hours to half-time and adding a second half-time employee to cover the rest of billing creates skills redundancy as well as cost-savings.

3. *Extract more value from every staff member.* Some bantering and socializing in the halls is laudable. It's a sign that people like each other, and it takes the edge off for patients and staffers alike. But too much standing around (and every good supervisor has a feeling for where the line should be drawn) is a signal of waste and poor customer care.
 - If you have extra time, but it's too early to clock out because more patients are on the way, serve and socialize with patients instead of fellow staff members. Offer a magazine, a coffee refill, or help out of a chair. Escort patients, rather than pointing them down the hallway.
 - Conduct patient satisfaction phone surveys. This is a "two-fer" . . . you get information to help improve customer care, and the patients you reach will be impressed that you care enough to call.
 - Fan out into the community and perform screenings, give talks, drop off information and snacks to referral sources.
4. *Extract more value from every provider.*
 - Call every post-op patient, and every clinic patient who appears to be nervous, apprehensive, or skeptical about the care they received today.
 - Show up to clinic 10 minutes before your first appointment. Huddle with the staff and give them a few coaching points for the day (and listen to their advice to you.) Help the tech team work up the first bolus of patients. By doing all of this, you may find that you can see more patients with the same staffing levels. Remember that just three more patients a day brings about \$100,000 to the bottom line per year. Or you may find that you can get by with one less staff member.
 - Use every spare minute in the office to do one of two things: either see patients . . . or engage in promotional efforts to generate more patients (outreach, better/faster consult letters, screenings, lectures, etc.).

- Pitch in and help the staff, even with the most mundane of chores. Not only will this lighten their load, but it will send a clear signal that you work hard, and expect them to do the same. Create a culture that says, “We all work hard together until the job is done.”
5. *Turn non-productive doctor offices into exam rooms.* I have often been called into practices where the doctors were about to trade in what they felt to be just-adequate office space for an expensive new facility. All the while, each doctor had their own, large office and private toilet. If you find yourself in the same situation, consider converting little-used private office space into productive exam rooms, and putting all of the doctors into one-oversized office with small individual cubicles. You’ll likely get a bonus in the form of more doctor-to-doctor interaction. Remember: Anything more than you need is wasted.
 6. *If yours is an urban, general ophthalmology practice and you are spending more than 32% of cash flow on staffing costs (30% for suburban setting, or 28% for rural practices) do whatever it takes to trim costs.* Your staffing cost levels are excessive, and the excessive costs are doing nothing to increase patient satisfaction . . . and may be starving the practice of needed technology or facility upgrades. You have a few options, none of them very pleasant or easy if you have been lax in this area. You can cut hours, cut positions, or cut hourly pay. That’s it. If you are an administrator who has been on the job more than 10 years, it’s quite possible that all three of these are unaccustomed tactics. Welcome to your new world and responsibility.
 7. *Doctors and Managers: Realize that we all work for love and money.* If you can’t pay your staff any more—or worse, need to make across-the-board wage cuts as some of you have, and more of you will—backfill their missing income with your attention, respect, training, involvement, strategic intimacy, and interest in their lives. When there is a lull in patients, make sure doctors give up one trip a day from the clinic floor to their private office, and drop in on the staff break room or the billing department or the front desk to say, “Thanks.”

8. *Do what financially thrifty restaurants do: Turn down the lights.* This yields several benefits. You'll use less electricity (and feel great about reducing your carbon footprint). Your dilated patients will be more comfortable. The tone of the office will be calmer and more serene. Waiting time will be more pleasant and somewhat camouflaged. AND the carpet and furnishings that you should have replaced, repaired, or deep cleaned a while back won't look quite so shopworn. Far better you should turn the lights down a bit now than to be forced one day to turn them off altogether.

The Three Buckets of Money . . .

The profits your practice generates can only be partitioned three ways. Wise practice owners actively examine from year to year how they partition and make adjustments based on the total environment and the big picture, not just on their immediate personal needs. Here are the partitions:

- *Lifestyle today.* This is your paycheck, used to pay for your day-to-day lifestyle costs.
- *Lifestyle tomorrow.* These are your retirement investments, which will determine what kind of a lifestyle you will enjoy in the future.
- *Practice-building investments.* This is the money you put back into the practice for growth, defense against competitors, quality-driven improvements, etc. It includes resources put into people, facilities, technology, and marketing.

. . . And the Four Buckets of Time

Similarly, there are only four basic areas in which you can invest your time:

- *Basic husbandry and hygiene (eating, sleeping, bathing, and the rest)*
- *Your family life*
- *Your professional life*
- *Your passions (e.g., volunteer work, reading, hobbies, spiritual pursuits, and the rest)*

WHY DO THEY PUT
BRAILLE ON THE
DRIVE-THROUGH
BANK MACHINES?

George Carlin



Share Practice-Performance Data with Your Staff

Mount graphs in the staff lounge showing the practice's monthly or weekly volume performance data. Graphs should go back at least one year and include patient visits and surgical cases. You may also want to show staff key performance ratios such as the number of staff payroll hours each month divided by the number of patient visits (an index of staffing efficiency and productivity).

Let Patients Know Your Credo

Practices pay a lot of lip service to customer service during periodic staff meetings. But these good intentions often slip away. You can remind staff and patients of your commitment to quality by hanging a simple poster in public areas. Any copy shop can produce large-format posters for you, which take on an even warmer and more personal image when signed by all staff and physicians. Here's a sample for you to copy:

OUR COMMITMENT

Milwaukee Eye Surgeons

We commit to enhance the total quality of life of every patient we serve through the treatment of eye disease and the restoration and preservation of sight. With this Total Life Enhancement in mind, we interact with every patient as a whole person, not just a pair of eyes, and care for them as we would a member of our own family. Our entire team strives to give every patient the latest advances in modern eye care accompanied by an old-fashioned approach to caring.

Put It in Writing

Growing practices eventually need to transition from a verbal to a written culture. Hallmarks of a written practice culture include how-to "cheat-sheets," memos, a staff bulletin, posted reminder notices, a practice operations binder, and a policy manual.

A fun way to orient your staff to the pitfalls of verbal communication is that old party game, "telephone." Line

your staff up in a row, side by side—this works best if you have 10 or more staff. Write down a simple order, such as, “Please make sure Mrs. Edwards in Room 3 is dilated, and get Dr. Jones on the phone for me before noon.” Whisper this message verbally to the first staff member in line. Have staff pass this message verbally along the line, whispering it from one person to the next. When you get to the last in line, have that person repeat the order out loud and compare it to what you first wrote down. The result is often a complete breakdown in the original message, demonstrating the importance of writing things down.

Documentation Allows Delegation

Make sure your practice has written guidelines regarding the frequency of contact lens exams, medication refill policies, and answers to common patient questions. To the extent possible, use this documentation, along with training (and periodic testing and retraining), with the reception staff to reduce interruptions for the physicians and techs when patients call with routine clinical policy questions.

Taking a Team Approach to Eye Care

It’s not unusual to hear patients complain that they were seen more by support staff than by their surgeon. Here’s a draft copy that can be used in brochures and introduction letters to help orient your patients to team care:

At James Eye Center, we take a team approach to your care. Teamwork starts with our scheduling staff, who make sure that just the right kind of appointment has been made for your needs—this generally means an optometrist for routine eye care as well as some portions of your postoperative care and an ophthalmologist for surgical and medical eyecare. When you make an appointment, you’ll be asked several questions to make sure we’re matching you with the right eye doctor for your unique needs. Our clinical care team is rounded out by our highly trained technical staff, who take precise measurements of your eyes and prepare you for your doctor; our optical staff, who can match your proper prescription with high fashion; and our business staff, who make sure that even your most complex insurance questions are courteously answered.

TO ABOLISH ALL
VALLEYS IS TO
GET RID OF ALL
MOUNTAINS.

Alan W. Watts



Developing a Practice Management Committee

In practices of every size, it's appropriate to have a group of supervisors from every discipline (e.g., clinical services, ASC, optical, reception, patient accounts, and marketing) gather frequently to discuss their progress with assigned projects and be kept in the loop on strategic issues. In the best practices, these department heads are often given details of the practice's finances and are responsible for a departmental budget . . . ideally, they should be *profit* managers, not just *process* managers.

I'M ALL FOR
PROGRESS.
IT'S CHANGE I
DON'T LIKE.

Mark Twain



What Makes a Team Great?

The notion of “teamwork” in practice management gets a lot of press, but it receives too little attention in the typical practice setting. The best practice teams look and act like *teams*. All hands are in the same uniform with identical name tags. Everyone is perfectly clear on near, intermediate, and long-term goals. All hands know how to keep “score” and know where they stand. Wins are celebrated by the group and rewarded. Losses are commiserated as a group. Here are some additional features of great ophthalmic teams and team players:

- They communicate—and especially listen—better.
- They understand the roles (“positions”) everyone plays on the team.
- They show appreciation to each other, up and down the ranks.
- Managers resonate teamwork to their peers and the rest of the team.
- Doctors are open to receiving and following through on the coaching efforts of their managers.
- They have fun and enjoy playing the game.
- They reward at every level: for ideas, performance, skills, motivating others, being flexible, trying, sharing, getting better, etc.
- Everyone on the team understands the historical context of the team . . . where they've come from.
- They realize that the more senior you are on the team, the more you need to lead by example.

THE PERSON

TRAVELLING WITH A
ONE-TRACK MIND IS
BOUND TO HAVE A
HEAD-ON COLLISION.

H.B. Dean



- They keep on making improvements in their product.
- They appreciate and serve all the fans in the stands: patients, their family members, payers, referring doctors, employees, their dependent family members, etc.
- They have increased quasi-social interaction to better develop relationships.
- They educate everyone on the nuances of every job, not only so they'll know practical job functions, but so that there can be greater empathy for every colleague's work situation.
- They develop specific expectations and standards and hold each other to these; they create a more accountable environment.
- They are open to the input and cross-coaching of their colleagues.
- They gather and develop a group-held understanding of the practice's performance data.
- They have a "playbook" (a written operations manual, care pathways, etc.).
- They create an environment in which it is expected the team will win.
- They act more as a group than as individuals.
- They deal with each other with empathy; they don't make fun of weak links in the team but rather help them.
- They maintain a tempo everyone can keep up with; they improve weak links or remove them from the team.
- They support decisive leadership and insist that the leaders lead.
- They foster effective and appropriate "followership," the ability of team members to rally around the leader, and respect the position always, even if from time to time they harbor concerns about the individual leader involved.
- They sacrifice for and compromise with each other.
- They forgive and forget.
- They remember there is no "I" in "TEAM."
- They make everyone on the team feel important.
- They play carefully to avoid harming themselves, others, or the company.
- When they get hurt, they stay in the game.
- Everyone plays . . . nobody sits on the bench.

Proper Use of Automated Call Routing

I strongly prefer using a live operator to pick up every inbound call. But if your practice is staff-constrained for reasons of cost, or has a younger patient base, you can get by with a recorded greeting that says something like, "Thank you for calling Smith Eye Center. You can reach our main operator at any time by pressing 0. To schedule an appointment, please press 1. For billing questions, please press 2. For our optical department, please press 3. For a prescription refill, please press 4. For any other departments, please press 0 or stay on the line and an operator will be right with you."

I'M A MARVELOUS
HOUSEKEEPER.
EVERY TIME
I LEAVE A MAN
I KEEP HIS HOUSE.

Zsa Zsa Gabor



Assistive Listening Devices

It's a nice touch and a great service to patients in geriatric practices to have a simple, inexpensive assistive listening device available for their use. Your hard-of-hearing patients can use these amplification instruments if they don't bring (or are too vain to wear) a hearing aid. The device will save a lot of shouting in your office and help ensure your patients understand their treatment instructions. There are many models available, starting with a low-cost unit from Amazon. If possible, buy a unit on which the patient can easily control the volume.

Substitute Books for Magazines

Even at professional-courtesy discounted subscription rates, magazines are an expensive form of entertainment for your patients. What's worse, most periodicals are biased toward negative reporting: "If it bleeds it leads." In today's increasingly creepy news world, do you really want to talk to Mrs. Abrams in room 5 about cataract surgery after she's read about narco terrorists, unemployment rates, and the Medicare crisis? Of course not. So, save both money and Mrs. Abrams' sensibilities by buying discounted coffee-table books. All the big-box chain book stores have displays in the back with beautiful selections costing \$10 and less. The bonus? Given their bulk and size, they won't get stolen as often as magazines, and they never go out of date. As they become worn, donate them to the local library or

nursing home and buy new copies. (P.S. The same logic goes for news programs on waiting-room TV sets. Ditch the TV, or play documentaries and classic movies.)

“The Physician Would Like . . .”

Some things are easy to ask patients to do. Other things—such as paying money, making the next appointment, or going across the hall to visit the optical dispensary—meet a bit more resistance. The best way to overcome this resistance is to be the proxy for the physician’s own instructions. So next time don’t say, “When would you like to make your next appointment, Mrs. Hawking?” Instead, say, “Dr. Able would like to see you back in two weeks, Mrs. Hawking. What’s best for you—a morning or an afternoon appointment?”

A Policy for Reappointing Patients

Almost nothing makes patients angrier than having their appointments changed two or more times to fit the physician’s 11th-hour vacation whims. In solo practices, the physician bears 100% of the burden for this behavior. However, in group practices, one “serial offender” can turn off patients for all the rest of the providers in the group. Therefore, it’s appropriate to consider a rule or policy regarding rescheduling appointments. Some ideas follow:

- Each physician may move, without advance notice, up to one full day of clinical or surgical patients per quarter without penalty.
- Beyond this, each physician may move up to four additional day’s worth of patient care per quarter upon not less than two weeks notice. However, in consideration of the costs associated with this, borne by all partners (e.g., staff time, loss of overhead coverage, patient dissatisfaction), there is a \$2000 per day charge (could just as readily be \$500 or \$5000) for the additional days lost.
- True family and personal emergencies are exempt from this policy.

Reducing No-Show Rates

In the average practice, 5% of patients or fewer should miss their appointments (excepting snow days in the East and big surf days out here in Southern California). Experience shows that this can edge upward to the 10%+ level if you have a large Medicaid population. In most settings, the staff cost to place a reminder call to patients is more than offset by higher attendance. While the typical practice calls one day ahead, I've found that calling two days ahead is preferable. This seems to give patients who have forgotten about their appointment the time they need to make other arrangements and gives the front-desk staff an extra day to add work-ins so the appointment schedule is closer to full.

THERE IS NOTHING
LIKE A DREAM TO
CREATE A FUTURE.

Victor Hugo



Reappointing Scripts for the Front Desk

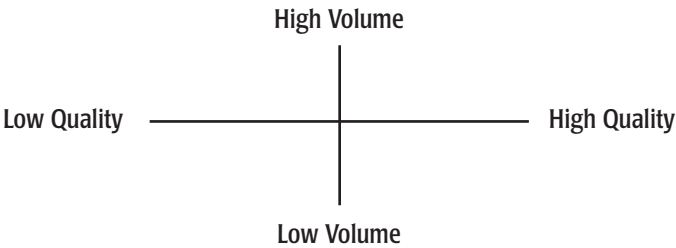
At checkout, try not to give patients an option of making an appointment or receiving a recall notice, even if the next appointment needed is not for another year (which is how long your template should be blocked). Instead, say, "I see that Dr. Gregory would like to have you return in 12 months. What's better for you, mornings or afternoons?" If patients are resistant because they don't know their schedules, then try, "Since we're rescheduling up to a year out now for some patients, how about if we set up a tentative appointment for you in 12 months? We'll send you a reminder about four weeks in advance, and you can just call us if this doesn't work out for you."

Mirror, Mirror on the Wall

Anyone who trains phone staff commonly says, "Speak with a smile in your voice." You can make that suggestion come to life by mounting small mirrors in front of every receptionist and operator.

What Kind of Practice Do We Have?

It can help stimulate partner discussion to draw a continuum plot like the one shown below and to place your practice on this plot. Is your practice today high quality but low volume? If you increase volume, what quality concessions, if any, are you prepared to make?



One More Hat for Your Administrator to Wear

Major corporations, and certainly all municipalities, have risk management coordinators. These are managers who do nothing all day but examine the organization for potential lawsuits, exposure to damaging publicity, or similar gaffs. This is one more hat to be worn by your practice's manager, ideally with formal input from your attorney. It includes keeping a defensive eye on everything from icy sidewalks to up-coding doctors to staff members who are in a position to embezzle.

The “Cigarette Butt Index”

Here's another one from the consultant's bag of tricks. I can walk a 50-foot perimeter of a practice with a plastic trash bag picking up discarded litter and tell you pretty accurately how well the practice cares for its patients. Practice managers and physicians who care how the outside of the building looks are probably even more careful about what goes on inside.

The Green Ophthalmic Office: Smart, Right, More Profitable

So what's the impact of your current professional life—and of your office practice—on the planet? Let's look at just one dimension: Annual gasoline consumption.

Assume that you have a very average two-doctor, 20-staff practice seeing 13,000 patient visits and surgeries a year . . . and that everyone involved drives back and forth to the office in their own 18-mile-per-gallon car, traveling an average of 20 miles round-trip. Oh yes . . . and the pharma vendors and workmen and delivery folks who support your enterprise, too. Let's include them. All up, that's something like 22,000 gallons of gasoline a year.

That's about enough fuel to fill your typical office space up to about mid-calf. At today's prices, every patient visit burns up about six bucks worth of fuel in one way or another. If you're comfortable thinking in terms of carbon units (and with six pounds of carbon generated per gallon of gas) that's about 10 pounds of carbon put out per patient visit to gunk up the planet.

And with a little over 15,000 ophthalmologists in America, we perhaps collectively consume directly or indirectly, perhaps 165 million gallons of gasoline per year.

And that's just the motoring fuel. Then there's energy for lights and heat and computers and lasers. Think about the amount of paper, plastic, steel, and the rest that passes though the typical office on the way to the landfill. And all the jetting back and forth for meetings.

I don't harbor any fantasies that going green in eye care—or for that matter in all of medicine—will save the planet. But as an ophthalmic economist, I'm sure it won't do any harm, and it might even help your bottom line. Here are some practical changes that are mostly low-cost, mostly easy to implement, and that might even feel good.

1. *Eliminate satellite offices that are no longer performing well.* If you run a multi-office practice, calculate the average monthly profit in each location. Divide by the number of doctor-hours spent in each location (including travel time.) The result may show that profitability in far-flung offices is far less than you thought. By eliminating locations, you not only reduce your carbon footprint but increase time available for more

profitable pursuits, while decreasing doctor and staff travel stress.

2. *Consider changing your office schedule from five 8-hour days to four intense 10-hour days.* Patients love the expanded hours, and staff members love the day off. (You might even rent the office out on the fifth day to a visiting subspecialist to help cover overhead.)
3. *Get by on less office space.* Here in America, it's typical for even the most obscure, struggling solo ophthalmologist to work in a 2000-square-foot office. In contrast, I've worked for very successful clients in pricey New York City who manage to get by on well under a thousand square feet—a necessity because of high rental rates. I once even visited a French ophthalmologist who cared for more than 100 patients a day in a one-lane office. Less space, if you can get by with it, means less energy use, lower facility costs, and a 5% to 15% pay raise.
4. *Get smart about commuting.* If you work in an urban hub and are fighting with everyone else to get into the city to work, shift your schedule to early or late hours to avoid the traffic rush. Provide incentives for staff to carpool or take public transit. The next time you trade in an office vehicle, downsize a bit (or upsize to a van, so that all of the staff can ride together to a branch office rather than driving separate cars).
5. *If you are planning a new office, try to locate on a public transportation artery—or even better, a transit hub.* You think that patients (and staff) are getting fidgety about gas approaching \$4 a gallon? Wait five years, when gas could be well over \$6 . . . and a quarter-tank of gas for a trip to the eye doctor creates a strong incentive to be a no-show patient.
6. *Combine trips.* Make the bank deposit, trip to buy office supplies, and run to pick up lunch all in the same circuit.
7. *If you have any say about how a new office is going to be built, ask your architect and contractor about green construction.* Built or renovated in an ecological and resource-efficient manner, green buildings protect worker health, improve productivity, use less energy and water resources, and reduce the overall impact on

the environment. A green building may cost more up front, but saves money and the planet over the life of the building.

8. *Turn off the electricity flow.* In the typical office I visit, all the lights are left on, often even after the last patient has left and hours before the cleaning crew arrives. Use motion-detector light switches in restrooms and other intermittent spaces. Mark the few office lights that need to be left on for safety after hours, and turn the rest off. As allowed by manufacturer specs, cut the juice to computers, TVs, testing equipment, and everything else typically left on stand-by power. The average PC wastes about half the energy provided to it, according to the Climate Savers Computing Initiative, an industry group dedicated to reducing greenhouse-gas emissions. Power strips are now available that will detect when your computer has been shut off and will cut power to its peripherals. Shift to lower-wattage bulbs.
9. *Buy a programmable thermostat* and adjust the temperature for *reasonable* comfort rather than summertime arctic chill and wintertime warm and cozy. Have light blankets or comforters available for patients who need a little extra warmth.
10. *Go with less-paper or paperless to the extent possible.* If you're using electronic medical records, don't (as so often still happens) have the doctors print out a hard copy of the most recent visit just to have something to hold onto. Print memos out in a smaller font, or use e-mail. Copy on both sides. Recycle and use recycled paper goods.
11. *Work in scrubs rather than street clothes.* Doctors, staff—even administrators. This has many advantages. It will reduce dry cleaning costs and pollution, increase teamwork, and present a more professional look to patients. Plus, it's like working in your pajamas all day.
12. *Decrease the use of disposable products, as is feasible.* Ditch everything from those nasty Styrofoam coffee cups to individually bottled water (put a water filter on your tap.) Purchase refillable printer-ink cartridges rather than the throwaway kind.
13. *Plant wisely on your property . . .* use water-conserving trees and shrubs rather than thirsty flowers or turf.

14. *Buy durable products.* Rather than purchasing the plastic veneer boardroom table that will last five years and get pitched, buy the nice one (built from sustainable forest products) and pass it on to the next owners of the practice.
15. *Buy used.* A mayo stand made in 1998 is precisely the same product—perhaps better—as the one you can buy new today, and it goes for a fraction of the cost.
16. *I'm NOT advocating care pathways here, but to the extent you are comfortable, reduce the number of post-op visits.* Some surgeons now eliminate the day-one cataract post-op visit in the interest of patient convenience and office efficiency . . . and ultimately because in their view, they are not going to catch any untoward development 24 hours after surgery.
17. *Hire staff who live nearby.* Screen prospective new hires for the proximity of their home address. Not only will you reduce consumption, but you'll be hiring a less-frazzled and less-financially stressed worker.
18. *As a doctor, live as close to your office as possible.* Again, less energy, less stress, and much easier to handle call duty.
19. *Don't give up national educational meetings, but send fewer people to the best meetings, and have them come back and educate their peers.*
20. *Put up signs.* Let patients know that in the interest of going green, you try to get all needed testing and treatment done during one visit and thereby save them time and cost overall (while reducing *their* carbon footprint.)

* * *

Surf the web and you'll find hundreds of additional ideas. Google "green office" and you'll get about 35 million hits. Nominate a task force and use the above list to develop a written "Go Green" plan in your office. Add up the costs vs. the savings, and you'll probably find yourself coming out ahead. Maybe *way* ahead. And after you've gone green at the office, try it at home.

Pinto's Eight Laws of Making Practice Changes

- All practice failure, great and small, arises from an inability to change.
- All change is driven by a desire to seek pleasure or to avoid pain.
- Change, itself, is terribly painful. You must develop a tolerance for this kind of pain.
- An emotional attachment to the benefits that would result from change is essential to success.
- So long as the pain associated with change is less than the perceived gain, your efforts at change will be successful.
- Change requires time. Only if you have time to spare will you be able to change.
- Data which support the need for change are worthless. The mere intent to change is meaningless. Committing to change is without value.
- Action, alone, has value and meaning.

Preparing Customer Service Standards

Does your staff really know what you're talking about when you plead with them to be nicer to patients? What are your practice's customer service standards? If you haven't written them down, chances are they don't exist. Here's a partial list to get started:

- The phone should ring no more than twice before being picked up.
- Patients should never get a busy signal. At the worst, their call should roll over to the messages-on-hold system; this should happen 20% of the time or less.
- Scheduled patients should wait no more than 15 minutes beyond their appointed time before they are escorted back by a technician to start the exam.
- Unscheduled work-in patients should wait no more than 40 minutes.
- After the technician screening is complete, undilated patients should wait in an exam room no more than 10 minutes for a physician and dilated patients no more than 30 minutes for a physician.

BEFORE I CONSIDER
ANY NEW PRACTICE
ACTIVITY IT HAS TO
BE SCIENCE-BASED,
PATIENT-CENTERED
AND PAYER-
FRIENDLY.

Richard Lindstrom, MD



- No-show patients should be called within an hour of missing their appointment.
- The next available exam for routine visits should not exceed 15 business days; for referrals and surgical consultations, five business days.
- Patients with urgent problems should be seen on the same day.

Two Kinds of Quality

Quality comes in two basic varieties:

- Q-1, subjective quality, relates to the patient's perception based on things such as office cleanliness, waiting time, staff friendliness and caring, room comfort, refreshments, and doctor affability.
- Q-2, objective quality, relates to actual, measurable care outcomes such as low complications rates, excellent continuity of care, and superior postoperative vision enhancement . . . along with tangible superiority in areas such as education, technology, documentation, and care pathways.

Note: Patients, behaving as "customers" are more often inspired by Q-1 than Q-2.

Why Don't We Do What We Know We Should?

The "knowing-doing gap" (a concept courtesy of Pfeffer and Sutton, who wrote a book by the same title) occurs when we know what to do but don't do it. To know, and to not do, is to not know, of course. Better that we pick five things to do at a time and complete these than to commit to 25 things and fail. Top reasons for the knowing-doing gap in your practice are:

- Overwork and exhaustion
- Failure to perceive a benefit proportional to the required effort
- Not knowing how to do . . . failure to secure an external source of expertise or discipline

- Lack of active encouragement, or the presence of active discouragement, from others
- NDD: Need Deficit Disorder (low ambition)
- Old-fashioned laziness

How to Be Nice

We pay a lot of lip service to being “nice” to patients, but we rarely get more specific. I once sat in on a terrific brainstorming session during which a practice’s staff tried to come up with all the dimensions of friendliness they could. Common sense? Sure. But how often do your physicians and staff adhere to even this partial list?

- Walk and move at a reasonable pace; don’t rush things.
- Smile until your cheeks hurt.
- When appropriate, introduce yourself by name.
- Wear a prominent name tag so patients can remember your name.
- Maintain eye contact; don’t talk to your chart notes.
- Greet all patients you come in contact with, even if they’re not yours.
- Have a pleasant tone of voice; leave your inner grump at the door.
- Explain tests and procedures before you do them.
- Be honest in forecasting waiting times.
- Don’t be silent; talk to patients during an exam.
- Offer coffee, water, and reading material.
- Explain your findings at a level appropriate to the patient’s understanding.
- Do whatever you must personally to decrease waiting time, even if it means delaying your own needs.
- Touch shoulders, arms, and knees appropriately to reassure.
- Apologize immediately when you cause a patient physical or emotional discomfort.
- Say “good work” or “great job” at least twice per exam.
- Acknowledge both patients and the visitors who accompany them.
- Ask, “Do you need a refill?”
- Be empathetic when you hear bad news.
- Compliment a patient’s attire, appearance, or accomplishments.

IF EVERY PERSON
ON EARTH WERE
TO TRANSCEND TO
THE VERY HIGHEST
AND MOST NOBLE
LEVEL OF EXISTENCE,
WOULD THERE BE
ENOUGH FISHING
RODS TO GO
AROUND?

*Cody's Twin Bridges
Credo*



- Be respectful; don't use first names unless appropriate.
- Use "Sir" and "Ma'am" liberally.

Five Pearls for Aligning Physicians and Managers

Even the most humble eye care business machine is stunningly complex, with a large number of "moving parts." Having *both* physicians and lay managers oiling and tuning these parts together in harmony is critical for success. Here are five practical pearls you can apply this month:

EVERYTHING WE
SEE HIDES
SOMETHING ELSE
WE WANT TO SEE.

Rene Magrite



- *Align the economic interests of key management staff and physician-owners with a profit-based bonus.* Few states allow lay ownership of your practice, but you can provide virtual stock ownership with a profit-sharing plan for worthy staff. Make sure that the staff who receive such bonuses are in a direct position to influence the bottom line by shaving costs or growing revenue.
- *Ensure management's competency.* Make sure the physicians have as much respect for the professional skills of the managers as the managers have for them. Send managers to training seminars. Bring in trainers. Have your accountant mentor an otherwise great (but numerically illiterate) manager.
- *As a physician-owner, let your hair down.* Hold meetings to talk not just about day-to-day operational details, but also about the overall direction of the business. Boil it down to a summary business plan that is regularly reviewed and revised by physicians and managers.
- *Be intimate with the details.* If the physicians are not willing to disclose the financial details of the practice with key managers, it means the managers are unworthy of trust or the physicians are unable to muster trust. I still go to multimillion dollar practices where the office manager has no access to the books, or even the payroll records of the staff being managed.
- *Have objective, numeric performance goals.* Surgeons compare their cataract care skills with peers based on professional standards such as complication rates—the same should apply to the business end of the practice. Benchmark the most important numbers in your practice, and

have the physicians and managers review and discuss each of these together monthly. Examples include collections per average encounter, new patient ratios, and surgical yields.

Running an Effective Practice Retreat

It's a tough and busy world out there. So tough and so busy, that the file labeled "Planning" on your desk has probably been sitting there for some years, buried under all the other files labeled "Doing." In the absence of a scheduled and disciplined opening, that Planning file may stay closed permanently, holding you and your practice back from what could be. Surgeons and their management team must make an appointment for professional renewal every year or two, just like their patients make an eye appointment. One of the best formal tools for business and professional renewal is a practice retreat. What is a retreat? It can be anything from a half day of private contemplation about the future of your career to an orchestrated, moderated, week-long, all-hands event at a faraway-destination resort. Most practices stake out the middle ground: one to three days, fairly close to home, held over a weekend to minimize lost production. Here are some helpful pearls:

1. Who should attend? It depends on the goals of the retreat and the openness of your practice. Increasingly, lay managers are being allowed in the board room to help the owners make decisions.
2. Although it requires more time and cost, it really does take two nights and two and a half days to foster the desired sense of being cloistered and part of a close group. This is especially true when you are coming from behind in the area of team development.
3. The most common and workable format for a three-day session is to start on a Friday evening with a social dinner followed by a couple of light, warm-up working hours. In the morning, start early, work through lunch on Saturday, and then adjourn at 1:30 PM or so to let everyone participate in one or more social or sports activities. Hold another short business meeting after a purely social dinner on Saturday . . . and find a bit

MY EYES WERE
MADE TO ERASE ALL
THAT IS UGLY.

Raul Dufy



more time on Sunday morning, adjourning at noon on that last day.

4. This format, with about five net work hours over two leisurely days, is a much more successful formula than burning the team out on a death march through 12-hour days.
5. It is helpful to take over a meeting facility rather than being lost among many on a larger property. These smaller properties cost a lot less and have a lot more intimate environment than a plastic, 2500-room resort.
6. You don't have to get on a plane to hold an effective retreat, although some boards treat themselves to an exotic destination every year. There is likely a wonderful and unique setting within an hour's drive of your practice.
7. Try to build your retreat around a defined theme (e.g., teamwork, profit enhancement, crisis resolution, development of a long-term strategic plan). Begin with a group exercise: Write out and review the specific goals of the session.
8. Book the retreat well in advance so that all participants can arrange their personal affairs to be completely free. Every participant should stay for the full allotted time and, if at all possible, should not be distracted by being on call.
9. Depending on your preferences, you might schedule a doctors-plus-spouses retreat. This can increase the social cohesion of the group. You may want to hold a 30- to 60-minute joint session for physicians and spouses toward the end of the proceedings. Provide a synopsis of how the company is doing, a move most spouses will appreciate.
10. During the retreat, assign one moderator or chairperson. This person isn't there to lecture or hog the proceedings but rather to ensure that the group stays on task and everyone gives input. The choice of an internal moderator (e.g., the practice administrator or managing partner) versus an outside facilitator is subject to commonsense judgment: Do you need outside expertise, or does your group have all the experts it needs in-house? Can you afford to bring in an outside facilitator? Will the facilitator actually "facilitate," or will the presence of an outsider inhibit open discussion?

11. If your retreat is effective, you'll do more than discuss topics—you'll also make dozens of decisions. Someone has to be responsible for taking notes and memorializing the agreed action.
12. After the retreat, distribute a written summary of the issues discussed and the decisions reached. Consider distributing a questionnaire to all participants while the retreat is still fresh in their minds: Did the event meet or exceed the stated goals? What was done well? What improvements should be made with future events? When and where should the next retreat be held?

The \$10 Million Club: Solving Problems on a Larger Scale

Only a small percentage of ophthalmic practices in the nation ever reach \$10 million or more in annual collections. But the lessons learned along the way by these market leaders are critical to pass on to practices still striving for this benchmark . . . and perhaps are equally valuable for surgeons with less lofty business goals. You'd think that the owners of these larger practices have it made. The truth is that practices in the "\$10 Million Club" have even greater difficulty than smaller practices deciding where they should be heading next. Physicians in these practices often reach an elevated threshold beyond which it's difficult to conceive their next strategic destination or operational priority.

Being the administrator or managing partner of a \$10 million practice is VASTLY more than 10 times the challenge of leading a \$1 million practice. Large practices commonly feel as though they have run out of mountains to conquer. By the time a practice reaches \$10 million or more in collections, virtually all possible ancillary services have been developed. There is usually at least one surgical center. Optical dispensing is old hat, and the special testing department can't really add any more patient services. In already large practices, all or nearly all appropriate subspecialty areas are covered, and any that haven't been added yet are likely of no interest to the founders because of an incompatible patient base (pediatrics) or lackluster economics (neuro-ophthalmology).

THE THING TO DO
WITH THE FUTURE
IS NOT TO FORECAST
IT, BUT TO CREATE IT.

Russell Ackoff



As the largest (or near largest) player in their market, practices in the \$10 Million Club often run out of the competitive zeal they once had. It's a little like becoming the best tennis player in your club . . . you no longer have a "pacer" out ahead, driving you to improve. This can carry over to the next generation of physicians. If the next lineup of partners is not ambitious, the practice is like a kingdom with an ineffectual prince in line for the throne. And when a lead physician leaves, you lose not only his or her leadership, but his or her production as well. Everyone else's overhead rises, and a negative profit spiral can ensue, reinforced in turn by the lack of leadership.

Practices at or near the \$10 million threshold can go through a period of "diseconomy," opposite the expected economies of scale, where sheer complexity and all the moving parts demand a stronger middle management team, upgraded information systems, new facilities, and endless meetings to facilitate communications up and down the line. It almost inevitably happens in these settings that the partners (particularly the cost-sensitive younger and older partners) develop a preference for optimizing near-term physician take-home pay rather than long-term success. This conservative bias halts the growth of a large practice in its tracks. On the revenue side, large practices have the "Proctor & Gamble problem"—it's hard to drive a large company to high percentile growth rates. Even a huge success is a relatively small addition to revenue. This takes some of the excitement out of the game for entrepreneurial physicians who remember the profit pop when they first added refractive surgery or an ASC.

All the same, these apparent constraints that come with scale are accompanied by a few gratifying opportunities for big-practice builders who get their second wind. Once you're in the \$10 Million Club, it's easier to take on projects that others lack the resources to execute. These opportunities include mergers and acquisitions, drug and device studies, the development of satellite offices, and stronger brand development.

To ASC or Not to ASC?

A general rule of thumb is that an ophthalmic ambulatory surgical center will become profitable at 50 or more cataract cases per month. The case volume threshold is somewhat higher in states where facility requirements are lavish, and somewhat lower—even sharply lower—where lax regulatory environments prevail or the surgeon is willing to cut corners (stock cabinetry, used equipment, tighter quarters, and cost-sparing decor). For higher-volume practices, as cataract fees shrink, an ASC is the best way to preserve and expand operating margins. If your practice is performing 50+ cases per month in a non-Certificate-of-Need state, start exploring your options. Even if you are on the edge volume-wise today, adding an ASC will improve your efficiency (as compared to the typical outpatient center) and will typically enhance each surgical patient's experience of his or her procedure.

Laser Skin Resurfacing, Botox, Hair Removal, and Other Sidelines

A modest number of practices have embraced laser facial skin resurfacing, Botox injections, and other cosmetic auxiliary patient services. Although I haven't come across any examples of profitable home runs, a number of practices are making modest gains. Here are some of the important success factors:

- Put one staff member in charge of outreach, patient education, and conversion.
- Make sure some of your staff have had the procedures in question and can provide in-office testimonials.
- Make sure you manage patient expectations about the postoperative course.
- Use what you have learned about outreach to optometrists to develop a similar program aimed at reaching aestheticians.
- It's critical that physicians in the practice actively seek procedure candidates from existing patients in the clinic; make sure you provide incentives for active doctor-to-doctor referral within the practice.

THE BEGINNING
OF KNOWLEDGE IS
THE DISCOVERY OF
SOMETHING WE DO
NOT UNDERSTAND.

Frank Herbert



- Seminars are reported to work well, as in the early days of RK and LASIK advertising.
- In larger urban centers with numerous competing advertisers, your success will be proportional to your commitment, patience, ad budget, and creativity.
- Don't get overly excited about an early, large patient flow in smaller markets . . . experience shows that word of mouth soon fans through smaller communities, and the relatively few candidates who can afford the procedure are soon served and removed from the market.

Questions That Can Improve Your Bottom Line

"Animal, mineral, or vegetable?" The children's game of 20 questions comes in a grownup ophthalmologist's version that can boost your practice's strategic sharpness, operations, and profits. Here's a starting point, with questions you can refine and apply daily, weekly, and in some cases monthly or annually, in your practice. Some questions should be posed directly to management staff. Some should be posed to rank-and-file staffers. Some answers will speak for themselves, and some should be cross-checked with outside experts.

- *Do we know what we want to do?* Too often, surgeons show up for work with goals that are no more defined than "Let's make it through the day."
- *How cohesive is our practice team?* Does your practice have sufficient organizational "connective tissue" so that the lofty goals held by the physician owners are being translated completely into workaday action?
- *Do we know what dimensions of our practice are growing, shrinking, or staying the same?* Practice financial data are often too late, too scant, too short term, or not sufficiently segmented to back up your hunches. Bookkeeping controls must be in sync with the scale and financial challenges of your practice.
- *Do we have control over the volume of patient visits and the mix and volume of surgical cases in our practice?* Rather than just taking what comes through the door, you should establish specific volume performance goals for the year.

The goals should describe the number of new and total patients and mix of services you want to provide.

- *Are there costs we could reduce without adversely affecting the quality of care we provide?* For example, replacing in-house patient transport vans with on-call taxis might still allow the desired end of serving indigent patients, but at a lower cost, with less liability, and with greater flexibility.
- *Would these cost-containment efforts backfire and actually harm profitability?* For example, by reducing marketing costs \$50,000 a year, you might reduce revenue by \$100,000. By dismissing two techs, patient waiting time may climb to the point of reducing alumni referrals.
- *Are there steps we can take to improve the quality of our patient care without adversely affecting profitability?* Remember that “quality” is not just clinical outcomes; it is patient perceptions as well.
- *When will we post charges, submit claims, and receive payment for the services we’re providing to patients today?* Too often, practices concentrate on the over-90-day account column when the real problem is far earlier in the chain of events; for example, a bottleneck in the insurance department that generates a delay in claims submissions. Ask staff on the front line about the time lag from service to posting to submission and what happens when a Medicare check hits the door.
- *How many hours do our staff members work every day, and how many hours are they paid for?* Practices, as they grow, can carry forward informal and sometimes even overly permissive wage and hour policies. (For example, paying 36-hour-a-week workers for 40 hours, done earlier in your practice as a perk.)
- *Could we have seen more patients in the clinic today or performed more surgical cases?* Most surgeons end their workday with a cushion of unsold “inventory.” It may not bother you that a few no-shows leave you with time to read the paper. But remember that marginal, incremental revenue represents the bulk of your profits since fixed costs are already covered. Just three missed exams a day in a typical solo practice can trim as much as \$100,000 or more from your annual income.
- *If we saw all the patients or performed all the cases we were capable of, what’s holding us back from doing more?*

If growth is a goal, look for opportunities to increase everyone's productivity.

- *Are we extracting a full measure of value from every staff resource in the practice?* Are techs just standing around waiting for a physician to emerge, or are they calling to remind the next day's patients of their appointment? Are receptionists hanging out, waiting for the next patient to arrive, or are they prepping the next day's charts? You wouldn't put your retirement investment portfolio in an interest-free checking account—why would you let a \$15-an-hour member of your staff not *continuously* earn their keep?
- *Are we extracting full value from every other resource in the practice?* Satellite office or surgical facilities left vacant most of the week were once affordable in an era of \$1500 cataracts . . . no longer.
- *Are we even in the right business?* Have we gone too far in turning a cataract practice into a LASIK practice now that fees for refractive surgery are falling and volume growth is stagnating in some markets? *Have we considered ourselves a surgical practice only and missed optical dispensing opportunities?*
- *What's our exit plan?* Smaller practices have an easy answer: Sell to another practice in the community, or bring a successor surgeon in a few months before retirement. Large and mega practices have a more complex challenge. Since the demise of corporate management companies and hospitals backpedaling from '90s merger mania, divestiture options have narrowed. For these large practices, succession planning should be nailed down at least five years before the retirement of the most dominant provider.

The Respective Roles of Boards and Administrators

Boards make objective, written, measurable policies and standards. Administrators are the *resource allocation authorities* who are responsible for executing policies. Resources include, capital, staff, expertise, data, training/retraining, facilities, and technology. The board's standards must be in balance with the resources it apportions to administration.

Conflicts between lofty standards and low resources must be reconciled. If the board decrees that there should be 0.9 tech payroll hours per patient visit, but there are presently only 0.6, which may boost staffing costs \$100,000 over-budget. Either the board must release the extra dollars for staffing, reduce its standards, or do a little of both. It's up to management to give the board clear, advance feedback on the consequences of its proposed policies.

Ready to Become a Super Star Administrator?

The bulk of managers, being average, don't particularly strive for greatness. They merely want to stay a couple of steps ahead of their physicians and staff . . . which as it turns out is a tall-enough order on most days. However, there are exceptional managers who reach for the brass ring. What should you do to become a star? Here's at least a partial list:

- *Start with an emotional, to-the-bone, commitment.* Commit yourself, consciously, to the considerable challenge of being one of the best practice managers in the country.
- *Make sure you're on the right team.* You can only develop as far in your career as your setting and support will allow.
- *Develop administrator peer-to-peer relationships.* Visit a practice or two each year, and connect with colleagues who are a few rungs up the ladder from you. Secure a mentor if possible.
- *Read avidly.* It would be appropriate for you to be reading one to two business books and one to two general business periodicals (e.g., *The Wall Street Journal*, *Business Week*, *The Economist*, *Harvard Business Review*) per month.
- *Seek out formal continuing education.* There may be areas that self-education can't cover . . . or can't cover as fast as formal coursework.
- *Continue to better understand and be intimate with the product you are selling.* This involves sitting at every possible station and trying various jobs (excluding surgery, of course). For example, even if you flub taking an

WE DON'T NEED
TO MAKE A 100%
RIGHT DECISION ON
THE BATTLEFIELD.
WE NEED TO MAKE
A 60% RIGHT
DECISION, AND
EXECUTE IT WITH
EXTREME VIOLENCE.

Anonymous
U.S. Marines Trainer



applanation pressure, your staff will hugely respect your efforts and you will gain insight into how hard it is to do many of the jobs in the practice. If you *really* want to gain insights, arrange it so you can try even one or two steps of cataract surgery on a pig or cadaver eye.

- *Stay close to your board, and remember that the practice you're managing is the composite product of the board members' individual professional careers.* If you can get to the point of deeply understanding their individual motivations, goals, and weaknesses—and if they know that you understand and care—you will be a better manager than 95% of your peers.
- *Stay close to your management team.* You're only going to go as far as they will take you, and vice versa. As with the providers, work hard every day to understand where they're coming from while helping them achieve not only their *job* objectives but their *career* objectives as well.
- *Put in the time.* As the saying goes, "If you're not much smarter than those other guys, you have to work harder and longer than they do to get ahead." With few exceptions, the peers you aspire to emulate work 50+ hours per week. Many work 70+ hours per week. That's not everyone's cup of java, obviously, and there are real sacrifices along the path you aspire to . . . realize that you'll get out what you put in. At the same time, set reasonable boundaries. Running an ophthalmic practice at this time in the history of the profession is one of the most fascinating and engaging things anyone could choose to do with their professional life . . . just don't let it swallow you up.

The Hardest Thing You'll Ever Do

In a group practice, every individual practice owner has a moral, as well as a legalistically formal, fiduciary responsibility to cast a vote for decisions that further the business interests of the *entire practice*, even when such decisions may periodically go against the interests of the *individual*. This cuts to the core of the most sensitive decisions made in the boardroom—adding and subtracting doctors, opening or closing a satellite, or revising the compensation formula. Here is a common example: A group practice's only

retinal surgeon is nearing the limits of his personal capacity. He must vote to bring in a fellow subspecialist who will, at least for awhile, reduce his take-home pay.

Getting Past Misperceptions

Practices should be fact-based organizations. But human nature is strong, and researching the facts is without much value if the facts conflict with established perceptions. That's why it's important—if you're a manager and change agent of a practice—to do more than simply dig into the objective data. You must delve into the subjective basis for a physician's or a board's position regarding something that you think needs changing. An example: Let's say you're the manager and you want to convert to electronic health records. You've run the numbers, and it makes abundant financial and operational sense. The only problem is that Dr. Luddite wants to stick to paper because he "likes" it. Until you can get to the bottom of the word *likes*, you're going to get nowhere with all your facts and data. Let's learn from the medical model: As business people, we should always investigate the subjective/perception-based position of our "patients" before we collect and show them the objective data.

NEVER MISTAKE
MOTION FOR
ACTION.

Earnest Hemmingway



CHAPTER 8

FACILITY DESIGN AND MANAGEMENT



*We shape our buildings and
afterwards our buildings shape us.*

WINSTON CHURCHILL

What Office Facilities Do You Really Need . . . ?

For the typical general ophthalmology practice, and before considering optical or ambulatory surgical facilities, it's typical to generate \$300 to \$1000 in annual collections per square foot of office space. Said another way, at the usual intensity of utilization (with each physician seeing 40 to 60 patients per day, three to four days per week), most practices need a square foot of floor space for every three to five new or established patients seen each year. You can beat these numbers with longer operating hours, part-time visiting physicians, and more efficient scheduling to reduce the uncomfortable crowding that ensues with excessive patient waiting time. Every competent medical space planner has his or her own way of looking at these ratios and should observe each physician in a clinic before remodeling or designing new office space.

This doesn't mean you can't live outside the norms. One solo client insisted that his architect provide 12 exam rooms . . . that the current eight rooms he was using weren't enough. He then proceeded to run a very efficient 110 patients per day (with minimal waiting time) using certified tech staff as active extenders. His patients were delighted, and his profits were high. It was clearly a wise and affordable use of space in his case, even if it represents overkill for most practices. At the other extreme, I've served numerous clients who are most comfortable working out of just two exam rooms, and they're even able to see 50 or more patients per day in some cases. I can report from the front lines that as fees continue to soften, both of these facility extremes are quite likely to survive. I believe that high-volume/lower-margin "assembly lines" and low-volume/higher-margin "boutiques" will both continue to find willing patients and enjoy survivable profit levels. Each service model has its own space requirements and its own economic boundaries.

. . . And What Can Your Practice Afford?

In the past, facility decisions were driven more by how much elbow room each physician wanted and less by the

THE MOST
BEAUTIFUL THINGS
IN THE WORLD CAN
NEITHER BE SEEN
NOR TOUCHED, JUST
FELT IN THE HEART.

Helen Keller



economics of efficient design. Let's examine what's reasonably affordable in your practice today. Facility costs include base rent or mortgage costs, utilities, maintenance and upkeep, and taxes. If you own your building, these costs are offset over time by any appreciation in value. But it's rare that the offset is substantial. The market value of purpose-built eye care office facilities can sometimes be sharply less than the original development costs. And the price appreciation of professional office space in urban markets like New York can be relatively flat. Be sure to seek local, professional real estate advice before transforming your rent checks into mortgage payments. Pride aside, and depending on your age and the broader business cycle, it may be better use of your funds to invest in the practice via super staff, marketing, or ancillary equipment than by owning your office building.

A reasonable cost ratio for facilities in a general ophthalmology practice is 4% to 6% of practice collections. In urban and suburban markets, facility costs will skew somewhat higher. First, the land, vendor, tax, and even utility costs can be much higher. What's more, urban patients expect more lavish surroundings. It's not unusual to pay 8% to 10% or more of revenue for retail-oriented facilities in the urban core. In contrast, rural facility costs are lower . . . as little as 1% to 3% of collections. Because building and land costs are lower in the country, owning your own office is far more common in rural America than in the city.

Facility Development Do's and Don't's

1. Know your facility utilization numbers. The best, coarse gauge of whether you need more space or not is to count up the number of active, fully-equipped exam rooms, multiply by 173 (the nominal number of hours your clinic is open each month), and divide the resulting figure into the number of patients seen in the average month. The resulting figure should be about 1.0, with units of "patient visits per exam room-hour." Here's an example:
 - Your practice has five exam rooms
 - So you have $5 \times 173 = 865$ room-hours per month
 - You serve 800 visits per month

- Divide 800 visits by 865 room hours, to get 0.9 *patient visits per exam room-hour*

If your practice has these statistics, your facility is running at only about 90% of potential capacity, and you don't need added space. This is obviously a gross, first-pass calculation. Depending on your subspecialty, the availability of optical or special testing space, pace of growth, or general layout flaws, you may still need more space.

2. Explore a "temporal" expansion before adding facilities . . . that's to say, think about expanding office hours rather than adding facility space and cost. If you are trying to make just four exam rooms stretch to serve two doctors who both want to work in "prime time," Monday through Thursday from 9AM to 4PM, shift clinic hours around so that the providers are a little less bunched up . . . one doctor working on Friday in alternate weeks, and running from 8AM to 5PM, for example.
3. Let's say you absolutely need to expand, but have to do so on a budget.
 - If your budget is tight, eliminate nonessentials. Are you so shy that you really need a private washroom for every doctor?
 - The same goes for private doctor office space (a group office with a meeting table and separate cubicles not only costs less but facilitates communication).
 - Use cubicles for business staff rather than erected fixed walls.
 - Fit out a "wow" waiting/reception area, but leave the back clinical space more industrial. (Consider doing what Hampton Inn and similar mid-grade hotel chains do . . . with a plush foyer and serviceable, but plain guest rooms.)
 - Leave out the crown molding, premium carpet, custom wall treatments, and original artwork.
 - Make sure your builder takes a second pass through your architect's plans to "value engineer" the final project.
 - Don't under-build . . . if you build for today's needs in a growing practice, the second phase of near-term

construction will be far more costly per square foot than if you're right-sized the first time around.

- Unless you feel you must, don't try to win architectural awards with offbeat, expensive designs. Build a box, and leave out the curves, both on the shell and on the interior build-out of the practice.
 - Don't buy more land than you need . . . but leave room for any obvious, future expansion. Very few ophthalmologists should take the entrepreneurial approach of building the 10,000 square feet they need today, plus another 30,000 square feet to rent to other users.
 - In most cases, create a new facility rather than redesigning an existing structure.
 - Don't try to save money by buying cheap, out-of-the-way land . . . the appreciation on your facility in the coming years will be far lower, AND you'll lose the promotional value of being on a major thoroughfare.
 - If you're in solo practice and have no solid succession plan, don't build a new facility if you plan to work for fewer than 10 more years. (And if you plan to practice for 10 years or longer, try not to rent, unless you work in a high-priced, inner-city environment.)
4. Don't overlook exterior appeal. Your senior patients are likely to be avid gardeners. They will "tsk-tsk" your dying shrubbery and project their first impression of your landscaping on the quality of your medical and surgical care. Keep up the parking lot resurfacing and stripes. Purchase the largest/brightest signage local zoning will allow.
 5. Don't pursue any significant expansion or building project without first preparing a realistic pro-forma showing the cost-benefit of the project in the years ahead. There are many factors to consider here.
 - Will your total facility costs, as a percent of total collections, be at or under 10% immediately post-project, and fall to 6% or less within five years?
 - Are you realistic in your projections of how fast practice collections will grow with a new facility?

- Do you possess the risk tolerance to handle the prospect of having facility costs escalate as a percent of collections if health reform leads to materially lower professional fees?
- What will be the future appreciation on your new property? Will you be able to find a buyer when the time comes, or is your area overbuilt with professional space?
- Are you properly hedged and able to carry higher facility costs in the event of a temporary disability, loss of a key provider, or similar difficulty?
- Will your personal net worth be higher or lower in 10 to 20 years if you develop a new facility?

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Sparing Facility Costs

Many practices are now in a catch-22. As professional fees fall, ophthalmologists need more office space to be able to maintain revenue, yet the cost for more space can exceed the increase in revenue. Here's what you can do to help contain facility costs:

- *If you're running out of space, consider a temporal rather than a physical expansion by increasing office hours.*
- *Rather than immediately building more office space to accommodate a new associate physician, start a part-time satellite office to take the pressure off.* If the associate doesn't work out, it will be much easier to pull in the reins on practice expenses.
- *Convert personal physician office space into patient care space.* Move the physicians to a single bullpen office, or "hot desk" doctors at small workstations.
- *Review your office's actual square footage with the contracted footage . . . errors are more often in the landlord's favor.* This strategy may allow you to reduce future expenses as well as get a refund check. (Note that an increasing number of lease contracts have a blanket clause forgiving the landlord of any measuring errors. Get an accurate measurement before you sign such contracts.)
- *Review your property taxes.* If your facility's market value has dropped, it may be possible to appeal your tax bill.

THE ONLY WAY
TO GET RID OF
TEMPTATION IS
TO YIELD TO IT.

Oscar Wilde



- *Even if you are delighted by your current cleaning and maintenance service, get new bids every one or two years. If you have no choice in services, insist on a reasonable standard of service for the price you're paying. Some practices have the daytime office staff bag and remove trash, handle light cleanup, and do dusting chores so that the frequency, scope, and cost of commercial cleaning can be reduced. (But don't do this in your practice at the cost of low staff morale or inattention to more critical job duties.)*
- *Install a "smart" thermostat that can be programmed to pare utility costs.*
- *Start lease renewal negotiations up to a year or more before the end of your current contract. If you can't immediately get the price you want, you'll have more time to shop around for alternatives.*
- *Ask your landlord—respectfully but firmly—for a roll-back in leasing costs. Explain the impact of falling fees on your practice. Before you ask, research not only the local per-foot lease and vacancy rates in your building and the general market but also the financial strength of your landlord. Your landlord may be vulnerable to a forced lease reduction (a) if he is not living up to his end of the lease agreement (giving you an opening to terminate for cause), (b) if he believes your practice is in financial trouble and only a reduction in rent will save his tenant, or (c) if the market is soft and you are nearing the end of your lease or renting month to month.*
- *Consider building your own facility if the age and location of your present office, conditions of your local real estate market, or tax considerations dictate. You may be able to get more work done in 3500 square feet custom designed from a blank page than the awkward 5000 square feet you're using now. It may be that what's holding you back is an obscure location, sub-standard signage, or poor parking, and that a move (even if it's to more expensive space) will wind up being more profitable long-term.*
- *Of course the easiest way to reduce the percentile cost of occupancy is to improve the top line of your practice.*

Moving from Office to Office as You Grow

Like a hermit crab exchanging shells, when you move to new office quarters, you can expect your facilities to feel oversized as you grow into the larger space over several years.

Be sure to look closely at your practice's realistic growth trends, and don't overshoot your needs. Make sure that in the foreseeable future, facility costs in percentile terms will taper back down into the 4% to 6% range. To prepare for any possible miscalculations in your needs, always design your facility so it can be easily subdivided and leased to a compatible tenant. Rather than taking on more space than you need today, negotiate with the landlord in advance for first-option rights to adjacent office space. If you're building your own facility, purchase enough land for ground-floor expansion and parking if possible . . . don't get boxed into the inefficiency and patient inconvenience of having to build an off-site annex or second story.

Working in Smaller Office Spaces

To spare costs, an increasing number of practices are having to forego office expansion and relocation. Here are a few ideas to help you live within your constrained office space:

- *First, get your mind right.* In New York City or urban Europe, where office space is costly, surgeons make do with far smaller facilities.
- *The patient volume-limiting bottleneck in practices is rarely the number of exam lanes.* The greatest limits usually have to do with poor physician work habits—things such as late arrival, time taken away to answer the phone, slackened work intensity, and excessive socializing with patients.
- *Smaller office space has two significant impacts on staff dynamics.* First, a positive impact: Communication is enhanced . . . everyone is forced to mix it up all day long. The negative impact is that all that mixing it up, with little room for escape, will make even the best staff periodically edgy. Like a submarine captain, you must pick your crew carefully for their emotional maturity and hold many air-clearing sessions.

ABSTAINER: A
WEAK PERSON WHO
YIELDS TO THE
TEMPTATION OF
DENYING HIMSELF
A PLEASURE.

Ambrose Bierce



A DOCTOR CAN
BURY HIS MISTAKES
BUT AN ARCHITECT
CAN ONLY ADVISE
HIS CLIENT TO
PLANT VINES.

Frank Lloyd Wright



- *In some practices, you may find you have sufficient waiting room space but not enough exam rooms.* If this is the case, free up a lane by moving your autorefractor and non-contact tonometer to a corner of the waiting room and conduct pretesting (but likely not history taking) in this setting.
- *Call in a professional decorator.* The decorator can magnify small spaces with smaller furnishings, mirrors, and neutral color themes.
- *Hire neatness freaks.* The smaller your space, the more important it is to reduce office clutter. Rotate the task among staff of sprucing up during the day. Handle storage needs off site, if necessary. Spring clean four times a year.
- *Microengineering your appointment schedule is critical.* In many settings, this can be as easy as delaying arrival of your midmorning and midafternoon patients.
- *Concentrate on the most profitable areas of your practice so that “sales per unit customer” is optimized.*
- *Take the leap to electronic health records to save storage space.*

Celebrate the Visual in Office Décor

Eye care providers should rightly celebrate the visual arts in their office. Colors should be tasteful, but bold. Add one or two abstract sculptures. Let a local gallery consign its artists on your walls. Since people—patients and staff—make up your professional life, have a photographer come in one morning to take candid shots . . . capture patients and staff interacting, a staff member on the phone, a tight shot of a patient trying out new glasses. Enlarge the resulting photos—in a mix of black and white and color—and rotate them throughout the office as the key design theme. Don’t forget to include family photos and shots of the doctors enjoying their hobbies.

Locating Physicians’ Personal Offices and the Staff Break Room

It helps to place both the staff break room and each physician’s personal office away from patient areas. Although this would seem to conflict with the common sense of reducing steps, experience shows that both physicians and staff have a tendency to hang out and hide between encounters.

A long hallway can inhibit easily distractible physicians from taking “just one short phone call” that often drags on for 20 minutes.

The ASC Should Be Adjacent to the Clinic If Possible

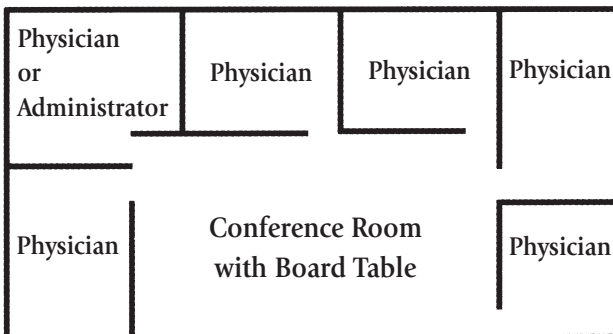
If it can be arranged, you should develop an ambulatory surgical center directly adjacent to your existing clinical facility. This is far more efficient and helps give patients the impression that their upcoming surgery is more akin to an office procedure than “major surgery.” The only exceptions to this are (a) if you are developing an ASC for multiple users who are not associated with your practice—neutral ground will vastly improve your chances of recruiting other users, and you have run out of space on your existing pad.

Where Should Our Patient Accounts Staff Be Located?

Billing staff are often shoehorned into a bullpen between the charts and the front desk. There, they are in the middle of the busiest and noisiest place in the practice, which significantly cuts down their efficiency. I strongly urge clients to place billing staff on the sidelines, at the very least in private cubicles, where they can focus on their work.

Physicians’ Personal Offices and Board Room Suite

In group practice settings, here is the best arrangement for the physicians’ private offices:



CONTENTMENT
CONSISTS NOT IN
GREAT WEALTH BUT
IN FEW WANTS.

Epictetus



NEVER GO TO A
DOCTOR WHOSE
OFFICE PLANTS
HAVE DIED.

Erma Bombeck



Placing the administrator’s office in this same suite helps convey a sense of higher authority and improves physician-administrator communication, even if it’s at the cost of some distancing from staff and clinic operations. Glass walls or doors leading into each doctor’s private office facilitate physician-to-physician and physician-to-staff access. It’s helpful in practices with any more than two or three doctors to also have a formal conference room, which can be integrated with individual office space as the diagram shows.

TO TAKE AS
PERMANENT THAT
WHICH IS ONLY
TRANSITORY IS THE
DELUSION OF A
MADMAN.

Kalu Rinpoche



The High Price of Privy Privacy

I remember advising a dear, old client on his new clinic and ASC facility plans. Among other “must-haves,” he insisted on having a private restroom adjoining his office—and he was certainly in a position to afford this perk. But it was interesting to pull the actual numbers associated with this luxury. After accounting for the building costs and depreciation, periodic repairs and maintenance, and the time value of funds tied up . . . and after making a few assumptions about how often these facilities would be used during the day, it turned out that every trip to his private facilities would cost my client about \$5.50. I sure hope he still likes that wallpaper.

CHAPTER 9

ADDING OR IMPROVING AN OPTICAL DISPENSARY



*I was walking down the
street wearing glasses when
the prescription ran out.*

STEVEN WRIGHT

Optical Profits Are Increasingly Vital to Practice Survival

The relationship between a general ophthalmology practice and its optical dispensary is a little like the relationship between a fine restaurant and its bar. An increasingly important percentage of practice profits comes from the optical dispensary. Those profits are passive, requiring little additional work from the “chef,” who’s back in the “kitchen.” When the clinic (“restaurant”) is overflowing, the optical (“bar”) is a nice place for patrons to hang out. Optical goods complement what’s on the clinic’s main menu. In optometry, optical sales often provide most of the practice’s profits. Although never to the same extent, I think this will increasingly be the case in ophthalmology. Certainly, few restaurants would have a positive cash flow if they did not also have libations.

Why Dispense?

Well over a third of the nation’s ophthalmologists now dispense glasses, and this figure is rising as the wisest providers in the right settings realize the benefits:

- An added margin of business security comes with diversification.
- Profits are augmented. In the typical setting, a dispensary can boost global profits by 10% or more. Surgeons who dispense today have at least partially offset falling surgical fees.
- If you don’t dispense glasses, your patients are forced to develop a customer relationship with another eye care vendor . . . a vendor that may one day *displace you*. Patient convenience, continuity of care, and retention are furthered by being a one-stop provider.
- Managed care access can be potentially improved.
- Commercial-aged patients, with no other eye care needs than routine checkups and refractive lenses, were once well down the list of desired patients. With the advent of refractive surgery, these patients are now a feeder for a highly gratifying surgical practice.

THE CURE FOR
ANYTHING IS
SALT WATER: SWEAT,
TEARS OR THE SEA.

Isak Diesen



Why Not Dispense?

At the same time, there are several conceivable contraindications to dispensing in a general ophthalmology setting, such as:

- A third or more of your surgical referrals flow from optometric providers, who would view your dispensing as competitive to their interests.
- Your practice's other revenue sources are so strong that the added complexity of acquiring an optical dispensary simply can't make a corresponding profit contribution.
- Your practice's physical plant is too small.
- Your practice's patient volume is so small that even a part-time optical dispensary can't be supported.
- Optical dispensing is so competitive in your service area and your patients are so conditioned to shop for glasses outside of your office that it's not worth the trouble to enter the fray.

What's the Bottom Line of Dispensing?

For an optical shop that is strongly supported by the physicians and well-integrated physically with the reception area of a general ophthalmology practice, you can expect that gross optical sales will be equal to 20% to 25% of the medical and surgical fee collections from that location, exclusive of any ASC facility fees (e.g., a million-dollar office practice will generate roughly \$200,000 to \$250,000 in optical sales) . . . this figure drops to 15% if patients have to open a separate door to enter the optical shop . . . and drops to 10% or less if the patient has to walk any farther than next door. According to optical expert Art De Gennaro, "The problem here is that this statistic echoes the performance of *existing* dispensaries in the MD world, which unfortunately, are seriously underperforming as a group." With full cost allocation for space, administration, staffing, and marketing, it's typical for an in-house optical shop in a typical setting to drive a 25% to 35% profit margin. According to De Gennaro, this could be closer to the 35% side with appropriate attention to the details. [PS: If you don't own a copy already, be sure to buy Art's terrific primer on opticals, "The Dispensing Ophthalmologist," published by the AAO.]

Beware Optical Discount Plans

The typical optical dispensary housed in an ophthalmology practice generates a 20% to 25% profit margin. Typical optical discount plans reduce your optical collections by 10% to 20%. Therefore, it can be dangerous to profitability—even if you're trying to drive incremental revenue or cross-sell managed care patients to elective surgical care—to sign up with discount optical plans.

Reducing the POF Rate

Every optician despairs when a parsimonious patient presents with 10-year-old frames that are oxidized, green, and outdated and simply wants the new lenses inserted. Here's scripting that may help the patient's own frame (POF) rate at your practice: "You know, this is a great pair of glasses you have, and they would make a terrific backup pair, but I have another frame design I'd like to show you that would look better on you and be more comfortable. . . ."

A Retail Planning Hit List

Although the very concept is somewhat foreign in a professional, fee-for-service environment, your optical shop is a retail outlet that deserves and requires the same attention to gaining a percentage point of profit here and there as your local Macy's or Neiman-Marcus. Here's a checklist (how many of these have you worked on this year?):

- Reduce refunds and returns by improving customer satisfaction . . . call customers post-dispensing to make sure they're happy with their purchase.
- Increase frame prices to the limits of the local market and your customer base.
- Up-sell products (e.g., ultraviolet protection and high index).
- Boost accessory sales (e.g., repair kits, cords, and cleaners).
- Reduce remakes . . . trace each remake back to its source and take corrective action.
- Engineering traffic flow in the office.
- Script what staff should say to direct and keep patients in the optical shop.

- Display proper merchandising to make your floor space as inviting as possible without the displays being a distraction.
- Closely examine sales per optician to identify and build on success factors.
- Float staffing levels to optical department traffic.
- Increase second-pair sales by discussing with the patient how different activities may warrant different glasses.
- Review and reduce the cost of goods (check by location, benchmark to standards and limit your vendor mix).

How Much Should Optical Stock Cost?

“COGS” stands for *cost of goods sold*. A reasonable COGS rate in the typical office is 30% to 40% of sales. A higher figure should trigger an investigation to determine whether there is overstocking, underpricing, overpaying, or diversion via theft by patients or staff. “I look for 28% to 33%,” says De Gennaro. “I agree that 40% is the top reasonable number, although I think that at that level you already have an inefficient buying/pricing program in place . . . or an unannounced partner.”

How Much Revenue Should We Generate Per Optical Sale?

Your practice’s average optical ticket—found by dividing total optical sales by the number of jobs—can be as low as \$150. If your practice is willing to be more sales oriented, that figure can climb closer to \$350 and higher.

More Optical Benchmarks

Optical sales can be benchmarked at about \$100 in net sales per dispensing optician payroll hour, although this may be lower in a setting in which opticians are fulfilling other duties and much higher in premium settings. Remake rates in the 5% range are normal but range upward rapidly if refractionist errors are not being caught. It’s useful to keep a remake log, by refractionist, to track actual statistics rather than relying on anecdotes and memory. Dispensing just lenses or just lenses with a frame is called a “job.” But the ratio of just lenses to total jobs should be under 25%; if

it's not, the most likely cause is an underaggressive optician or a physician who is trying a little too hard to save patients money by being conservative.

Peak Sales Months for Optical Shops

According to U.S. Department of Commerce figures, the three peak months for glasses sales are March, August, and December. The three weakest months are January, February, and November.

Where Are Glasses Purchased?

Ophthalmologists only sell about 13% of the optical goods in America today, according to figures from Jobson Optical Group. Optical chains sell about 37%, optometrists 32%, and independent opticians about 17%. Ophthalmology will clearly never lead the pack, but the expectation should be that with an aging population, ophthalmic dispensing will enjoy a net gain. According to statistics published in a 1998 edition of *Vision Monday*, the top reasons patients were motivated to purchase from an in-house dispensary were the ability to buy the glasses where they received their exam and the physician's recommendation to use the in-house shop.

Make It Easier for Opticians to Sell Up

Physicians commonly treat their optical dispensary as a patient convenience instead of a profit center—then complain at the end of the year because margins are scant. One better way to increase optical shop margins is to cross-sell needed (or at least appreciated) extras. Your optical prescription pads should have check-off boxes for various upgrades including premium lens materials, ultraviolet coatings, tints, and progressive lenses, as well as reminders for the optician to discuss the possible need for second pairs and sunglasses.

What Percentage of Optical Prescriptions Written Should Be Filled In-house?

The typical optical conversion rate—the percentage of glasses prescriptions written that result in jobs done

in-house—is a figure that varies wildly. Conversion rates are as low as 35%, although the national average is closer to 60% . . . a figure that has not changed in several years. De Gennaro aims for an optimum rate of about 80%. When optical utilization is low, the most common reason is physician disengagement. “Disengagement is an important factor, but equally important is a lack of *any* qualified in-house expertise. Neither the physician, the administrator, nor the optician understands optical retailing well enough to create the profit formula and working model for the business, hence they flounder,” says De Gennaro. That leaves the practice at a huge disadvantage to street-savvy commercial competitors and optometry. Because they derive such a large percentage of their revenue from optical (65%), they traditionally put more emphasis here. The reason physician involvement helps get things going is because if the boss gets motivated, the rest of the staff get pulled along.

IMAGINATION IS
MORE IMPORTANT
THAN KNOWLEDGE.

Albert Einstein



Adding a Dispensary Needn't Kill Referrals

Are you holding off on dispensing because you're concerned that you may offend referring doctors? Practices with a high optometry referral rate (e.g., more than a third of all surgical cases come from ODs) *do* need to be wary of adding an optical dispensary. However, the addition of an optical shop is no longer the danger for comanagement relationships it once was. Expect no more than a 10% to 30% drop in referrals in most settings, then work backward and do a cost-benefit analysis of adding or avoiding dispensing, or even unwinding an existing optical shop.

Boost Optical Sales with Timed Discount Coupons

All dispensing practices struggle to increase the percentage of scripts that are filled in their dispensary. Physician and tech selling skills are the core tools, but these tools can be more effective in some competitive settings (or with price-sensitive patients) when the practice provides limited-time discount coupons. Industry experience is that dollars-off

work better than percent-off coupons. Discounts for a second pair of glasses and coatings/tints can also be used, either alone or with other offers.

You Can't Sell Patients Glasses If They Are Not Physically in the Optical Shop

Nothing could be simpler, yet many dispensing practices overlook this basic truth and place their optical shop out of easy reach of the patient. Or they fail to physically escort patients onto the optical shop floor. Do whatever it takes, including:

- Free cleaning and adjustment of glasses pre-exam or post-exam
- An obligatory pre-exam visit to the optical for lensometry readings
- A main reception desk situated in the middle of the optical displays
- A free lens cleaning cloth, available only in the optical shop
- Escorting patients through the optical shop on the way to the exam, and then after the exam
- Filling out and distributing the glasses prescription to the patient in the optical shop

Cross-Check Optical Prescriptions Versus Jobs Filled

Ideally, 60% or more of your patients who receive a new glasses prescription should be filling it in your optical shop. A simple spot check or an ongoing review can give you great insight into actual optical sales. Use a duplicate Rx pad (carbon paper will do in a pinch), with one copy to the patient and the extra copy to the optical department. Dig beyond the actual closing percentages, even if your numbers are favorable. Call nonbuyers and ask why they held off. Fix the problems they describe. Not enough selection? Increase and diversify your displays. No one waited on them? Make sure that you have enough staff and that others besides those in the optical shop are available to help for short periods during peak traffic. Prices too high?

Verify your competitors' prices and stay within a reasonable spread of the competition. If your prices are lower than the retail chain averages—which is likely the case—raise prices or tell your patients about your favorable pricing with handouts and signage.

This Is More Fashion Than Science

Professional medical offices are rarely trendy. With just a few year's wear and tear, most can look pretty drab. This retards optical sales. One of the most common deficits of smaller ophthalmic dispensaries is the lack of attractive displays and merchandising. Ask your distributors for assistance. Visit larger commercial chains for ideas. Spend a little extra for seasonal displays. Invite a local retail trade business student or professional window dresser to your practice to provide advice. Improvements in overall office appearance, as well as staff grooming and attire, can have a great impact on retail optical sales.

Make Optical the First Step, Not the Last

When checking in at the front desk, patients who wear glasses should be directed (escorted is better) to the optical shop to have a lensometry reading and their present glasses cleaned and adjusted. This helps camouflage excess waiting time and gives the optician an opportunity to encourage the patient to discuss new glasses with the physician. It also saves the techs or front desk an extra step.

A Smooth Handoff from Physician to Optical

When an exam that includes a new glasses prescription is complete and the patient is being told about his or her optical options, ask a dispensing optician to come to the exam room. Introduce the patient. Talk to both the patient and optician about the patient's special optical needs: "I've suggested to Mr. Jones that he consider an extra pair of sturdier glasses or sports goggles since he is active in an adult softball league. I would also recommend an antireflective coating on his everyday glasses since he's working with sales leads all day long and would like to make the best possible eye contact."

In Optical, What You Say Is What You Sell

There are virtually no walk-in patients in an ophthalmic dispensary . . . the most important influence is what the physician tells the patient to do. Be direct. Give patients specific instructions to go to the optical shop rather than suggest they do. “Well, your eye exam is complete for another year—I’m very happy with what I’m seeing. Here’s your new glasses prescription. Take this down the hall to Wanda in our optical shop. Be sure to ask her about high-index plastic so we can make those lenses as thin and light as possible.” (Remember that what you say to the patient about your optical shop, as well as requirements to provide a prescription, are legally imposed on your practice.) Be proud. Don’t hide that you own the optical shop. Say something like, “I’m so pleased with the staff we’ve selected to help our patients with their optical needs—they are real pros who will make this prescription I’ve written for you fit right and look great. I’ve added a special note to your prescription telling Wanda to give you some extra attention with those bifocals, since you’re trying these for the first time.”

The Tech–Optician

Many of the skills needed to be a great ophthalmic technician—strong work ethic, manual skills, high tempo, good memory, thick skin, sensitivity to patient needs, precision—are the same skills needed to be an excellent dispensing optician. Consider cross-training some or all your techs to be dispensers and all dispensing opticians to be (at least) fill-in techs. I have seen one office in which patients are served by the same tech–optician during their entire transit through the office and handled with the same care they would receive from a Nordstrom sales associate. You might consider the approach taken in dentistry, where the patient’s chief bond is with the dental assistant who performs the bulk of the semiannual cleaning and checkup.

Don’t Hide Your Optical Lab and Staff

Some of the finest restaurants in the country have an “open concept” with their kitchens, putting the entire culinary staff—from prep cook to master chef—on display. Patrons

love the show, and those working in the kitchen do their best work under all the scrutiny. Like old-fashioned kitchen drones, optical lab staff are often made to feel like second-class citizens in their practices, hidden from view. Clean up the lab and tear down the walls (or install glass). Make sure lab employees are invited to general staff meetings. Don't overlook that these workers often have significant mechanical aptitudes that can be applied to keeping ophthalmic instruments in good repair and troubleshooting building maintenance problems.

Optical Stocking

Optical buyers too often choose stock based on their own tastes, which can leave your patients with the impression that your optical inventory isn't worth a browse, much less a purchase. Make sure all frame boards are completely filled and that the patient's first glance shows a wide selection of styles, age groups, gender mix, and prices. A trip to several comparable optical shops in your area may supplement your sense of what's selling. Extra display units and stocking costs almost always lead to markedly higher sales.

Don't Neglect High-End Designer Frames

Ophthalmic practices that mostly serve older patients, especially those in rural and inner-city settings, often underestimate their patients' willingness to upgrade their frame selection. Consider stocking more high-end products, at least on a trial basis. Optical staff should be oriented (and given incentive) to sell up-market first and not make assumptions that a patient should be directed to the Medicaid frame board on the basis of his or her attire or appearance. In most settings, "budget/union/Medicaid" frames should not be prominently displayed. This will increase the chance that patients are exposed to a wide range of quality and value before making a purchase decision.

Optical Inventory Management

Most ophthalmology practices with optical shops lack regular protocol to inventory their frame stock, objectively assess what's selling, or review the cost of goods sold. Even the smallest optical shop should have a monthly paper

inventory control protocol. Larger or more sophisticated practices can use computerized optical inventory modules available from many major computer system vendors and at least one major frame stock supplier.

Medicaid Optical and Medical Payment Trends

In an apparently increasing number of states, Medicaid patients and their providers are being forced to outsource optical goods to central vendors. In such states, the treating doctor gets a token service fee to dispense glasses. This is unfortunate because optical profits are often one of the last remaining incentives for accepting Medicaid patients, along with a spike in the recent past—in selected states—in fee payments secondary to the tobacco settlements. Now that many states are running budget deficits, Medicaid money is on the chopping block. It seems clear that all health reimbursement signs, public sector and private, point to sharp curtailments.

WHO YOU GONNA
BELIEVE, ME OR
YOUR OWN EYES?

Chico Marx



Your Optical Shop as Polling Station on the Practice's Customer Satisfaction

As some of the last practice employees patients see, your optical staff can add real value by reporting their impressions of patient satisfaction. A few simple leading questions can lead to conversations with patients, which can lead to improved service and the elimination of minor patient irritations: "Did we solve all your problems/answer all your questions today?" "Now that your visit here with us is just about over, is there any other way we could have served you better today?" "If there's one more thing we need to do in this practice for nice patients like you, what would it be?"

Think Retail

It's hard to think like a store owner when you're a professional selling your time. Getting into a retail mindset is focusing on (and stimulating) what a customer wants more than on their core needs. Retail is about easy accessibility and availability—medicine, despite recent competitive changes, is still about this: "I'm so good you'll wait for

me if you want the best.” Optical superstores do most of their business on the weekends and evenings, a time when most physicians are home enjoying their families. Retail is about choice, fun, and the “shopping experience.” Having only a couple hundred frames on two walls with an optician on a stool in the middle is not fun. Having 500+ frames is essential . . . 800 or so is better. Lavish lens option displays make selling “up” easier. Merchandising is easier if you limit your practice to just five to seven vendors and let these vendors manage their section of your store.

CHAPTER 10

CLINICAL MANAGEMENT PEARLS



*Nagging is the repetition
of unpalatable truths.*

BARONESS EDITH SUMMERSKILL

Who Wants a Raise?

What's the easiest way for physicians to give themselves a raise? Work an extra few hours a month—simply a few extra minutes (or a little more intensely) each clinic day. Here's how. Assuming you have the patient base, you can see more patients at little or no additional cost. At a typical \$165+ in collections per average patient encounter, seeing just three more patients per clinic day (and assuming four clinic days per week times 48 weeks per year) yields a remarkable \$95,000 or more in revenue, almost all of which drops to the bottom line.

Take This Practice Stress Test

If you are already proud of your office and would simply like to find the next level of productivity gains, put stress on the office—just as a coach gives an Olympics-bound athlete an extra tough workout or a cardiologist administers a treadmill stress test. To see what your organization can *really* do, pick a week to be “hell week.” Explain to the staff that you will be testing the practice by taking on more work for that week than you ever have, and that the purpose is to find out what expansion capabilities—and limitations—the practice may have. Book the clinic 30% to 50% heavier than is ordinarily the case. Have your staff meet to discuss how they're going to cut corners to keep the system running. Then go out and survive the week. You'll likely find that it was *far easier* than you expected. Patients were all seen on time, the staff was pumped up, nobody got bored with his or her job, and the hallway gossip sessions diminished. Clinical profits, along with surgical cases scheduled that week, will climb. You'll also probably identify a few rate-limiting steps—the need for an additional exam room, a couple of techs who need to speed up their history taking, or a physician who runs out of steam in the afternoon because he's not eating and exercising properly. Use this test to set new volume performance goals for the practice and fix the rate-limiters.

Hints for Better Scheduling and Patient Flow

The perfect schedule has yet to be invented, and it never will be. That's because an ophthalmic clinic is not a factory. Human variables will monkey wrench the best engineering every time. But hope springs eternal to make the best of human vagaries, so here is a short inventory of ideas to help in your setting:

- It's essential that all staff with a role in patient care and patient flow convene periodically to discuss the effectiveness of the current schedule. It never works when only the office manager or a physician makes scheduling decisions.
- Once a new template is developed, it should be allowed to work for several months, if possible, before it is fine-tuned.
- The toughest environments for scheduling are clinics that have a highly diverse patient base. Shifting gears back and forth between LASIK and cataract and routine patients can be hard for the entire team. Try to cluster similar patients into separate clinics.
- Physicians alone, especially employee physicians, should never be allowed to make unilateral decisions regarding changes to their template, or how late their work day runs . . . this should ideally be a team decision.
- Focus your greatest efforts on the main choke point of the practice. This will typically fall in one of five areas: physician discipline/tempo, exam room availability, the number of technicians, technician skill/tempo, and overall traffic flow control (generally provided by the lead technician).
- Eighty percent or more of the time, the most important choke point is related to physician tempo. Often, this is nothing more than getting to the office on time, staying off the phone, and avoiding excess social discussion with patients when the clinic is backing up.
- It helps to have brief, intermediate, and long exam slots, even if the front desk will never perfectly triage patients into these designations. Triage instructions should be in writing, and staff should be observed in role-playing

exercises and live at the front desk to make sure they're getting it right.

- Avoid falling into the trap of creating 10 or even 20 different kinds of appointment slots, which is far too many. This will confuse staff and markedly slow the appointment process. "Shorts" and "Longs" are fine for most practices.

Just One Visit Per Customer, Please

Long ago, clinical tradition held that patients should be seen by the physician two times per office visit—before and after dilation. The new standard of care and efficiency is that techs (who also refract) should be trained and authorized to make the decision to dilate or not dilate. The resulting single pass is far more efficient. The dilation protocol should be written and drilled to perfection. Note that most high-volume practices stretch the limits to avoid dilating whenever possible.

Avoid Building a Drop-In Practice

Many rural practices have fallen into the habit of allowing an ever-larger portion of their patient base to come in without an appointment. For all its ills and frustrations, a patient appointment schedule beats the alternative of a purely drop-in practice. Even in lower volume practices, the result is chaos and inefficiency . . . recall is difficult to administer . . . continuity of care is lost . . . and it's difficult to staff for peak traffic. If you've spoiled your patients, it may be time to reverse course. Send a letter announcing the availability of appointments, and with each new patient visit, get him or her to commit to the next appointment time. The only exception to my recommendation would be if your practice is using drop-in appointments as a competitive advantage. Even then, I would limit patients to one or two no-appointment/drop-in days per week.

LET US ENDEAVOR
SO TO LIVE THAT,
WHEN WE COME
TO DIE, EVEN THE
UNDERTAKER WILL
BE SORRY.

Mark Twain



The Greatest Practice Builder

Great patient relationships can be fostered by a single verb: *nurture*. Nurturing is a touch, a smile, a thumbs-up gesture . . . but it's mostly what you say. Nobody wants to

WE'RE LIVING IN
AN AGE OF MEDICAL
SPECIALISTS.
WHAT 4 OUT
OF 5 DOCTORS
RECOMMEND IS
ANOTHER DOCTOR.

Anonymous



hear (while you stand way across the exam room), "I'm not happy with what I see going on in the back of your eye, Ms. Davis. This may need a lot of additional tests that aren't very comfortable." Instead, you should say (while you hold the patient's hand or touch a shoulder), "With just one small exception, I'm very happy with what I see here today, Ms. Davis. With your permission, I would like to perform three additional tests. Two are a breeze . . . one may make you a little uncomfortable."

Communicate More Effectively with Your Cataract Patients

There are dozens of obvious, clinically obliged, mechanical steps to removing and replacing a cloudy lens. Each step has evolved and improved markedly over the past 25 years. But in many practices, even those with vanguard surgical technology, the mechanics of appropriate communication are still quite primitive. Consider the following points:

- *You can't "sell" (and I use that word advisedly) the solution of cataract surgery unless your patients understand their problem of visual disability.* Not only is it common sense that your patients must acknowledge their difficulty, it's obviously embedded in Medicare regulations that patients volunteer a sufficient level of complaint.
- *Some patients, hearing the diagnosis of cataracts for the first time, will be baffled and nonplussed.* Rushing them briskly to your surgical counselor for a discussion of what will happen next may not serve your interest (or theirs) in having them see clearly as soon as possible. A few more reassuring words from you as the operating surgeon may help, and be worth the time spent.
- *Most patients are perfectly capable of absorbing verbal information to understand your orientation to cataract symptoms, diagnosis, and treatment.* Other patients will better absorb the same words in writing or on a videotape/DVD they can take home and watch at their leisure.
- *You don't need to give your patients a graduate course in cataractology.* Even if you have the time, avoid spending more time than it takes to get the job done. Otherwise, some of your patients, while they're smiling and

nodding their heads at you, are likely saying to themselves, “Goodness, when is he going to stop? I have to get on to my golf game this afternoon.”

- *Many patients have poor or no English skills.* When appropriate, consider adding one or more bilingual staff members to your practice or learning how to examine your patients in a second language—something that’s much easier in eye care than in internal medicine.
- *The odds are that your cataract patient does not hear well.* You can overcome this in several ways. First ask, “Am I speaking loudly enough?” Punctuate your patient education with the question, “Do you understand?” Ask the patient’s companion or escort to help you adjust the volume of your voice if your patient does not seem to be hearing you. Look at your patient when speaking.
- *Be sure to speak to everyone in the room.*
- *Like any good professor, sum up—simply—in the last 30 seconds of the encounter:* “Okay, Mrs. Connors. We’re all set. Those birthdays have finally caught up with you, and we’re going to take care of that cataract in your right eye in a few weeks. Sandy here will explain all the details. You have a great Thanksgiving with your grandchildren, and I’ll see you early next month. Meanwhile, keep using your glaucoma drops every day.” It takes years to mature into a polished, higher volume cataract surgeon. Happily, as you get older and your cataract practice gets busier and demands more adroit communication, your communication skills will likely improve . . . at the same time that your empathy and patience for others increase. By keeping these simple points in mind and adding your own unique repertoire of personal one-liners, the subjective impression you give patients of your service, your care, and your caring will rise to match your objectively excellent surgical skills.

THE PEN IS
MIGHTIER THAN THE
SWORD! THE CASE
FOR PRESCRIPTIONS
RATHER THAN
SURGERY.

Marvin Kitman



Dictation Pearls

Physicians who dictate their chart notes should do so in real time in front of the patient. Patients love to hear their case synopsis. After completing your exam, but before briefing the patient, dictate your chart note or letter to the referring doctor. Then, turn to the patient and say, “That’s just a fancy way of saying that . . .” and go into your finding

IF IT DON'T APPLY,
LET IT FLY!

*Overheard in
Tupelo, MS,
birthplace of Elvis*



and plan. To save time, you may also use short-form cover letters with a copy of *neat* chart notes when sending consult reports. Alternately, in some subspecialty practices, your reports may fall into a small enough variety that you can simply use a scribe who functions at a high enough level to generate most consultation letters. When possible, get the job done by touching the chart only once.

Where Might Preferred Practice Patterns and Electronic Medical Records Lead Us in the Future?

Perhaps the biggest megatrend ophthalmologists will face over the next 20 years is the movement toward evidence-based medicine (EBM) and the top-down development of clinical practice guidelines (CPGs). I believe we may be moving through the early, innocuous-feeling stages of a potentially major paradigm shift in eye care . . . from a 2000-year-old era in which the art and science of medicine are intertwined (with large allowances for each provider's personal impressions to guide treatment) to a modern era in which CPGs and EBM edge out A-R-T. This trend is slow to be appreciated in ophthalmology, in which the penetration of electronic medical records is low and surgeons are largely fragmented into small groups. But imagine the following scenario, which could be here and completely in place in just 20 years. The means and the technology are here today.

- The federal government mandates and encourages the development of a uniform EMR platform. (This was hinted at in the third edition of this book during the Bush-II administration and is now a reality as this edition goes to press . . . An agreed EMR format for the nation has now been rolled out . . . an increasing number of providers will be obliged to go paperless in the years ahead.)
- The American Academy of Ophthalmology and other medical specialties continue the development of preferred practice patterns and care pathways, culminating in a growing, nationally sanctioned treatment "cookbook."

- The content of third-party claims submissions becomes vastly more robust, with not only patient demographics, diagnosis, and treatment codes, but also the results of all history taking and testing and the entire, step-by-step treatment plan.
- Payers use algorithms to kick back claims-cum-records that depart from agreed norms. What's "normal"—the community standard of care—becomes narrower over time.
- Precertification of surgical and medical treatment plans, unlike the clumsy protocol of utilization review nurses of not so long ago, could be readily automated, and even automatically indexed to the state of the Medicare budget . . . with 20/50 cataracts not being approved toward the end of the Federal fiscal year.
- Outcomes measurement could become automatic, with quarterly reports comparing your performance to that of peers.
- All physicians could and, perhaps eventually would, be scored for how far their treatment patterns deflected from orthodoxy. This scorecard and the digital records behind it could come to shadow every aspect of a physician's work life—his or her reputation in the community, access to patients and managed care plans, cost and accessibility of malpractice coverage, and exposure to liability.

Experts are still debating whether CPGs will make medicine better or worse. But everyone agrees that medical care will become far more transparent and its providers will become far more accountable and liable for error. Some attorneys are already telling their physician clients to be careful about formally nominating care pathways in their offices lest a future malpractice attorney use these as the rope to hang providers who didn't precisely follow their own rules. What happens when patient care "rules" become the law of the land? If past is prelude, codifying what should be done for patients will more often be used by payers and courts to prove what the provider didn't do than by the provider to prove what he or she did. Welcome to the future.

PIGS GET FAT. HOGS
GET SLAUGHTERED.

Wall Street Wisdom



Has Anyone Seen Maggie Fischer's Chart?!!

Although we are heading toward 100% electronic medical records, lost patient charts will continue to plague practices until they go fully electronic, including digitized images. The problem is compounded in larger practices, practices with satellite offices, and offices in which the physicians need help gaining the discipline to close out their charts on time. If you are still using paper, try to avoid pulling a chart unless absolutely necessary. It is rarely necessary to pull a chart when making an appointment, although many practices do this routinely—a habit left over from before they had a patient accounts computer system in place. Put one person in charge of medical records, even if many people are involved pulling and filing charts. This “chart leader” will have a greater sense of ownership than if everyone is in charge of pulling and filing charts. This will improve the chances that other staff members will respect the orderly system you have created.

MY FAVORITE WORD
IS “WHY?” MY LEAST
FAVORITE WORD IS
“NO.”

Stephen Lipsky, MD



Help Patients Help You

Most patients want to perform their best for physicians and technicians. This can often prevent them from receiving the best care possible. Here's an example: A patient who is a terrific candidate for functional blepharoplasty is having a field examination during which she struggles mightily to lift her brows to compensate for droopy lids. It's more likely that you'll be able to document the need for an appropriate procedure if you explain to patients that they should not make heroic efforts and to take the test while they exert normal efforts to see well. The true results of a nonheroic exam will help you educate your patient about the benefits of surgery, as will one additional pearl: Hand your patients a mirror, and have them look at themselves as they blink tightly; let them see how much of their eye is occluded by lid margin as they slowly open their eyes.

Now Where Did I Put That Patient?

Have you ever lost a patient behind one closed exam room or another? Or wondered where a staff member or doctor might be? Do what I once saw a Midwest clinic do: Install peep-holes on each exam room door, so that from the clinical hallway you can spot how a room is being used, or where a staffer might be without having to knock on the door and enter.

How to Get on with the Examination of Overly Talkative Patients

Here's a pearl for dealing with patients who are using you more as a social outlet than as their eye doctor. According to one, extremely smooth client of mine, when a patient is excessively talkative, he simply hands them something. This can be a brochure, an occluder, anything.

Let Patients Know When the Exam Is Over

At the end of an exam, it helps to provide patients with both a verbal and a nonverbal signal that you are about to leave, rather than simply turning on your heels, like some busy surgeons I know. The popular term is body language. Others call it "social cuing." When the exam is complete, shaking a hand goodbye and passing the patient off to a scribe in the room with a glance of your eyes (and by having the tech step forward) will make your exit much smoother and curtail excessive, often irrelevant social banter.

I KNOW NOTHING
EXCEPT THE FACT
OF MY IGNORANCE.

Socrates



The Magic of Touch

Marine Corps recruiters have found that they double the number of young recruits who sign up when they reach across the table and touch the prospect. Waitresses get a 40% larger tip when they briefly touch the customer. I've even heard that surgical mortality goes down when the anesthesiologist touches the patient during a preoperative consultation. Take a lesson from all this in your clinical practice. Touch patients in an appropriate fashion during every visit.

IF THE DOCTOR
SHOWS GENUINE
FEELING AND DEEP
CONCERN FOR US,
AND IF HE OR SHE
SMILES, THEN WE
FEEL OK. BUT IF
THE DOCTOR SHOWS
LITTLE HUMAN
AFFECTION, THEN
EVEN THOUGH
HE OR SHE MAY
BE A VERY GREAT
EXPERT, WE MAY
FEEL UNSURE AND
NERVOUS.

The Dalai Lama



Visiting Subspecialists

Busy general ophthalmology practices that seek to expand services and revenues but don't have sufficient volume to substantiate full-time subspecialists might consider the part-time addition of auxiliary providers on a practice-leasing basis. The visiting physician is provided with all needed support—appointed patients, facilities, support staff, billing—and pays the host practice between 40% and 60% of collections. This is a convenience to patients, the quality and timing of care are enhanced, and both parties receive appropriate compensation for services rendered. Such arrangements should be memorialized in a contract drawn up by your attorney.

Nd:YAG Laser Treatment of Comanaged Patients

The advent of optometric comanagement for cataract surgery led in some unwatchful practices to a mild slip in postoperative follow-up for Nd:YAG laser treatment. Try to arrange with any referring optometrists whose own follow-up you suspect is poor to see postoperative patients back in your office at the one-year mark to make sure that a capsular opacity has not formed.

Botox Treatment

Only a small percentage of ophthalmologists provide Botox treatment to their patients, and most of those who do provide this service at very low numbers. Indeed, a recent review of client practices yielded an incidence of only about one treatment session for every 350 patient visits. Typical treatment session fees range from \$250 to \$1000 or more, depending on how many zones are treated. Treatment is ideally repeated two to three times a year, and direct expenses for the Botox toxin itself run about \$100 unless you're only doing a case here and there and the amount of waste is high. So, for a compliant, repeat customer, that's perhaps \$1500 per year in revenue and \$1200 in gross profit. Sound great so far? The problem with this service, as with all other non-eye elective aesthetic services

in an ophthalmic setting, is the average patient's confusion about why you are trying to cross-sell this cosmetic service during the course of the functional eye exam. Physicians who have trouble enough coaxing their patients to the optical shop will *not* find success with this class of services. Those with more marketing skills will find their practice's elective services are much more actively used. Success factors include physician commitment, outreach to aestheticians, and a designated patient educator/outreach coordinator.

Treating Dry Eye

Some eye surgeons, like some predators in nature, are specialists and tend to concentrate on just a few "prey" species. When cataract volumes soften, they find it hard to shift the hunt to other disease entities. Other eye surgeons are more versatile, and when one area of practice softens they can morph to another area. Of course the most successful surgeons (not to mention the most conscientious clinicians) keep their eyes open for every possible way to help a patient. The most overlooked opportunity is treating dry eye. Here are some strategies for treating these patients:

- Patient awareness of dry eye continues to grow. This, in addition to an aging population, means that more patients will be asking you for help than in the past.
- Your tech's history and screening questions should include a question about medications that may be causing dry eye or living/working conditions that are contributing to the problem.
- Arthritis and dry eye commonly coexist.
- Testing and documentation can be elaborate and involve more than just a choice between drops and plugs. Learn about specific treatment options at national meetings or from vendors.
- Network through dry eye-oriented vendors to find and visit practices that are a few steps ahead of you in their dry eye testing and treatment protocols.

USING OUR
ELECTRONIC
MEDICAL RECORDS
SYSTEM IS LIKE
TRYING TO SMELL
WITH YOUR EARS.
IT'S AN
UNNATURAL ACT.

*Anonymous,
Frustrated Tech*



A Visible Guide to Tech Productivity

Some practices have technicians who cherry-pick patients to work up or who see relatively fewer patients than their peers. Print out a copy of the day's schedule, post it at the nurses' station, and assign each tech one highlighter pen of a different color. After a patient has been worked up, the tech highlights that patient's name with his or her pen. By the end of the day, it's obvious who's leading the team and who needs remedial help. You can do this on a one-time basis or as an ongoing system of monitoring.

Clinical Checklists

With all the hundreds of details swirling around on the clinic floor, it's easy to skip the basic housekeeping duties. Checklists were invented to ensure that smart people (e.g., pilots and COTs) stay on top of all the boring details. These checklists come in many forms to serve many areas of your practice; here's a sample:

Clinic Closing Checklist

- Turn off all testing equipment.
- Turn off patient education video system.
- Make sure all exam lanes are restocked and closed, and equipment is covered.
- Turn off all lights except those marked "night."
- Post next day's patient schedule at the nursing station.
- PM call to all surgical and minor procedure patients.

Cross-Train Your Techs and Scribes

Some practices firmly partition their clinical support staff into techs, who work up patients and perform special testing only, and scribes, who assist the physician chairside and help with escorting and educating patients. This works fine, but it works better to have at least a limited amount of cross-training. Strive for complete cross-functionality of techs and scribes so that everyone on the team can do just about everything and there's less wasted time. A bonus is that techs improve vastly when they periodically hear and see first hand what the physician is doing with the patient they just worked up.

Tech Staffing in Multiphysician Practices

In most group practice settings, physicians will be more efficient—and happier—if they are assigned one permanent “lead” tech rather than a team composed of rotating techs from a pool of workers. Although physicians would be even happier if they had an entire, stable team dedicated to them (like every soloist enjoys), the slight gains in potential efficiency are trumped by political infighting among techs (“I only work for Dr. Smith”), insularity among physicians (who break off into their autonomous pods), and much higher staffing costs.

HE WHO CANNOT
FORGIVE OTHERS
BREAKS THE BRIDGE
OVER WHICH HE
MUST PASS HIMSELF.

George Herbert



CHAPTER 11

MERGERS AND ACQUISITIONS



*Nothing was ever accomplished
by a reasonable man.*

George Bernard Shaw

Merger Psychology 101

Many years ago, as reimbursement began to fall and patient bases started eroding to managed care plans, those in ophthalmology borrowed an oriental maxim from colleagues who consult for industry—the Chinese calligraphy for “crisis” is composed of two characters, one for “danger” and the other for “opportunity.” Here’s an update. To understand the profound current ophthalmic ground swell of consolidation, you need only look as far as two primal, practical emotions that Wall Street merger specialists have harnessed for years: fear and greed. If your practice is trying to be a consolidator, you need to deeply understand the balance of these two emotions in each of the potential merger targets in your community. If you resonate with these emotions by delivering a shield from danger and a credible vehicle for opportunity, your merger plans are more likely to succeed.

IT IS ONLY WHEN
WE BELIEVE THAT
LIFE IS TAKING US
NOWHERE THAT IT
BEGINS TO HAVE
MEANING.

P.D. Ouspensky



Merger Fever Cools, Then Reheats

Professional expectations 30 years ago were that America would by now be dominated by gigantic corporate practices. It was believed that these superpractices would be formed largely through the merger of small practices into behemoths with 15, 20, or more providers in multi-subspecialty, multilocation groups—groups with all the “Os” under one roof. The reality, of course, has fallen profoundly short of this for many reasons . . . and will likely resurface again:

- National health care reform stalled in the 90s and has been quiescent until the passage of the Affordable Care Act . . . which in turn will be subject to reform or replacement . . . which will continue ad infinitum until we catch up with the rest of the industrial world and adopt some form of single payer care.
- In line with the tempo of reform, fears of falling reimbursement will continue to sink and resurface many times over the coming years, stimulating with each cycle a significant motivation to merge.
- There have been numerous corporate attempts to build national provider networks as well as to drive local,

in-market consolidation. Few of these enterprise models have been financially viable or commercially stable. The current bloom of private equity firms in the ophthalmology space is just the latest, likely transitory manifestation of this.

- Although success rates are far higher for local, private consolidation efforts, enough local mergers have faltered to give others pause.

Although most consolidating surgeons and managers still expect to find abundant economies of scale with any contemplated merger transaction, poorly conceived or executed practice marriages can actually result in profound *diseconomies* of scale. It's critical to financially model any contemplated merger to see whether facility and staff consolidation, complementary subspecialty interests, equipment sharing, marketing under one unified brand, and other potential drivers are sufficient to substantiate the deal.

Provider Motivations to Merge

Ambulatory health care—and particularly eye care—has long been characterized by fierce independence. However, nationally we can observe a continued movement toward the consolidation of quality solo/small group providers into large regional “supergroup” practices. I believe that, at least in some markets, these larger, integrated practices will be the dominant platform for the delivery of specialty care. Here is a short list of actual and theoretical provider motivations:

1. Economic security and access to patients by being part of a larger provider group, which is in turn affiliated with a regional hospital or national single-specialty firm.
2. Increased access (and reduced cost through group purchase) to emerging technology including laser refractive surgery and management information systems.
3. Increased per-physician profits due to expense reduction and sharing, facility consolidation, and joint marketing . . . note that these profits will still be far lower than they are today.

4. Increased access to capital at favorable rates for growth and expansion.
5. Offsetting business risk . . . the risk of any one practitioner will be pooled with his or her colleagues. The group as a whole is likely to grow faster and be more risk-taking than an individual doctor or small group.
6. Cross-vending of services . . . for example, optometric patients will have direct, in-practice access to refractive surgery services and ophthalmology patients will have direct, in-practice access to optical and contact lens dispensing. On balance, this will be better for patients and economically favorable for providers.
7. Increased management sophistication . . . highly qualified administrators will be augmented by outside advisors—either might be more difficult for any one practice to afford.
8. Independent private optometrists will gain a direct professional partnership with ophthalmologists. This will enhance clinical interchange and continuing education. The emerging eye care industry is somewhat more threatening to private optometrists than private ophthalmologists. In the face of this threat, most eye doctors would rather collaborate as business partners than be competitors.
9. Increased practice liquidity and improved exit strategy options . . . physicians will have greater future security that they will be able to sell their share of the larger group practice. And the whole will be worth somewhat more than the sum of its constituent practice parts.
10. Fun: I simply believe that given the future health care environment, we will all—ophthalmologists and supporting professionals—enjoy our respective professions more fully in a larger group setting. (I note that the frustrations associated with building a large group practice will often make you wonder just when the *fun* part is going to start!)

How B-I-G Is Big?

Following are rough guidelines a group of merging practices can use when deciding how large they can grow and should aspire to grow:

- Take the natural service area as defined by the local regional hospitals—this may be just part of a single county or 20 counties, depending on population densities. Determine the population of this service area—let's say it's one million people, with an average distribution of seniors (about 14% and growing). Subtract from this head count for patients locked up within staff-model HMOs and add to this head count if your service area contains a significant senior population—which uses services—or if your service area is growing rapidly.
- Assume that you conservatively need approximately only one ophthalmologist per 25,000 people . . . dividing our example of one million people by 25,000 yields a crude manpower estimate of 40 fully employed ophthalmologists.
- Assume that you need three optometrists for every one ophthalmologist (instead of the current 2:1 ratio) because of the expanding scope of optometric practice, the increasing efficiency and sophistication of general ophthalmic providers, and the increasing need for refractive eye care. That means we need $40 \times 3 = 120$ optometrists in our example.
- Now for some market share estimates. If yours is a highly competitive market and you are starting small, assume that you may only be able to grow to 10% or less of the total market. However, if your market is not competitive and/or your group is already large, you may be able to dominate 20% or more of the total market. For the sake of our example, let's use 25% as our endpoint market share goal.
- Putting it all together. By adding a few other assumptions we consultants like to throw in, we can summarize by saying, "We believe that our subject market of one million people will support 40 ophthalmologists and 120 optometrists at endpoint and that *our* regional group practice will have a total of 10 ophthalmologists and 30 optometrists. These doctors will work in a central facility with an ASC and full subspecialty coverage, plus 12 additional satellite offices from 3 to 40 miles from our main office. Every office will operate under a common brand name and offer optometric primary care and optical dispensing. Our total practice will have an

annual net revenue run rate of \$25 million and be supported by the equivalent of 160 full-time staff.”

A Natural Staging for All Human Relationships

Throughout the world, in hundreds of distinct cultures, human marital relationships follow the same basic hallmarks. This same natural sequence is present in the most elaborate and high-stakes corporate consolidations. I’d suggest you use the same steps as you merge with another practice:

**Meeting→Dating→Engagement→Marriage→
Honeymoon→The Real Work**

Meeting. Somebody always has to make the first move.

Dating. Business courtship can take years, although as in romantic courtship, excess time doesn’t always increase the chances for an eventual marriage. Time is not a friend of most consolidation events.

Engagement. The intent letter, a statement to the world that you’ll likely merge and will spend more time getting to know each other through the due-diligence process.

Marriage. Public promises, the signing of a contract; the start of knowing what your partner is really like.

Honeymoon. A brief, idyllic period meant to reduce the stress of transition and catch your breath for what follows.

The Real Work. The difficult details, compromises, disappointments, and triumphs.

Testing Merger Economics

Practice mergers will continue to be an active trend over the next decade and longer. Growing on the experience of mergers that fail, there should be an increase in the percentage of practice marriages that deliver real economic benefits. A spreadsheet analysis combined with other, more subjective and strategic analysis can help to discriminate rational deals from wishful thinking. This spreadsheet

THE MORE I SEE OF
MEN, THE BETTER I
LIKE MY DOG

Frederick the Great



should be built showing a 12- to 24-month pro forma budget, before and after a proposed deal. Almost every such pro forma, even for the very best deals, shows a temporary sagging of profits to pay for the cost of development. These nonrecurring costs include: professional fees for attorneys, architects, accountants, and management consultants; moving costs; facility upgrades; and other one-time expenses. Of course, some deals will demonstrate a permanent diseconomy of scale—this is commonly the case when two practices decide to merge, but then they pursue no facility or staff cost consolidations or synergistic revenue development.

The Practice Consolidation Spectrum

Although the eye care industry has buzzed in the past with practice-to-practice merger activity, and will likely do so again, merger is just one part of the spectrum of consolidation options, some of which have been around for years. The options include the following:

- *Networks and alliances* are a form of partial consolidation in which the physicians agree to integrate on a narrow platform, most commonly for managed care contracting. This has been a tremendously active dimension of practice consolidation, but it too often results in an expensive and frustrating “physician’s club” rather than the achievement of any practical business goal. In many settings, the pace of managed care contracting, especially on a single-specialty carve-out basis, is much slower than anticipated, so the “club” has little to do and gives little value to its members. In other settings, the pace of contracting far exceeds the organizational state of the “club”—there is no central computer system, no active contracts officer, and no common agreement on what constitutes an acceptable contract. State-by-state any-willing-provider-legislation has reduced the need.
- *Expense-sharing associations* traditionally spring up when two physicians desire the cost savings of sharing a single building, and perhaps a reception staff and computer system, but want to maintain separate professional corporations. Such associations can last happily for years

THE ONLY FUNCTION
OF ECONOMIC
FORECASTING IS TO
MAKE ASTROLOGY
LOOK RESPECTABLE.

John Kenneth
Galbraith



without going any further, or they can mature into full partnerships when the parties decide they really are compatible. In a frustratingly large number of cases, however, such cohabitation can lead to overt competition and turf squabbles. I'm convinced that a lack of ongoing communication—especially about additional ways of sharing overhead—is the prime cause of the difficulties. For example, ongoing communication between principals and their office managers in the form of a friendly monthly dinner meeting can help head off these problems.

- *Management service organizations (MSOs)* are formal legal entities established to provide a narrow or wide range of management services for collaborating practices. Taken to its fullest context, the MSO becomes the employer of all nonprofessional staff, owns or leases all facilities and equipment, and handles all business and contracting affairs for the doctors. An MSO can potentially allow optometrists and ophthalmologists to be virtual partners in a common practice, even in states where ODs and MDs are not legally allowed to be partners in the same professional corporation. In the mid-90s, there were efforts to develop large public and private physician practice management firms that were simply highly sophisticated and complex MSOs, working regionally or nationally rather than in a single market.
- *Acquisition* is the purchase of another practice, with or without the subsequent employment of the selling doctor. This can be one of the least expensive ways to market—you are literally buying a patient base. It can also involve very low risk on the part of the buyer, with the selling doctor acting as the lender in the deal, and the payout pace indexed to subsequent practice performance. Optometric practice acquisition is an excellent tactical consideration when faced with a competing practice that comanages and enjoys most of the OD referrals in your market.
- *Merger* is the full economic integration of two or more practices into a single, legal professional entity: Smith and Jones, who used to own 100% of their independent organizations, now own 60% and 40% of the much larger Smith–Jones Eye Clinic. Merger involves a much

MERGING DOCTORS
IS LIKE TYING CATS
TOGETHER BY
THE TAIL.

Sam Bass



higher ego hurdle and a much higher exit barrier than looser forms of affiliation and requires three critical agreements:

- On the fair values of the preexisting independent practices (and whether money should change hands to equalize ownership)
- On the compensation model (and the means for its periodic adjustment)
- On the governance model (and who is going to control what decisions)

Noncompete Agreements and Mergers

Except in states like Alabama, which, the last time I looked, essentially prohibits noncompetition clauses of any kind, a noncompete agreement should be in place to discourage the breakup of any merging supergroup practice. After an initial six- to 18-month honeymoon period, this noncompete agreement should stipulate significant penalties (e.g., forfeiture of receivables, contributed capital, and capital equipment) for doctors who leave the newly formed group and compete within the defined market. Consider having this noncompete clause waived in the case of any doctors who leave with cause, which can include the internally disputed (nonunanimous) divestiture of the practice to an outside party, such as a hospital or practice management company.

Checklist of Terms to Cover in Merger/Acquisition Negotiations

Here is the summary checklist of issues and terms to discuss with any prospective merger/consolidation partner or acquisition target:

1. How will the values of the merging practices be derived?
2. What will be the initial and subsequent partnership share apportionment after the merger?
3. What will be the form of business (e.g., partnership, LLC, PC)?

4. What future conflict resolution procedures will be used?
5. Who will be the initial managing partner or medical director? What will his or her term of office be?
6. What are the buy-sell provisions, and how are life and disability insurance policies used to fund buyouts?
7. What about ancillary business interest division: ASC, laser center, aesthetic/elective cosmetic services entity, optical, capital equipment leasing company, buildings, and properties?
8. What will the chain of command be, and what will the organizational chart look like?
9. What compensation methodology will be used initially, and how will this be reviewed from time to time?
10. What are the policies about vacation and CE time off?
11. If a partner takes excessive time off, what event does this trigger?
12. What will be the name of the new practice?
13. What termination procedures will be used (with and without cause)?
14. How will noncompete issues be handled? Will prohibitions be absolute, or will we take a liquidated damages approach?
15. Who remains on the advisory team (e.g., lawyer, accountant, compliance, computer, marketing)?
16. What roles will the current staff play, and which staff can be outplaced to realize postmerger savings?
17. Who will be the administrator?
18. What are the details of the strategic plan; is there an agreed, common vision? (Any unresolved, open issues should have closure before the merger takes place.)
19. Are there other local practices we should consider as consolidation targets?
20. What is the desired endpoint practice, and how fast will we get there?
21. For any physicians approaching retirement, what will the timing and approach be (e.g., stop altogether, or stop surgery and slowly wind down)?
22. What will be the individual partner's spending authority without group approval?
23. How soon will we converge staff benefits, policies, uniforms, training, pay ranges, etc.?

24. What terms will be applied limiting the outside business activities of partners (e.g., in unaffiliated optical or ASC entities)?
25. What will be the frequency and venue for board and management meetings? What will be the financial performance reporting intervals?
26. How are conflicting priorities resolved; that is, will our conjoined practice put first priority on quality, market share, profitability, or doctor lifestyle issues? What's the second priority? Third?

These specific questions should be followed by discussion and resolution of various “what if?” scenarios, such as disability, death, business interruption, major contract loss, and outside purchase overture.

Merging? Call Your Attorneys and Accountants Last

I once got a call from a prospective client. This prominent seven-physician urban practice had been trying without success to merge with two other separate, solo rural practices for more than 14 months. They had collectively spent some \$150,000 in professional fees. The reason? They called in the full squad of professionals much too early in the process. Here's a better approach:

IN POLITICS IF YOU
WANT ANYTHING
SAID, ASK A MAN;
IF YOU WANT
ANYTHING DONE,
ASK A WOMAN.

Margaret Thatcher



- *Select a single facilitator.* This can be an attorney, a consultant, or a senior-level administrator acceptable to all of the parties.
- *Hold a long, formal planning session, preferably offsite, over a weekend.* Every principal, as well as every partner-track associate, must attend. Manager attendance is optional, based on the manager's role and seniority in the practices. This session should be 75% business and 25% social.
- *During your business sessions, work through an agenda that covers—and attempts to make an interim decision on—every detail of consolidation.* This includes the potential models, the pace, the leadership and governance model, valuation, ownership, compensation, prospective subsequent

merger targets, the endpoint scale desired, whether you want to stay private or divest, and whether you want to stay single specialty or align with providers of care not related to the eye.

- *Have the facilitator put everything you agree on—as well as the open issues—down in writing.* This first draft should not occupy more than 10 to 20 pages. It's not a legal document. Write your conclusions and open questions in lay language. It should be simple enough so your head technician could read it and understand what's being proposed.
- *If after this meeting you are still destined to merge, select a merger task force comprising the facilitator plus one physician and one manager from each practice.* This group will eventually be joined by your agreed accounting and legal professionals . . . but not yet.
- *Hold whatever subsequent meetings are needed to get to a final draft of your lay working document, and get everyone's signature on this nonbinding statement of purpose.* There should be sufficient detail so that an attorney and an accountant can review what you have in mind, prepare an opinion on the best legal and economic models, and submit an estimate for their professional fees to consummate the deal.
- *Pick one accounting firm and one law firm.* It may or may not be appropriate for these parties to be neutral, with no preexisting professional relationship with either merging practice. Sign off on intent letters, prepare draft agreements, and complete due-diligence work. As a final step, call in the merging practices' existing accountants and attorneys (if they have not been involved up to now) for their opinions on the deal. Realize that it's natural for these preexisting advisors to be somewhat critical of the deal. First, it's their business to find the flaws and point them out to you. Second, their egos may be bruised when they learn that they have not been involved from the start. And third, they will realize that consummating the deal will likely lead to the group practice hiring just one law firm and just one accounting firm.

Sample Letter Agreement for Merger Discussions

Below is a sample letter agreement between three practices laying out the general terms for the exploration of a potential merger transaction. Obviously, this agreement should be reviewed and revised by your attorney before being used.

Seaside Eyecare/Smith Eye Clinic/Eye Surgeons, Ltd.

PRACTICE CONSOLIDATION LETTER OF INTENT

The undersigned eyecare professionals have initiated discussions relating to their goal of consolidating the operations of their independent practices into a common professional entity.

This letter of intent documents our current understanding of what we intend to do in potentially merging our practices.

1. Our ongoing discussions will relate to our developing a joint business relationship. Although we all have mutual interest in this relationship, we have not yet reached any final agreement regarding structure, function, terms, timing, or conditions.
2. None of us will disclose to other parties (other than our attorneys, accountants, and other professional advisors) the financial information and business plans that we have discussed or will discuss with respect to this matter.
3. It is contemplated that our discussions will continue over several months. For as long as our discussions continue, it is understood that none of us will participate in discussions with any other parties that could involve entering into competing business relationships. At any time, any of us may notify the others in writing that our individual participation in discussions is to be discontinued. However, the non-disclosure agreements contained in Paragraph (2) above would continue to apply.
4. So as to establish a fund to develop our joint business activities, each undersigned physician shall contribute the sum of \$15,000 in the form of checks payable to "Eyecare Escrow Account." The funds in this Escrow Account shall be applied largely to the cost of professional advisors including

consultants, attorneys, and accountants, whose work shall be directed to developing a sound business plan, financial projections, legal structure, and legal documents associated with our prospective joint business. Additional expenses in excess of initial funding are likely to arise before we have completed the consolidation process. The above initial amounts, along with an executed copy of this letter of intent, shall be due no later than _____. Each physician's executed letter of intent and fund contribution shall be mailed or delivered to _____ at _____. All such initial and subsequent funds, if any, should be considered nonrefundable; in the event that a physician withdraws from the group planning discussions, he or she should not expect to receive a return of the funding he or she has contributed to this exploratory process.

5. Funds in this Escrow Account shall be dispersed at the discretion of the simple majority of votes of the Consolidation Committee, which shall consist of two physicians from each practice. A valid quorum of this Consolidation Committee shall be three—one physician from each practice. The members of the Consolidation Committee shall exert their best efforts to develop a business organization on behalf of the undersigned, but their success in this endeavor is by no means assured. Neither is it certain that the funds collected from the undersigned shall be sufficient to complete this exploratory process. The undersigned shall hold each other, the Consolidation Committee, and the Committee's professional advisors harmless from any and all claims arising from their work associated with this business development project.

Due Diligence Between Consolidating Practices

Subject to review by your attorneys and accountants, each practice and partner should undergo the following basic pre-merger review:

- Financial audit for accounting or tax irregularities
- Chart audit for clarity/completeness/appropriate care/overutilization or underutilization

THERE IS NO
EDUCATION IN
THE SECOND KICK
OF A MULE.

Sam Rayburn



- Reimbursement audit for correct coding, absence of fraudulent billing
- Legal audit for outstanding malpractice or other civil/criminal claims or liens
- Labor practices audit: review of recent claims, hourly/salary standards, etc.
- Personal financial overview: a TRW or similar credit report on each principal
- Facility/equipment/supplies inventory

The above review is for everyone's protection. Minor problems in most of these categories should not subject the target practice for exclusion but should be used to set a benchmark and to help make ongoing improvements. Certain sensitive information, such as personal financial data, can be reviewed by outside parties, scored on a pass-fail basis, and kept private, if requested by prospective partner practices.

Key Merger Success Factors

It's relatively easy to merge practices. It's relatively difficult to merge successfully—to have the internal organization actually work and be validated by commercial success. My candidates for the leading success factors are listed below.

- *Cost structure.* In the long run, you will only be viable in an era of health reform if you can be among the lowest cost providers of eye care. Your success will be maximized if you can be *the* lowest cost provider. Toward this end, it will be vital to keep staff, debt, facility, and material expenses low, while keeping productivity high and practice volume elevated to within a few percent of maximum facility capacity. You can't just have blind faith that joining into a large group will deliver economies of scale. Indeed, there can well be diseconomies of scale.
- *Linkage to colleagues and institutions.* In some markets, it will be critical for you to associate with an integrated health care delivery system (e.g., a hospital with multi-specialty services on campus and an eventual underwriting capability). If you have snubbed primary care physicians and others in your community's medical hierarchy, you may be destined for isolation and failure.

- *Quality facility/staff/equipment.* As the cost has risen to assemble a world-class eye care delivery system, it is now virtually impossible for an individual or small group to create a quality full-service practice. The latest advances in refractive surgery, optical dispensing, and geriatric eye care all require significant capital outlays and risk. As both the business and clinical dimensions of modern eye care become more complex, staff specialists are required—specialists who are difficult for smaller entities to recruit and retain.
- *Access to managed care patients.* The outcome and utilization statistics needed to satisfy future payers will be more feasible to gather with sophisticated software that may only be available in the context of a larger practice. Presenting these data in a professional manner, with a single-signature authority, on behalf of a geographically and clinically diverse large professional staff can help to ensure a managed care “win.”
- *Access to general consumer/self-referred patients.* Absent major reform, a majority of services provided by your group will continue to be purchased by self-referring patients for many years ahead. Even in an environment heavily biased toward prepaid care, you can expect significant patient choice of providers within a given panel. Therefore, you will likely need to conduct an active general consumer advertising campaign for the life of your new and larger organization.
- *Leadership: strategic vision combined with implementation.* One word characterizes health care delivery for the foreseeable future: *change*. I believe that you will be able to identify that change faster as a group than you can alone. However, larger institutional groups such as the one you may be developing are often troubled by internal dissension, which can bog down the observation/decision/implementation cycle. The physician-shareholders must delegate sufficient authority to a managing partner and an administrator to ensure prompt decision making and action taking in an increasingly competitive environment.

CHAPTER 12

PROVIDER CAREER ISSUES



*Life is not a journey to the grave with the
intention of arriving safely in a pretty
and well-preserved body, but rather to
skid in broadside, thoroughly used up,
totally worn out, and loudly proclaiming . . .
“Wow, what a ride!”*

Hunter S. Thompson

Take This Career Development Test

How satisfied are you with your career progress? For each of the five questions below, choose an answer that best fits you. Tally your score, and derive an average A, B, C, D, or F letter grade—a “career GPA,” if you will.

- Compared to where I thought I would be *overall* at this point in my career I am
 - A significantly ahead of my expectations.
 - B somewhat ahead of my expectations.
 - C about even with my expectations.
 - D somewhat or significantly *behind* my expectations.
 - F an abject failure as an ophthalmologist.

- I believe that people who live in my *professional* world (e.g., my patients, staff, colleagues, advisors, etc.) think I am
 - A among the most caring, accomplished, and exceptional physicians they have ever met.
 - B easily within the top third of physicians they know.
 - C about average, as ophthalmologists go.
 - D probably not the sharpest scalpel on the mayo stand.
 - F a good candidate for retraining in a different, less-taxing profession.

- I believe that those people who inhabit my *private/personal* world (my friends, spouse, children, parents) think I am
 - A among the luckiest people in the world, who not only has a great job I relish and do well, but who also strikes a nice balance between my professional and personal lives.
 - B one of those fortunate people who gets to enjoy what they do for a living, and does a pretty good job at it.
 - C just like most people, with things I like and dislike about my job . . . but not so frustrated that I’m about to rock the boat and change what I do for a living.

GOOD PITCHING
WILL ALWAYS STOP
GOOD HITTING,
AND VICE VERSA.

Casey Stengel



- D basically miserable about my career, something that spills into every other part of my life.
 - F on the verge of abandoning medicine.
- It's a weekday morning. When I'm getting up and preparing for work, I usually feel (answer as a composite of your feelings about your surgical and clinical and management work)
 - A alert, happy, and eager to get to the office/operating room.
 - B perky, but with one or two fleeting thoughts of unpleasant tasks ahead in the day.
 - C relatively cheerful, but aware that on many days there may be some things I'd really rather be doing instead of coming into work.
 - D in dread of the day, gritting my teeth and basically willing myself to go through the motions.
 - F like calling in for the rest of the year and telling my staff I'm not coming in.
 - When I get to the end of my workday (or night!), I generally feel

SILENT GRATITUDE
ISN'T MUCH USE
TO ANYONE.

Robert Louis Stevenson



- A tremendously satisfied . . . as though there was almost nothing I could have done that day that would have been as fulfilling; I'm energized for whatever the rest of the day may hold.
- B satisfied and proud of a job well done, but eager to move on to what is a comparatively more pleasant part of my day.
- C terribly glad that the day is over and I can go home and recuperate.
- D completely spent, and already dreading the fact that in just a few hours, another unpleasant day will be starting all over again.
- F on the verge of collapsing at my desk.

Using the familiar grade point average, what was your overall score? Does it work out to a "B+"? A solid "A"? An "F"? Is it lower than you would like?

Ophthalmic Careers Now and Then

Perhaps, like many physicians, you don't think of your professional life as a "career" to be molded and managed. This is understandable. At least until recently, the pattern was that when ophthalmologists exited formal training and landed their first job, their career development days were over and their professional setting was relatively static. Having seen more than a full generation of eye surgeons mature, I sense this is changing. Younger surgeons now seem to actually expect their careers to be more fluid. When I talk to younger physicians about a new job they're investigating, they speak in terms of the job being just another stepping stone rather than the end of the path. Interestingly, a significant minority of new graduates I speak with are asking, "Do I even want to be a partner in this practice or just stay an associate?"

For midcareer and slightly older surgeons, the reverse is often true. They were raised in an era when the expectations were high for lifetime employment in the same city and same practice, with an ever-increasing income. If circumstances—practice financial difficulties or a falling out among partners—force them to move on, it can be terribly disorienting. Perhaps the somewhat lowered expectations of the latest generation of surgeons will make it easier for them to get through the changing times ahead, albeit at the expense of that bedrock sense of professional stability enjoyed by their elders. I predict that this will have interesting consequences for the profession over the next 20 years. Manufacturers will find the current generation of physicians more circumspect about buying high-priced capital equipment on a whim, thinking that incomes will expand endlessly and cover any missteps or extravagance. I believe it will be more difficult for senior practice owners to find associates willing to pay premium valuations for a buy-in.

Armoring Yourself for the Future Health Care Environment

Given this new career fluidity, ophthalmologists at every career stage should be practical in their personal financial planning to make sure their lifestyle is not overshooting

HOW CAN YOU

THINK AND HIT AT

THE SAME TIME?

Yogi Berra



THERE IS ONLY
ONE CORNER OF
THE UNIVERSE YOU
CAN BE CERTAIN
OF IMPROVING
AND THAT'S YOUR
OWN SELF.

Aldous Huxley



their future income. Gone forever are the days when you could have a couple of strong LASIK months and project on the strength of this that you could carry a jumbo mortgage for the next 30 years. You should make efforts now to stay informed and to change what you can locally. This includes staying engaged with local managed care development and remaining visible within the primary care/referral community. The rationing of managed care is not dead. It's just been on an extended vacation, gathering strength for the next health reform battle. Finally, you must constantly improve the quality of your product. This is not just improving surgical or clinical outcomes, although that's obviously salutary. What may matter most in the future at the contracting table will be the patient's perception of your quality, including staff courtesy and timeliness, short waiting times, easy appointment access, and pleasant facilities.

The Many Dimensions of Career Success

Every eye surgeon gauges his or her professional success a little differently. One surgeon's sense of wild success constitutes another surgeon's sense of failure. I often ask, "On a 10-point scale, how happy are you with the standing of your professional career?" You would be amazed at the answers. It's not unusual for surgeons who are doing far better than their peers to report they feel they are not doing very well at all. It's also not unusual for surgeons to say their career ranks pretty low, a three or four let's say, even though they:

- Generate well more than \$1 million in annual collections and bank much more than the average ophthalmologist's \$300,000 annual pretax income
- Have one of the most active surgical practices in town
- Have excellent outcomes and good patient rapport
- Are ranked among the top eye surgeons by the local general practice community
- Have a serene office staff, with high morale
- Enjoy a stable home life, with a supportive spouse

The most common success metric is surgical case volume. Every week in physicians' lounges across the country, it's

the same question: “Who’s doing the most cases?” Manufacturers’ reps are the chief scorekeepers and form the backbone of the rumor mill for who’s pulling ahead in the race. But if you think about it, and look more deeply, raw case volumes correlate poorly with career happiness . . . or even incomes. Many surgeons with the highest case volumes aren’t taking home the largest paychecks. Although they may be among the most driven physicians, they certainly aren’t always the happiest. By the time you’d back out optometric comanagement fees and the marketing costs needed to drive a top-tier practice, the annual income hero in your town may be someone you’d least expect, especially when calculated on a profit-per-hour basis.

There are lots of other ways of keeping score in the career success race. Some ophthalmologists have gotten their greatest career tickle by developing a showcase facility. One physician in the Eastern U.S. sinks more than 15% of every dollar he collects into his architectural award-winning masterpiece (4% to 6% is more typical). His net profit margin is only about 20%. Yet he is so pleased with his decision to develop a showcase facility to work in every day that he’s willing to cut back on other lifestyle costs. Another physician I know loves his practice team. His large staff contingent is among the brightest I’ve ever met as a group—and the most expensive. This physician spends about 45% of his cash flow on staff wages and benefits (25% to 32% is more typical). But he is tremendously fulfilled, careerwise.

As they say, free time is the ultimate luxury. I know a physician, a bachelor, who takes a luxurious 20 weeks off each year. His practice performance shows it—his annual pretax income is well under six figures, yet he’s probably one of the happier surgeons I’ve met in the past few decades. He’s never fatigued, and he has plenty of time for budget travel and other personal interests. Yet some would gauge him a failure in his career.

There are several other qualitative and existential career measurements, metrics that go beyond the raw numbers of dollars or patients or cases. Some physicians who dislike the grind of routine clinical care (but relish surgery) hire

THE MOMENT OF
TERROR IS THE
BEGINNING OF LIFE,
SO TAKE THOSE ‘NO
FEAR’ STICKERS OFF
YOUR TRUCK.

Mark Twight



medical ophthalmologists and optometrists. In practices with older patient populations (or patients derived from consumer advertising), these extenders are well-accepted as a surrogate for most visits with the surgeon, allowing the surgeon to do what he or she loves best. As long as patients are satisfied and outcomes are high, the potentially lower overall percentile profit margins from this practice model are perfectly acceptable, especially since the net profit to the surgeon-owner of such practices can be higher since his or her own time is used more productively.

For other physicians, the reputation of patients, staff, and peers is paramount. These physicians use their own time and money for outside help on quality-assurance initiatives, staff education, and satisfaction studies. Of course, real progress in quality often begets commercial success. So if a practice owner focuses on quality first, the bottom line tends to take care of itself.

Good partnering, although all-too-rare, results in some of the highest levels of surgeon satisfaction. To the extent it can be learned, and I believe it can, the elusive ability to find and cultivate superior partner relations should be on the curriculum of every medical school and residency program. Professional partnerships are at least as complex and prone to disharmony as marital partnerships. If you and your practice partner are killing career satisfaction for each other, it may be time to seek counseling or a divorce rather than continue to struggle for years. These open issues must be resolved before any meaningful practice development work can begin.

Job Hunting? A Mixed Environment Awaits

The first thing you'll have to manage when looking for a position in today's mixed environment is your expectations, at least if you desire a partner-track position in an urban center. Potential future trends in the largest and most attractive markets are toward relatively more permanent associate/employee positions and relatively fewer

THERE REALLY
AREN'T JUST SEVEN
WONDERS OF THE
WORLD—THERE ARE
MORE LIKE SEVEN
MILLION.

Kobi Yamada



partnership opportunities. Base salaries for both new grads and older physicians have been comparatively stagnant in the most attractive urban settings, but are rising sharply in secondary markets. The same general ophthalmologist who can now command as much as a \$350,000 base wage in rural America may have to settle for \$150,000 or so in an urban hub.

Check Out Your Prospective Employer

If you are seeking a position it's critical that your choice be correct. Consider seeking professional help to assess the strengths and weaknesses of the prospective practice you are joining and, at the very least, to represent your interests when reviewing a contract. It's reasonable and common practice for a candidate associate, especially one on a partnership track, to ask for and receive confidential practice data. A minimum would include historical records on clinical and surgical volume, and financial statements, much of which you can interpret on your own. It's highly useful to interview as many informed parties as you can: practice staff, prospective colleagues in the community, former physician employees or partners, and hospital and managed care executives, along with chamber of commerce and real estate sources.

Your diligence should be doubled if the prospective community is already over-served by eye care providers. As a general benchmark, any more than one ophthalmologist per 20,000 population is likely to mean the community is over-served unless there are mitigating factors (e.g., a lack of ODs, an elevated 65+ population, many ophthalmologists nearing retirement, a nearby retirement haven, scant managed care encroachment or relatively few surgeons in your subspecialty area).

Even with the most thorough review, chances still exist that the practice you are considering an association with today will still be subjected to unforeseen, drastic market changes.

INSISTING ON
PERFECT SAFETY IS
FOR PEOPLE WHO
DON'T HAVE THE
BALLS TO LIVE IN
THE REAL WORLD.

Mary Shafer



YOU ONLY LIVE
ONCE. BUT IF YOU
WORK IT RIGHT,
ONCE IS ENOUGH.

Joe E. Lewis



Study Your Prospective Employer as Much as They Study You

Remember that you're not hiring on as some factory hand, with a union boss to protect you if you're mistreated. As a free-agent ophthalmologist, you are a "union of one," and you need to think that way well before you sign off on your employment agreement. At the same time your prospective employer is vetting you, you should be vetting the employer. If you're being considered for a partner-track position, you should have access to at least some of the following due-diligence information once you have been accepted as a finalist for the position:

- Financial statements for recent years
- Production and income statistics for each physician over the past couple of years
- The provider-to-population statistics in the practice's service area
- A copy of any business or strategic plans extant
- A copy of a typical partner employment contract and compensation methodology
- A summary of prospective partnership terms
- A written description of efforts that will be undertaken to help you build a practice
- The names and contact information of any partner-track associates who have left the practice in the past five years

Not long ago, physicians signed employment agreements with a blind eye to the details of the contract or the strength of the employer. Increasingly, new grads and midcareer job candidates are spending thousands of dollars for professional help to comb through this due-diligence data . . . inexpensive insurance given what's at stake.

Off to Work We Go

What are the key success factors for an ophthalmic job search? Consider the following 10 points:

1. *Start early.* Start your search well before you need to . . . at least one year before you are to graduate from your training program or leave your current position.

Although few employers will make a firm hiring commitment more than six months in advance, it will take several months for you just to get oriented and establish a network of contacts.

2. *Know where you're going.* The most important selection influence should be where you and your family would like to live. With luck, at least one of these communities will be marginally underserved or near underserved pockets into which you can satellite. Visit these communities and network with ophthalmic and non-ophthalmic colleagues.
3. *Use a laser, not a flashlight.* Don't expect to get an offer, especially in the more medically crowded areas of the country, by sending out blind query letters. It's far better to visit a community and say, "My husband and I are planning to move to Smithtown. Before taking on the cost and risk of establishing a private practice, I'm visiting with as many colleagues as I can to see whether there is an established practice that may be looking for an associate."
4. *Be flexible.* As an old mentor once told me, "It's not the price, it's the terms." Knowing that the typical employer is likely to be risk-averse these days, setting your base compensation lower and your bonus opportunities higher will help to secure your position. Your willingness to accept a somewhat lower base will speak volumes about your self-confidence. Be flexible in what you're willing to do. If you are subspecialty trained, show a willingness to do some general care. You'll ultimately win if you're the candidate who is willing to work a few Saturday mornings or weekday evenings, take extra calls, or travel to outlying satellites.
5. *Have a strong work ethic.* Older physicians have long remarked that the new crop of younger generation physicians lack a solid work ethic. (I suspect this has always been the case . . . I heard it over 30 years ago when some of the most economically productive ophthalmologists in U.S. history were just graduating.) Discussing what you're willing to do to grow your practice will be especially attractive to a prospective employer.
6. *Be mature.* Unfortunately, physicians-in-training often have a mild case of arrested development . . . 20- or 30-somethings with the maturity of teens. The real

YOU SHOULD NOT
CONFUSE YOUR
CAREER WITH
YOUR LIFE.

Dave Barry



world of spouse, kids, a mortgage, and your first malpractice case polishes your people skills and moderates expectations. For this reason, some practices will only recruit midcareer surgeons. Show maturity in your attire, behavior, and follow-through as well as in the questions you ask. Most important, once you're in practice, don't take it badly when the inevitable small portion of your patients complain to your supervising physician or administrator. Learn what you're doing wrong and change it.

7. *Have subspecialty training or interest.* Retinal and glaucoma fellows are far more employable, at much higher base wages, than general ophthalmologists.
8. *Be willing to work in rural America.* There are still plentiful opportunities in underserved areas of the country. (Contact hospital administrators in these communities or high-volume single or multispecialty practices in urban centers within a hundred miles . . . either may be in a position to sponsor you logistically and economically.)
9. *Cast a wide net.* Don't expect prospective employers to find you. Check all the usual "position available" listings in the trade press and their associated Web sites. Access every professional society's listing program. Write or call recruiters, even if you're not interested in their listed positions; they will likely know of other positions that have not yet made it to the classifieds. Ask everyone you talk with whether they know someone who may be able to help with your search.
10. *Enjoy teamwork.* Solo and small group ophthalmic practices are gradually scaling up via consolidation into much larger single and multispecialty organizations. The typical vanguard urban eye care practice today now covers all major subspecialty areas, has an increasing percentage of optometrists, and has multiple locations, a formal board of directors, and a hundred or more support staff. You should be able to demonstrate your ability to work on a multidisciplinary team and defer to group decisions.

AFTER YOU HAVE
DONE A THING THE
SAME WAY FOR
TWO YEARS, LOOK
IT OVER CAREFULLY.
AFTER FIVE YEARS,
LOOK AT IT WITH
SUSPICION. AFTER
TEN YEARS, THROW
IT AWAY AND START
ALL OVER.

Alfred Edward Perlman



In Praise of Workaholism

Let's assume you've just taken a job . . . any job. What's the next stage of actively managing your career? It's simple, really. For real success, you must work harder than you ever thought possible. You must work and think like an owner, even if you aren't one yet. Practice owners value hard work. Your first years as an ophthalmic associate are more profitable and less gruesome than the first years you would have spent as a junior associate in a law or accounting firm. All the same, it really helps to jump-start your practice by self-imposing a level of workaholism that very few surgeon-bosses would impose on you themselves. By exceeding their expectations—and perhaps your own as well—you'll jump-start success for the balance of your career. And this work should not be all clinical. In the first five years of your career, you should be putting an extra eight or more hours a week into marketing, outreach, and learning the business of eye care. Actively decide, all along the way, your desired balance between work and the rest of your life. Many young surgeons start out their careers affirming, "I'm not going to get into my father's rut—he worked 55 hours a week as a physician. . . . I'm not working over 40 hours." Check back in 10 years, and this same physician, rounding the corner to middle age and a maxi mortgage, is probably treading his dad's same footsteps. So it goes. In truth, working *smarter* will only go so far in today's medical business climate. In a fixed-cost business, it's simply too punishing financially not to work 45+ hours per week. Fortunately, what takes hold of almost all ophthalmologists by this stage in life is a kind of "work hardening" that allows them to see a few more patients every year but not feel any more exhausted because they're becoming more efficient and toughening up—both physically and mentally.

I WILL HAVE NO
MAN WORK FOR
ME WHO HAS NOT
THE CAPACITY TO
BECOME A PARTNER.

J.C. Penney



What Do You Get Paid For? V-A-L-U-E

We are all paid for value, or at least the perception of value. The tough reality of this is sometimes harder to swallow than a double-garlic milkshake. But it's a basic fact of life that if you're not getting paid what you think you deserve, it's because you're not adding as much value as the people

THE BEST CURE
FOR BOREDOM IS
CURIOSITY. THERE
IS NO CURE FOR
CURIOSITY.

Ellen Parr



who *are* earning the big bucks. Receptionists make less than marketing staff because they don't generate as much value for the company. Techs make less than surgical nurses and optometrists. Most subspecialists are more valuable to patients and payers than most generalists. But even if you missed out on subspecialty fellowship training doesn't necessarily mean you have to forego subspecialty-level success. Make a list of what you currently do for patients—how you give them value—and a second list of what you refer out. Do you need fellowship training to competently perform your own PRPs or uncomplicated cosmetic lid surgery? Of course not. Increase your skill set and thus your value to the patient, and your career and income will rise.

Stay Hungry. Stay Scared.

It vastly helps your career (if not your sense of well-being) to fake yourself out a bit and start each day with a healthy dose of fear: "I'd better get going here, or . . . our profits are going to falter . . . our competition is going to climb right up our backs . . . my skills are going to get rusty." This especially helps you fight the complacency that comes with midcareer success. If you haven't yet developed the next big goal to drive to in your career, at least keep the engines roaring to stay ahead of the pack.

Avoiding the Six Most Common Blunders of Your First Year in Practice

Based on years of advising practices of every size and market position, from rural and solo to urban market leaders, here are the biggest mistakes I've seen even the smartest new ophthalmologists make in their first years of practice. Although most of these points are germane to physicians joining established practices, most also apply to those few rugged individuals who are still going to establish their own practices from scratch.

- *If you're a partner-track associate, don't act like an employee.* I talk to a lot of senior, employer physicians who are unhappy with their new associates. The most common complaint is not about clinical skills, but about junior associate behavior. Lapses include dating or harassing

staff, discussing confidential practice business matters in the community, or grumbling openly about their salary. Decide whether you are going to be a practice owner or employee in the future, and then behave accordingly.

- *Don't assume you're doing a great job.* If you haven't been given one already, prepare a list of things you would like to accomplish in your first year of practice and share them with your employer. Be sure to include extracurricular duties (screenings, community involvement, etc.). Check with each other at least quarterly to compare notes on each others' perceptions of how you're doing.
- *Don't adopt a lesser work ethic than your boss.* The average managing partner in a group practice is working much harder than ever before to maintain personal and clinical productivity as well as manage the practice. While the boss is pulling hard in the harness, the last impression you want to leave is that he or she is dragging you along.
- *Don't be a loner.* Many practices are scaling up via consolidation into much larger single and multispecialty organizations. You should be able to work on a multidisciplinary team and defer to group decisions.
- *Don't live on more than 80% of your net after-tax income.* If you start investing now, even with falling fees, you'll retire comfortably in your 50s if you desire. Steady wins the race. Watching your net worth rise year after year is a powerful antidote to the uncertainty of modern ophthalmology.

CHARACTER IS
MUCH EASIER KEPT
THAN RECOVERED.

Thomas Paine



Still More Advice for Junior Associates

Expand your reading list . . . your business education is likely just starting. The advent of managed care is obviously not the end of entrepreneurial eye care—it's just forcing the winners to tune up their game. Even if you're an employee, try to act like an owner. Ask your employer to provide you with—and help you understand—the critical economic and volume performance numbers in your practice. Attend practice management meetings. Volunteer to take on nonclinical or quasi-clinical management projects for the practice, such as improving recall or revising the superbill.

MEDICINE IS
AN OCCUPATION
FOR SLAVES.

Benjamin Rush



Physicians: Ask for Feedback

Most staff members, even the sassiest, are shy about going to their physician and pointing out faults. This can lead to serious deficiencies in your understanding of your career performance. Taking the advice and counsel of staff with an open mind can markedly improve your abilities as a provider and your practice as a business. You should publicly and frequently ask your staff to give you feedback. This can be direct and face-to-face, or it can be anonymous. The most common suggestions will likely be the following:

- Come to the office on time, and get right to work instead of dawdling.
- Please be sure to fill out the fee ticket correctly—every time.
- When we need to come to you for a signature or clarification, be cheerful and don't act as though we're interrupting your day.
- Don't take personal calls when we're running behind.
- Stop giving out excess courtesy discounts or free care to people you barely know.
- Don't pick out staff favorites and give them special treatment.
- Don't pick on the same people over and over, and don't do so publicly or out of proportion to the offense.
- Don't roll your eyes, pout, or tell us, "It must be kill-the-doctor day." Your staff members really are trying their level best to make this a great practice.
- Be more positive. Make a concerted effort to provide positive reinforcement to areas of the practice you don't work in, such as insurance.
- Please don't have your spouse work at the practice unless he/she is competent enough to hold the same job at another practice.
- Tell your spouse to stop calling you so many times a day and interrupting clinic.

Practice Building for New Employee Doctors

Once in practice, the younger surgeon's challenges are to hone skills, become more efficient, build confidence, and develop a patient following. Unless you have elected to open a new independent practice, much of what you now need to do will be coordinated—or at least approved—by your employer. So your first practice-building task is to *write down* a baseline of (a) your existing clinical and surgical volumes, (b) a simple description of where you would like your individual practice to go vis-à-vis the group, and a plan of action to get there.

Take the initiative. If you currently work in a group practice, bring the first draft of an individual practice-building plan to your administrator or managing partner. Here are some of the critical points the action section of your plan should include:

- *Internal research.* Use patient satisfaction surveys, exit interviews, focus groups, and the impressions of your colleagues and support staff to find out what patients think of the job you're doing. Ignore your natural inclination to be defensive. Use every scrap of data you gain to improve the quality—and *impression* of quality—of the services you provide.
- *Audio record your encounters.* Slip a small digital recorder into your lab-coat pocket for a few exams . . . play back the tape and you're certain to hear patient questions you glossed over, chief complaints you never really addressed, or subtle signals from the patient that could have lead to a deeper discussion about a surgical procedure. Obviously, this activity raises potential questions about patient confidentiality. Follow your own instincts and the advice of local counsel if you decide to try this. Apply common sense in erasing the recordings afterward.
- *Measure/analyze transit times.* Look critically at patient waiting times and flow patterns.
- *Ask for new patients.* Make sure that all patients are asked *by you* for their referral support at the end of

LET ME TELL YOU
THE SECRET THAT
HAS LED ME TO MY
GOAL: MY STRENGTH
LIES SOLELY IN MY
TENACITY.

Louis Pasteur



their exam . . . hand them a few business cards with the words: “Be sure to tell your friends about the importance of regular eyecare.” (Any surgeon uncomfortable with this overt approach should delegate this step to staff, although this is far less effective.)

- *Recall/continuity of care.* Check to confirm that all departing patients are given a return appointment at an appropriate interval. Make sure that nonresponders to your recall system are followed up actively. Recall gaps underlie most faltering practices.
- *External outreach to colleagues.* Old fashioned as it may seem, pressing the flesh with eye and non-eye colleagues in the community can be highly effective, especially if you are a subspecialist. This activity is often overlooked by mid- and late-career surgeons, who have well-established referral lines, have already alienated their colleagues beyond repair, or see outreach as beneath them. Your efforts should include the usual round of couples socializing and hospital committee work, along with more direct face-to-face visits and overt requests for referrals. Set a monthly goal for the number of such contacts you will achieve, log each visit with a brief contact report, and track the resulting change in referral patterns. Obviously, you should be careful about stealing referral relationships from physicians in your own practice. Every physician in a group setting should have his or her own agreed “book” of business.
- *Satellite clinic development.* Explore the potential for negotiating a part-time clinic in outlying facilities controlled by optometrists, primary care physicians, or general ophthalmologists (if you are a subspecialist).
- *Consumer ads.* Both introductory and ongoing support ads should be purchased if this falls within the budget and ethical bounds for you and your employer.
- *Managed care outreach.* This is becoming a critical issue for some associates in some markets. Typically, Dr. Old has no desire to serve managed care, has a large referral base of past patients, and can ignore managed care because of a pending retirement. Meanwhile, Dr. Young predicts (correctly in many markets) a limited run of fee-for-service practice, to be followed by limited panel access, utilization constriction, and capitation. This sample practice, if it is to survive into the next generation,

SUCCESS IS HOW
HIGH YOU BOUNCE
WHEN YOU HIT
BOTTOM.

General George S.
Patton



needs to deeply understand the dynamics of its market, gain panel access, and commit significant resources to making a transition to managed care—alone or in partnership with other practices, institutions, or payers.

- *Get out of the office.* Particularly in smaller communities, your participation in civic groups, speeches to service clubs, and general visibility can be critical success factors. The impact of this activity is somewhat diluted in large urban centers.

Financial Planning for Younger Surgeons

The bad news: The new generation of ophthalmologists will have less marginal income to set aside, fewer and less creative tax-avoidance options, and perhaps a less robust equities market than the older generations. The good news: You will still have plenty of time, if you start in your 30s, to retire very comfortably in your 50s or 60s. Remember that with the magic of compounding interest, steady wins the race. From the earliest stages of your professional career, you and your family should have a fee-only financial planner or qualified accountant who will act as an educational resource, a strategist . . . and most important, a disciplinarian. Volatile investment home runs aside, history seems to bear out that regular, level contributions to broad domestic and international equity funds, along with a containment of personal expenses, will make you at least as secure as your elders. Watching your net worth and security rise year after year is the most powerful antidote I know to the insecurity of modern medical economics. Graph your net worth at annual intervals.

New Midcareer Syndrome Identified

Surgeons I know who are in the mid to late phase of their careers, who have conquered the world, and who have paid for all their houses often evidence NDD: Need Deficit Disorder. Unless they truly enjoy clinical practice, these surgeons lose their business momentum, and their practices can spiral into difficulty or failure. The cure requires that the surgeon find new needs and motivations. Passion for a new business opportunity, a charitable cause, or an expensive hobby can help shake the blahs. Unless your city has a

WHERE SELF-
INTEREST IS
SUPPRESSED, IT
IS REPLACED BY
A BURDENSOME
SYSTEM OF
BUREAUCRATIC
CONTROL THAT
DRIES UP THE
WELLSPRING OF
INITIATIVE AND
CREATIVITY.

Pope John Paul II



THE BEST WAY TO
HAVE A GOOD IDEA
IS TO HAVE LOTS
OF IDEAS.

Linus Pauling



handy Midlife Crisis Treatment Center, talking to older colleagues and business acquaintances can be the best available way to explore your diminished interests.

The *Other* Midcareer Temptation

The pressure to stay ahead economically, along with the natural competitiveness of surgeons, can lead to another common midcareer problem. For some surgeons with exceptional stamina and skills, “the wall” is hit at about 100 clinic encounters a day and 30 or more cases per surgical session. For mortals, even half this volume can rapidly take its toll. Higher clinical volumes and overconfidence in case selection can lead to serious utilization and quality assurance problems for the most aggressive providers. Avoid the temptation to overbook, overtreat, and overbill, which will have increasingly severe consequences in the current era of computerized medical records and almost total payer and peer-review transparency and oversight.

The Shrinking Ophthalmic Middle Class

The ophthalmic “middle class” is being hollowed out by changes in medical economics. “Upper” and “lower” classes of providers seem to be emerging, and their ranks will grow as the number of Boolean distribution middle majority practitioners shrinks in the years ahead. The major dividing line is practice ownership.

- *Owner/shareholders.* These are physicians who own part or all of a private practice or retain significant control by owning their professional corporation, which contracts with one of the emerging practice management companies. As an owner, you will receive both the active profits of your own work and the passive profits of indirect productivity, including employed physicians, surgical facility, and the optical and testing departments of the practice.
- *Worker/stakeholders.* These are permanent employee associates in practices who have little or no control over their work environment or practice governance. Such physicians may be employed by other physicians, hospitals, HMOs, or corporate practices in the expected increasing

number of states that will permit the corporate practice of medicine. There is obviously no dishonor in being an employee, but for many surgeons, the resulting lack of control sharply reduces motivation, performance, and job satisfaction. Also, compensation will generally be lowest for employed physicians.

It's critical to understand the distinction between these two clearly emerging destinies and their effect on your professional and financial life. Use this understanding to motivate yourself to appropriately plan your career.

COURAGE IS FEAR
HOLDING ON A
MINUTE LONGER.

*General George S.
Patton*



The Economics of Midlife Health Habits

The health, diet, and fitness habits adopted or abandoned during your late 30s and 40s will strongly influence your future economic productivity. A regular exercise program can give you the energy to see hundreds of patients each week and mitigate the stress of modern practice. As I go around the country to work with both successful and faltering practices, it's obvious that one of the most important contributing success factors for high-volume surgeons is their personal health regimen. If your health battery needs recharging, seek out professional dietary, exercise, and related expertise—just as you would find a lawyer or accountant for legal or financial problems.

Famous Star-Surgeon Quotes

I don't want to give the impression that high-volume surgeons are uniformly cynical, but they are under extraordinary stress, and in the heat of battle, their true feelings bubble to the surface. Perhaps you can relate to these direct quotes from some well-known American ophthalmologists, who will remain anonymous for obvious reasons:

- "If you're not living, working, and playing close to the edge, you're taking up way too much space."
- "With the kinds of partners I have around here, my main job as managing partner is to administer sunshine enemas PRN."
- "He seems to have a wonderful sense of himself and real career ambition . . . I'm sure we can work that out of him." (in reference to a physician job applicant)

ART IS A LIE THAT
TELLS US THE
TRUTH . . . I AM
ALWAYS DOING
WHAT I CANNOT DO,
IN ORDER THAT I
MAY LEARN HOW
TO DO IT.

Pablo Picasso



- “The secret to success is sincerity . . . once you can fake that, you’ve got it made.”
- “When anyone talks to you and uses the word ‘but,’ everything else that follows is likely just a bunch of poop.”
- “I’ve found that the best way to keep staff happy is to offend everyone equally.”

Control What You Can, Smile at the Rest

The ophthalmologists who are happiest in their careers are those who are flexible, and realize they can’t control everything. They don’t get inappropriately angry with minor staff errors, confused patients, work-ins, or cancellations. They exert control where they can—voting on the practice board, getting subspecialty training, or learning about the nuances of the business. They don’t get bent out of shape by things beyond their control, such as Medicare fee reductions or the addition of competing physicians to the community. They enjoy teamwork in all its forms and can shift happily from leadership to “followership.” Physicians in nominal control of their career write down their goals and review their lists often. These goals, to be most useful, must be measurable and objective—not “I will do more surgery,” but “By this time next year, I will average 28 cataract cases per month.” Not “Our practice will be more profitable,” but “Our practice profits for next year will exceed \$700,000.”

Physicians who craft great careers are often wide-ranging in their interests. They’re as drawn to reading a book on business, history, or art as they are to reading the technical manual for their latest retinal camera. They can relate to a wide range of staff, patients, and fellow providers. And, lest you think that success is an always “on” or “off” switch, recognize that some of the most successful physicians today are the most successful in global terms and have not always enjoyed such success . . . they rose from failure. It is like the client who was abused in a group practice setting but who went on to spectacular success in solo practice, or the physician who went down miserably with a failing management company but rose right back up again.

More Surgical Care, Less Clinical Care?

Every surgeon I've ever met desires more surgery and less routine medical and post-op patient care. Up to certain levels, especially in mature practices, this can generally be accomplished.

- Assess the actual portion of your clinical practice that could be transferred in-house to extenders (junior associates, optometrists, techs) or to outside offices (e.g., optometrists who support your practice). Most surgeons working without an optometrist on staff will admit that at least a third of their office practice could be transferred to an optometrist's care.
- The transfer should optimally be handled one patient at a time, with the surgeon using a script along the lines of "I'm very pleased with your progress. Now that your surgical (medical) care is complete, I am going to have you seen by my colleague, Dr. Smith, for the next several exams."
- Make sure that the transfer process is incremental and that you don't overstep, leaving yourself underemployed. Start with patients whose transfer will have the least impact on subsequent surgical case identification and revenue generation (e.g., bilateral pseudophakes).
- Patients who refuse to transfer to other doctors should, in most cases, be allowed to remain with their current doctor. As happy patients, they are vital referral sources.
- Monitor patient satisfaction with the transfer. Make sure patients aren't lost as a result of the transfer.
- Make sure you are promoting your surgical services enough to replace lost routine visits with new surgical candidates.
- Realize that unless you are in a position to develop a pure referral-center practice, there are natural limits to how far you can distance yourself from routine eye care. In most settings, an ophthalmologist should continue to perform all initial surgical consults to identify appropriate candidates and optimize conversion rates.

LIFE MUST BE
LIVED AS PLAY.

Plato



Some Big Cutters May Be Left Behind If Consolidation, Managed Care Return Strongly

A MAN WITHOUT
A SMILE SHOULD
NOT OPEN A SHOP.
SWEET TEMPER
AND FRIENDLINESS
PRODUCE MONEY.

Chinese Proverbs



The core skills of America’s most financially successful ophthalmologists—fierce independence, surgical aggressiveness, and overt public promotion—are now yielding to collegiality, conservative clinical standards, and behind-the-scenes politicking for managed care contracts. A premium is now being placed on long-term professional relationships, which is why subspecialists are often in the best position to act as the spark for consolidation within their communities (and renegade surgeons—the proverbial “big cutters”—may be left entirely out of opportunities). Solo general ophthalmologists may be left behind if we return to an era of mergers and acquisitions; they may be isolated and vulnerable to loss of their patient base. To survive, it’s critical that these practitioners consider reconnecting with their professional competitors (hospitals and other eye surgeons) or building a single or multispecialty coalition of compatible fellow “outsiders.”

The Power of Personal Financial Planning

Fewer than 20% of the surgeons I know had a personal financial plan when we first met. Physicians—old and young, rich and (especially) poor—should have at least a brief, but formal financial plan. The preamble of this plan can be little more than filling in the following blanks with the help of a financial planner (who should not be a securities broker or insurance agent, but rather a fee-only planner or qualified accountant):

At present I am years of age. My net worth is \$ _____ and total funds under management generating passive income for my family are \$ _____, which is generating a recent annual income of \$ _____ before taxes. I am currently netting \$ _____ per year before taxes in active earnings, from which I am investing \$ _____ in tax-qualified instruments and \$ _____ in nonqualified instruments. I currently intend to work at my present or greater intensity until I am _____ years old and desire that my net after-tax active income reach \$ _____ by this time. At this time, my net worth will be \$ _____ and

total funds under management generating passive income for my family will be \$ _____, which will be generating supplemental annual income of \$ _____. After accounting for passive investments, inflation, and our future lifestyle requirements, I presently expect to be financially independent at _____ years of age. Once I have reached this nominal "finish line," I will _____.

Career (and Life) Flexibility

From the time you first declared an interest in medicine, your career and life path have been much more channeled for you than they would have been in almost any other profession other than perhaps the military. Tradition has always held that after training, physicians shall go into practice, do the same job, and live in the same community until retirement in 30 or 40 years. This is all changing. Physicians who never thought they could live in rural America are now working in the country to escape urban oversupply. In fact, hundreds of specialists around the country have retrained to become primary care physicians. Private practice surgeons who never thought they would be willing to work for a hospital or HMO are now sending out their CVs. Be flexible and you'll bend with the significant changes ahead . . . be rigid and you could snap.

The Fine Art of Quitting

General George Washington's army lost more battles than they won . . . and yet they prevailed in the Revolutionary War. In a syndicated column, George Will wrote that America won the Revolutionary War not so much because of decisive victories but because of its superior retreats, such as the one after the British landed on Long Island with an army larger than the local population. Perhaps it's useful to think of your practice career, panoramically, in the same terms. By the time it's over, you will have had some 30 years of victories and defeats, advances, and retreats. For those of you reading this who are older, you already know that your career has been shaped as much by the strategic retreats you've made as by the advances. Whether in battle or in business, there's no dishonor in withdrawing to fight another day.

TWENTY YEARS
FROM NOW, YOU
WILL BE MORE
DISAPPOINTED
BY THE THINGS
THAT YOU DIDN'T
DO THAN BY
THE ONES YOU
DID DO . . . SAIL
AWAY FROM THE
SAFE HARBOR . . .
EXPLORE. DREAM.
DISCOVER.

Mark Twain



BY THE TIME YOU'RE
80 YEARS OLD
YOU'VE LEARNED
EVERYTHING. YOU
ONLY HAVE TO
REMEMBER IT.

George Burns



I THINK I'M LUCKY.
I WAS BORN WITH
VERY LITTLE TALENT
BUT GREAT DRIVE,
AND I THINK I DID
TREMENDOUS THINGS
OUT OF DRIVE.

Anthony Quinn



There are many such strategic retreats in modern practice. One of the most common is the retreat that lower-volume refractive surgeons are making from vision correction surgery. Hundreds of ophthalmologists who thought it would be professionally interesting and highly profitable to add a modest LASIK service to their largely geriatric businesses are realizing that it's easier in most circumstances to grow by adding services of interest to their existing customer base than finding an entirely new pool of customers. The same can be said about the shopping basket of cosmetic and aesthetic services such as dermabrasion, facial peels, and even elective cosmetic (as opposed to functional) blepharoplasty. These are services that seem intuitively sensible to add, right? But they end up being empirically wrong in almost every setting. With very few exceptions, the profitability of these services is terrible compared to that of mainstream ophthalmic care.

What other battles should you quit? Let's turn to low-profit and no-profit managed care contracts, often paying no more than 80% of Medicare rates. These are signed innocently enough when you sense your clinic is not busy enough. (Have you noticed that contract signing time often coincides with those times of the year when practices are less busy?) After all, better to fill those empty appointment slots and enjoy a little marginal revenue, right? Wrong! Unless you're desperate for a near-term capital infusion, accepting ultra-low-fee and low-capitation contracts will only lull you into a sense of practice satiety, just like eating wood chips might give you a sense that you're well fed. Instead, such contracts devour the time needed to improve service quality and to plan and execute the marketing and outreach necessary to attract, over time, a higher yielding patient base. You should also retreat from the people who are wrong for your practice. Think to yourself, "Do we have any lay staff or associate physicians who should be terminated today? If so, how long ago should they have left the practice? Why have we kept them so long?" The same question set applies to your fellow practice partners. Should you keep up appearances—or worse yet, the heat of battle—or retreat from a partnership that isn't working? If you're an employee in an unwholesome setting, should you be quitting the battlefield your practice has become?

Continuing down the cut-and-run list, have you been putting off abandoning equipment that no longer works properly or that should be replaced by a more profitable or clinically appropriate alternative? Are you maintaining unprofitable satellite offices—maybe branch offices that worked a decade ago when you were more energetic or worked for higher fees but that are now personally exhausting or diseconomic? Should you retreat from surgical or clinical procedures that you don't do all that well or have not kept up with? Are there business procedures your staff now do more by rote, from outdated standing orders, than for any practice benefit? Are you still gathering financial or volume performance data that you're no longer using to make management decisions? Ponder each of these questions, not in the abstract, but as they apply to your specific setting.

Are you doing things for yourself within the practice, such as payroll administration or office cleaning, that a vendor could do better and less expensively? On the flip side, has your practice become larded with an overabundance of vendors who are performing functions better left to internal staff? Go through your general ledger, vendor by vendor, and give each a score for necessity, performance, and value added. Finally, and most broadly, is it time to drastically change your professional context? Is it time to be leaving the academic world for private practice, or vice versa? Is it time to stop your surgical career or leave medicine altogether?

Is it OK to quit? From time to time, no matter how foreign "giving up" is to the average eye surgeon, the answer is "absolutely." By confronting these difficult questions—and achieving a better life and practice with a little well-timed subtraction and backtracking—you'll be more inclined, like General Washington, to win over the long run.

Every Career Rises, Every Career Falls

I'll let you in on a little secret that very few surgeons recognize as they enter their careers. In raw earnings terms and raw control, *every* surgeon is destined to rise and fall. Your income and control will start out low, rise slowly or quickly through a decade or more, reach a plateau, hang at this

ALWAYS YOU HAVE
BEEN TOLD THAT
WORK IS A CURSE
AND LABOR A
MISFORTUNE . . .
IF YOU CANNOT
WORK WITH LOVE
BUT ONLY WITH
DISTASTE, IT IS
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SHOULD LEAVE
YOUR WORK AND
SIT AT THE GATE
OF THE TEMPLE
AND TAKE ALMS OF
THOSE WHO WORK
WITH JOY.

Kahlil Gibran



THERE CAN BE
NO JOY OF LIFE
WITHOUT THE
JOY OF WORK.

Thomas Aquinas



level for a greater or shorter period of time, and then erode and collapse. It's all as natural as birth, growth, maturity, senescence, and death. Let's examine each phase in turn and attach a rough age span to each.

*Phase 1: Growth
(± 30 years old to 40 years old)*

All options and nearly all career pathways are still open to you. You are like a stem cell, capable of differentiating into whatever you desire. Your training is over and your professional career truly starts, probably by working for someone else. You have a base salary. Within a couple of years, you're producing enough to enjoy a modest bonus on top of this base.

You may be offered a partnership opportunity. Once you make partner, in economic and control terms, you're a liberated adult for the first time in your life—before this you were, for all practical purposes, absolutely subject to the control of parents, professors, or bosses. Of course, you've taken on a new set of overseers: third-party payers, referring physicians, the managing partner of your practice, and that surly lead tech they've given you who enjoys bossing you from one exam room to the next all day long. Oh yes, and your patients. They're each, quite literally, your boss, as well. If they're not happy, your practice won't grow and your old college loans (along with your new mortgage and the bill for your first child's braces) won't get paid.

These new pressures notwithstanding, you are still advancing year by year and probably making more money. Your annual tax bill now eclipses what you once made as a resident or fellow. It doesn't matter if you're rising slowly from \$200,000 or quickly to \$2 million—the point is you're still rising. If you've selected the right market to practice in (where the people are and the physicians aren't) and have joined the right practice, you're probably set for life. If not, you still have a lot of time to get it right. The most common mistakes made by young physicians who find themselves in the wrong setting (e.g., bad market, nasty boss, not enough patients to go around) are to wait too long to

seek out a better situation or to sit around passively expecting others to make things better for them.

Phase 2: Professional Maturity (± 41 years old to 55+ years old)

Somewhere along this 15-year or longer timeline, you reach a plateau. Although your surgical density improves every year and your raw output rises as you become more efficient and work-hardened, you reach a point of equilibrium at which your annual output growth is nullified by inexorable fee reductions and, probably, your inability to manage a larger organization. It's the time for midlife crises of various shapes and colors. It's the time for wondering, "Is this all there is?" "Will I ever perform more than 17 cataract cases in a single session?" "Will my collections ever crack the \$1 million mark in a year?" "Is it time to start a new family with my technician Mary Lou, who I'm convinced, despite the 24-year age difference, really does love me for who I am, not my wealth?" The most fortunate surgeons thread their way through the labyrinth of this career phase relatively unscathed—or massively scathed, but at least somewhat happier.

By 45, you were thinking about retiring in your early 50s. By your early 50s, you're now thinking of retiring in your early 60s. You're beginning to suspect that in another decade, you'll be thinking about retiring in your early 70s. So it goes. You've climbed high enough on the ladder to enjoy the view. Unfortunately, toward the end of this career phase, you can also now see the slide that starts at the top of the ladder and goes back down. What's more, if you work in a competitive practice or market, there are a lot of younger physicians below you on the ladder who are trying their best to push you along so they can be on top.

If you're at least moderately successful and emotionally balanced, you'll pass through this career phase with pride, great memories, and little more than a few invisible bruises. If not, you'll be a prime candidate for career burnout. Here are some pearls for physicians at the apex of their careers:

WE REJOICE IN
OUR SUFFERINGS,
BECAUSE WE KNOW
THAT SUFFERING
PRODUCES
PERSEVERANCE;
PERSEVERANCE,
CHARACTER;
CHARACTER, HOPE.
AND HOPE DOES
NOT DISAPPOINT US.

Romans, 5:3–5



GREAT WORKS ARE
PERFORMED NOT BY
STRENGTH BUT BY
PERSEVERANCE.

Samuel Johnson



- *Ask yourself, honestly, whether you've chosen the right field and subspecialty interests.* It's not too late to go back to law school or taper your practice to the areas you enjoy most.
- *Don't get strung out or overextended.* This has many dimensions: the solo surgeon with four satellite offices who feels like a permanent visitor no matter where he's working; the surgeon with a perfectly terrific geriatric practice who thinks it would be swell in her mid-50s to be the 18th doctor in town to get into LASIK surgery; the physician who gets so wrapped up making a \$25,000 honorarium as a drug company consultant that he drops \$250,000 in practice revenue.
- *Don't back down too fast or with insufficient planning.* Ophthalmology is a business with high fixed expenses. An innocent 10% cut in patient volumes can claw 30% from your take-home pay.
- *Beware of hubris.* Just because you've managed to cut things close to the edge with extremely aggressive surgical patient selection or billing protocols, don't keep forcing the odds just to make payments on that ski condo. Remember the adage: Pigs get fat, hogs get slaughtered.
- *Challenge your old assumptions about how to practice medicine and how to run the business.* Visit the most successful practices you can find, and copy what they do.

Phase 3: Professional Senescence (more a state of mind than an age, but let's say 55+)

The last few winding-down years are poignant and bitter-sweet for most surgeons. This phase must feel very much like the last months of a senescing lion's proud lifespan. One moment you are at the top of the food chain, and the next moment you yourself are susceptible to depredation.

There are still many important career decisions to make: "Should I learn that new surgical maneuver, stick to my old method, or pass certain difficult cases on to others?" The happiest surgeons I know at this stage in their career aren't the richest. They're the physicians who are surrounded and sustained by many rich practice relationships, such as the office manager who is just hitting her stride although she started in the practice 16 years ago as a front-desk clerk, or the physician you hand-picked as a junior associate two

decades ago but has just been appointed managing partner of the group, taking over your old position. And, of course, there are your oldest patients, whose adult children your partners now see for their emerging presbyopia and early cataracts. Most retiring surgeons report, with sincerity, that they are winding down their careers at just the right time. I believe that they believe what they're saying.

Phase 4: Professional Death (as early as your 40s, but increasingly common to stretch to 70+)

There are no more professional career pathways left to choose, but a host of new personal pathways open up. Thousands of patients have announced their own retirement to you over the years. Now you stand back and watch your own lips say the words, "I'm leaving practice this June." Although I have a long time to go until my own retirement, I find myself listening more closely than ever to clients in peri- and postretirement for their ideas of what works. Here's what they say:

- *Plan at least 10 years ahead.* Don't stick your head in the sand and be surprised at the last moment.
- *Take a sabbatical to test what retirement feels like.* Pretend you've retired. Just hang out for a few weeks with no responsibilities. (If you're like most who have tried this, you'll run back to your office after the mock retirement and thank your stars you don't have to leave practice quite yet.)
- *Don't rush into retirement.* Just because your dad retired at 62 doesn't mean you should. If you really like practicing, do it for life. And if that's your plan, live accordingly, with health and stress management habits that will let you truly go the distance.
- *Be ready for surprises.* You may be happier than you ever thought possible after giving up the responsibility of practice, or you may be much sadder than expected.
- *Have something to go to when you leave practice.* Make goals, large or small. Work through a checklist of countries you've never visited and books you've never read. Master a new language. Volunteer by doing something you love that helps others. Teach.

OUR GREATEST
GLORY IS NOT IN
NEVER FALLING,
BUT IN RISING
EVERY TIME
WE FALL.

Confucius

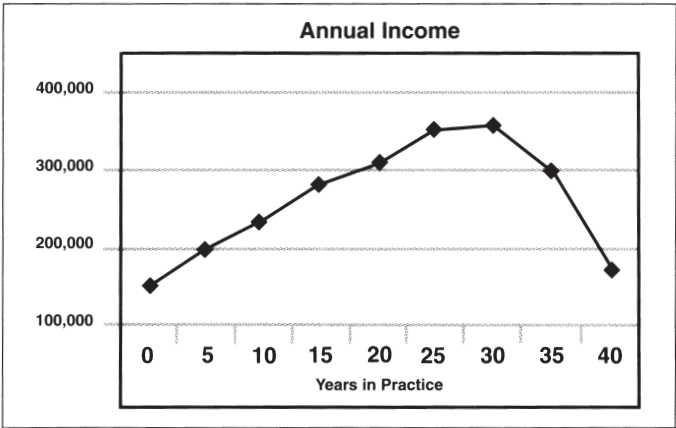


- *Do yourself what you've been advising everyone else to do all these years: Eat right and stay physically active.*

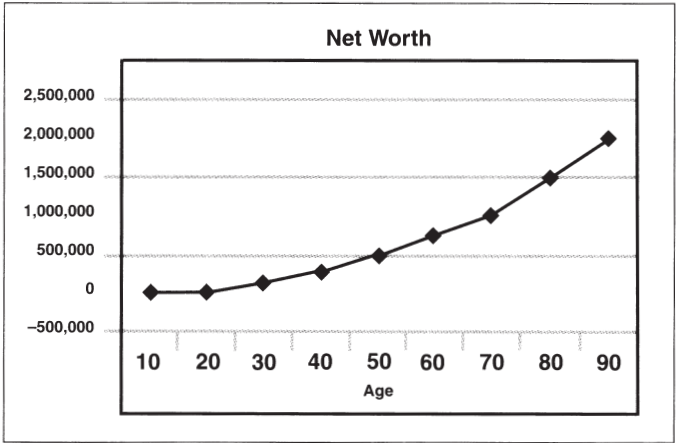
One day, the career you now loathe or cherish will be past tense. Along the way, you alone can judge how successful you are. Some surgeons will always use economics as the core measure of their success. For such physicians, comparing one year to the next as they stride through 30 years or more of a career leads to an inevitable, sad moment when annual income stalls and then declines. Income growth, maturity, senescence, and death make up the normal, natural parabolic curve of your career life:

TO ACQUIRE
KNOWLEDGE, ONE
MUST STUDY;
BUT TO ACQUIRE
WISDOM, ONE
MUST OBSERVE.

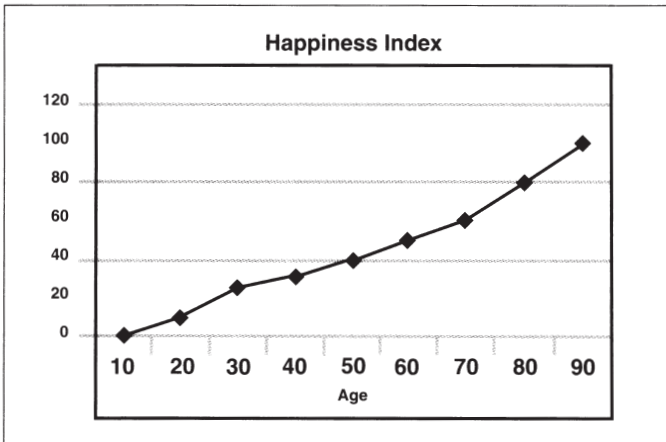
Marilyn vos Savant



For slightly more enlightened doctors, there can be a more comforting perspective. Rather than looking at economic success as annual income, you can see it as your steadily rising net-worth curve:



Of course, for the most enlightened ophthalmologists, the life and career curve they're really looking at every year and using to gauge success is probably something more like this:



Ophthalmology Practice Alternatives

Many biochemists become ophthalmologists. Many family practitioners become ophthalmologists. Mobs of optometrists become ophthalmologists. But very, very few ophthalmologists go on to alternative careers, at least voluntarily.

On the other hand, many eye surgeons, from time to time, have been burned out enough professionally to at least think about alternatives to a hectic practice life. Here are some strategies that seem to work best for transient career burnout:

- *Slow down and do less.* In an environment of falling fees, rising costs, and urban competition, it's easy to work just a little more intensely each year until you reach a personal breaking point. Adjust your practice and/or personal expenses, and go back to taking half a day or more off each week. Bring on an associate. Even adding a part-time optometrist to take over routine care may help take the edge off.
- *Speed up and do more.* You may be bored with a pedestrian ophthalmology practice. Get more involved with the business side of the practice. Learn about marketing

SEEK NOT WHAT
YOU WANT TO
HAPPEN; SEEK
TO WANT WHAT
HAPPENS.

Epictetus



YOUR VISION WILL
BECOME CLEAR ONLY
WHEN YOU CAN
LOOK INTO YOUR
OWN HEART. WHO
LOOKS OUTSIDE,
DREAMS; WHO
LOOKS INSIDE,
AWAKES.

Carl Jung



to increase your surgical yield. Learn about clinical efficiency, and work on seeing how many more patients you can serve well each day. Learn a new surgical maneuver and add a new dimension to your practice.

- *Examine the periodicity of your time off.* It's a little like sleep requirements, with some people getting by only with nine hours a night and others thriving on catnaps. Some people are refreshed after a long weekend holiday, while others need a full week or two weeks to recharge. Think about your personal needs, and schedule accordingly.
- *Take a block of time off.* Sabbaticals are nearly the norm in academic and legal circles. If you think you would be refreshed only after a long block of time, make arrangements (during the winter lull or with a locum) to take a month or more off from practicing. If you're like most surgeons, you'll be climbing the walls after no more than three weeks and itching to get back to the office.
- *Volunteer.* It goes against common sense, but some surgeons dissipate burnout by working even harder. They perform local community services or they travel to Third World countries for humanitarian work.

What if you decide you really do want to get out completely? There's always early full retirement—if you've managed your finances appropriately. Unfortunately, when it comes to midlife transitions, once you've become accustomed to ophthalmic wages and personal control, it's difficult to find a job that even comes close in either dimension. Some surgeons harbor fantasies of becoming attorneys, or politicians, or corporate tycoons—and some actually make the switch. But for most ophthalmologists, greener pastures, on reflection, do not exist. If you're fundamentally unhappy with what you have *right now*, chances are you'll eventually be unhappy with anything else as well. Whether you are young or old, it's probably better to fine-tune the career you have than to take a widely divergent left turn.

What Did You Really Buy from the University?

What do you possess, really, when you leave formal training and enter the world as a newly minted ophthalmologist?

Knowledge, to be sure . . . in abundance. A few scars. Enough wild-haired stories to fill a small novel, if you've been lucky and well-rounded. But what you *really* possess is a brand new baby career. In the 30 or more career years that stretch ahead to the horizon, you'll likely serve more than 25,000 different patients, if you're at all ambitious. You'll perform more than 150,000 examinations and over 5000 major surgical cases—for which you'll be paid well in excess of \$30 million and get to keep, after expenses and taxes, perhaps \$7 million or so. With any discipline and care, you'll be able to retire, early if you like, with a net worth of several million dollars and the deep satisfaction that comes with doing your best and serving others well. Or, if you don't manage your career especially well—if you passively float through your professional life—you'll work less fruitfully, earn substantially less, and retire later and with less financial security than you might prefer. The choice between these two divergent outcomes is *entirely* yours.

DOUST THOU LOVE
LIFE? THEN DO NOT
SQUANDER TIME,
FOR THAT IS THE
STUFF THAT LIFE IS
MADE OF.

Benjamin Franklin



Active Management to Reduce Career “Deathtraps”

“Doing” a career is not like doing cataract surgery. Unlike the plan you’ve been taught to craft stepwise for each of thousands of surgical cases, you’ve had no formal training and no logic tree to follow in navigating your career. And, of course, you only have a single career to get perfectly right the very first time you try. Thankfully, you have years and years to correct all the errors you will make along the way . . . and few mistakes are completely irreversible.

Today, the number of urban job offers has shrunk somewhat while the diversity of opportunity has exploded: small and large single-specialty group practices, multispecialty practices, corporate LASIK centers, staff-model HMOs, teaching positions, and VA hospitals and related government service. Most offers are solid enough, like the institutions behind them. But today, there’s a much higher percentage of career “deathtraps” than before. They include:

CONFIDENCE

IMPARTS A

WONDERFUL

INSPIRATION TO

ITS POSSESSOR.

John Milton


- Corporate centers too thinly capitalized to make payroll, much less market your services
- Practices with razor thin profit margins
- Institutional positions in highly politicized departments, where you'll spend as much time dodging the chairman's bullets as doing surgery
- Private practice opportunities, where you're promised the moon verbally but end up with pixie dust, no partnership, and little wage equity—until you leave, only to be replaced by the next naïve short-termmer
- Well-meaning practices that hire a partner-track associate before they have enough business to support this next surgeon

Be Conscious and Pay Attention

Average ophthalmologists—perhaps like average people—don't think very often or very deeply about their motivations to continue in practice or how well they're progressing in their work. Enlightened ophthalmologists think often about their progress. They figuratively hover above themselves in the course of a day, saying, "Nice catch," or "I guess you pretty much muffed that one . . . try harder next time." This internal self-coaching dialog is a common signpost of the most successful surgeons. They've replaced external drivers—favorite teachers and loving parents—with their own gentle, encouraging internal patter. If you're thinking consciously about your career and manage it actively, you'll come to realize that to be happy as an ophthalmologist, you must love one or more of these five main dimensions of this kind of work:

- The act of serving and helping each patient
- The experience of working as part of a complex, cohesive, changing team
- The intellectual and tactile stimulation of the service you provide
- The acclaim and social position medicine brings you
- The financial comforts and security medicine can generate

Of course, which of these you love best is a measure of your development and evolution as a person and your sense of security in the challenging private practice environment that lies ahead. To which of these motivations are you most attached? The signs that you are not managing your career well are simple to spot. Your sense of career satisfaction rises and falls in lockstep with your monthly income. You dread coming into work or returning to clinic after your lunch break, and you find every possible excuse to lighten your schedule. You wince more than a few times a week when you have to enter a room to serve a difficult patient. And at the end of the day, you're consistently happier that the day is over than you were in the morning when the day was starting.

Satisfaction is what's left when you compare your expectations with your perceived reality. Eye surgeons who enter medicine with low expectations and who then perceive that they gain much more than this are the happiest and most satisfied in the profession.

MEMORY IS
THE CABINET
OF IMAGINATION,
THE TREASURY
OF REASON,
THE REGISTRY
OF CONSCIENCE,
AND THE COUNSEL
OF THE CHAMBER
OF THOUGHT.

Saint Basil the Great



CHAPTER 13

SUCCESSION AND RETIREMENT PLANNING



*It is good to have an end to journey
toward but it is the journey
that matters, in the end.*

Ursula K. Le Guin

Planning in the Last Five Years of Practice

Today, even the most successful practices are vulnerable. Even if you now sit on a highly successful plateau, don't think you can bypass business and personal financial planning. You'll know this is accomplished when you have a written document that provides highly specific and informed answers to each of the following questions:

1. How much longer do I want to be practicing and at what intensity/productivity levels?
2. What are my earliest, latest, and most likely retirement dates?
3. What are my assumptions for inflation and passive income from investments?
4. Based on the current investment portfolio, and after accounting for divestiture of unneeded personal and business holdings (e.g., practice real property and equipment, adjoining unused vacation property, and vehicles) and asset appreciation between now and retirement, what will the investment portfolio be?
5. What sideline business (e.g., investing and part-time patient care), if any, do I plan to pursue in my retirement, and what cash flow will I expect from this business?
6. What will be our living costs at that point? How flexible and happy will my spouse and I be in adjusting these costs downward if our assumptions are incorrect? How long will we each live?
7. If we are not yet financially independent based on the above answers, when will we be independent based on current rates of net worth accrual, with and without any significant proceeds from eventual sale of the practice? With and without growth in the practice?
8. Are we are now (or are we nearly) independent—or bound for almost certain independence if we continue practice for X years at current levels, even if we are not able to sell the practice upon retirement? If so, the only possible motivations to develop the practice further are (a) the intrinsic pleasure of service, competition, growth, and development; (b) the desire to build an institution that lives beyond myself; (c) the fear that others will take our local franchise away from

GOOD PITCHING
WILL ALWAYS STOP
GOOD HITTING,
AND VICE VERSA.

Casey Stengel



us before we are ready to retire; or (d) the wish to have a practice to hand down to a child.

9. At endpoint, what will be our likely (and fallback) practice divestiture options? A young physician? A local practice? An emerging multispecialty clinic? An optical chain? A national or regional management firm? Will I want to sell and retire, or sell and enter an employment agreement with the purchaser?

It's Hard to Downshift to a Less Intense and Less Active Practice

Like most other service-sector businesses, a large portion of your practice expenses are fixed. You should therefore avoid the temptation to slow down unless you have the discipline to reduce practice costs in proportion to falling revenue. Even taking a half day off a week or a little extra vacation time can have a disproportionately large impact on your bottom line. If you do want to back off from clinical responsibilities, apply a little logic. Taking three-day weekends throughout the year will be potentially less damaging than adding several two-week vacations, even though the time off is exactly the same. If you live in the Snow Belt, closing your office down in January (when both Medicare deductibles and winter put a chill on patient volumes) will likely have less effect on your net income than four one-week vacations spread throughout the year. However you ultimately decide to back off your schedule, be sure to make simultaneous expense cuts and other changes in your practice. Furlough staff or reduce hours during blocks of time you are off . . . transition to a larger float pool of part-time employees to allow more flexible scheduling and to reduce benefits costs . . . rent your office out to subspecialists during down times . . . as you reduce your hours, increase your work intensity somewhat.

THERE ARE
YEARS THAT ASK
QUESTIONS, AND
THERE ARE YEARS
THAT ANSWER.

Zora Neale Hurston



Cashing Out and Retiring

I ask hundreds of surgeons each year what they would like to accomplish in the years ahead. The average mid-career or older surgeon typically declares: "I would like to work very hard for the next five years, become financially independent, and then *be in a position to retire*." The reality is

that the same surgeon will likely work for at least another 10 years or longer.

At least until the Great Recession came along, our American society had made retirement and the end of compensated work such a romantic concept. Most surgeons buy into this by their 30s and 40s, not really knowing what retirement might be like—highly ironic given the average age of their patients! The surgeons I know who have transitioned from working clients to retired friends tell a different story. Compared to the intellectual challenge and patient admiration of modern practice, retirement is, in many regards, a step back.

Most older surgeons of my acquaintance are by no means excited about the prospect of retirement. Even those who are financially rock solid still express some concerns that they don't know how they will react to giving up their professional life. Taking a sabbatical of several weeks or months can help resolve your questions. Despite the obvious high cost of being away from the office for this extended period, clarifying your future may be far more profitable than drifting along with unresolved conflicts about your goals. If after six weeks away from the practice you are full of exciting new business or clinical ideas and can't wait to get back, your business will be better off than if you never left. If the same six weeks confirms that you're burned out on medicine and are ready for the next stage of life, the clarification will be invaluable in helping you get on with it.

Contemporary Practice Valuation

Opinions on current and future ophthalmic practice values are widely divergent. Acquisitions by hospitals generally anchor the low mark. Hospitals often pay solely for the fair market value of capital equipment and provide sellers with the fleeting security of a few-year employment contract. Such transactions, for the moment, are now very rare—most institutions put ophthalmic practices on the bottom of their shopping lists. Physician-to-physician transactions still follow a decades-old (if now declining) familiar pattern of paying for facilities and equipment at fair market

THE PLEASANTEST
THINGS IN
THE WORLD
ARE PLEASANT
THOUGHTS; AND
THE GREAT ART
OF LIFE IS TO HAVE
AS MANY OF THEM
AS POSSIBLE.

Michel De Montaigne



HOW OLD WOULD
YOU BE, IF YOU
DIDN'T KNOW HOW
OLD YOU WERE?

Kobi Yamada



THERE IS NO WORSE
BITTERNESS THAN
TO REACH THE END
OF YOUR LIFE AND
REALIZE YOU HAVE
NOT LIVED.

M. Scott Peck



value, and between 10% and 50% one year’s profits as a goodwill payment . . . if goodwill is valued at all. Physician practice management companies (PPMCs) once offered in the 1990s valuations that represented as much as a 100% premium over physician-to-physician transactions. Such firms are now defunct, but have been replaced by private equity firms, most of which I believe will have the same destiny as the legacy PPMCs. Meanwhile, surgeons nearing retirement should be *highly* conservative in forecasting the value they will extract from their practice and, for purposes of personal financial planning, assume salvage value only.

Your 10-Year Countdown to Retirement

I’ve worked with some clients through the years—thankfully a minority—who have delayed retirement planning until the last possible moment. It got me to thinking about what the ideal countdown might be for a surgeon departing active practice. What timeline should the most thoughtful ophthalmologist observe?

Following is a list of activities, placed into a somewhat artificial year-by-year staging. Obviously, every situation is different, and you should not use this list as a substitute for personalized input from your attorneys, accountants, consultants, partners, coffee buddies, sympathetic colleagues, mental health counselors, senior managers, clergy, and whomever else you turn to for blunt advice on the nitty-gritty of life and work.

Let’s say you’re 50ish . . . the typical age at which eye surgeons start thinking seriously about retiring in a decade, or perhaps a little later. Force yourself to sit down, completely alone, for at least a couple of hours in a quiet place. Make a list of everything you have, everything you want, everything important you have experienced, and everything you would like to experience. What’s the bottom line? At 50 something, even with the most auspicious genes, you probably have little more than 30 years of sentient, physically active life left on this planet. And the clock is ticking.

The patients you see every few minutes of every working day are living validation that *you* have sauntered from

birth through youth, jogged to maturity, and may now be galloping onward toward senescence and oblivion. What would you really like to accomplish in those comparably few, fleeting years you have left? Write it all down. Formulate the first draft of a plan. Then, consider overlaying your plan on the following 10-year countdown to retirement. This countdown list is obviously incomplete and doesn't cover all the details. But I truly hope it serves you and the important people in your life as a starting template for more detailed planning. You should feel free to move some hallmarks up and down the calendar and to omit others altogether.

Year 1

Discuss with your spouse and family the life goals and retirement timeline you've written down. Discuss your goals with your business partners and your senior staff. When I suggest this, some clients blanch, thinking this will result in staff resignations: "What will happen when they know I'm approaching retirement?" Trust me. Early disclosure will not lead to any material staff defections. Instead, it will give the most important support people in your professional life the confidence that you are thinking way, way ahead. Also, if you've not been doing so every couple of years already, start meeting formally with your personal financial planner or accountant to verify that your retirement date is scheduled with a sufficient margin for error—*later* than the date when you will most assuredly be financially independent.

Year 2

Fine-tune and continue enjoying the practice you have right now. To the extent financially feasible, dismiss unpleasant patients and payers from your world . . . or at the very least send them down the hall to your junior associates. Remove the most galling and underperforming staff members. Arrange your schedule to fit your natural tempo (as well as the practice's economic realities), even if it means you have to dismiss the least economically viable patients to leave room for the ones you find more financially, socially, or intellectually satisfying.

ONE LIVES IN THE
HOPE OF BECOMING
A MEMORY

Antonio Porchia



THE ONLY
DIFFERENCE
BETWEEN A
TAX MAN AND
A TAXIDERMIST
IS THAT THE
TAXIDERMIST
LEAVES THE SKIN.

Mark Twain



Year 3

Physical fitness and personal health issues loom. Good dietary and exercise habits maintained from this point forward will determine your vitality not only in retirement, but in the last years of your career. You may be a better clinician and surgeon than ever, but face facts: If you're not exercising regularly, eating right, and getting enough sleep by the time you're in your mid-50s, you will start running out of gas for every afternoon clinic. If you have not planned well for retirement and find that you must now work involuntarily well into your 60s or 70s, you had better adopt a healthy lifestyle so you can keep the gears churning as long as necessary.

Year 4

Take another look at your personal financial plan. If you have little margin to play with as you compare your net worth with your lifestyle costs, now is the time to get your household budget in order. A visit with any competent financial planner will inevitably circle around to an examination of your personal budget. As tycoon James Rohn loved to quip, "If your outgo exceeds your income, your upkeep becomes your downfall." (Of course, for those of you reading this in your 30s and 40s, slight adjustments in your lifestyle costs today can accelerate the day when you are financially independent and can make decisions about how you work based on what you enjoy rather on what you must do.) Year four is also the time to noodle out a formal business plan that will help sell potential new associates on the viability of your organization. This does not have to be a 100-page nightmare to write but rather 10 clear pages outlining the practice's prospects and likely trajectory. If you're considering partial sale of ancillary ASC facilities to a corporate partner to reduce the purchase hurdle for new physicians, start negotiating now . . . they typically like to see the alpha doctor stay in place for at least five years after the transaction.

Year 5

If you're in a solo practice—or even a small group—it's important to start recruiting at least five years before you actually plan to withdraw. That gives you a couple of years

to flail around, find the right physician, and get him or her profitable enough to be able to afford to pay you for the practice. So start the recruitment process. Establish a formal internal search committee, and get on with the preliminary steps of writing the position description and draft contract terms, creating and placing the ads, sending out mailings, scanning various available databases of prospects, and vetting candidates. For strong practices with a fair offer in favorable markets, it may only take a few weeks or months to secure a pool of candidates and make a hire. It may take far more time—and even more luck—in less attractive settings.

Year 6

Make sure any new physicians added to your practice as part of a transition plan are becoming successful. Even before your new colleague arrived, you should have been front-loading his or her schedule. Unless you have a backlog of patients waiting, some of this volume will have to come from the schedule of existing providers, some will have to come from new promotional efforts, and the rest must be left to time. Unless your young physicians are super successful, they will be unwilling and unable to buy into the practice. In addition, nothing is more frustrating than having to dismiss a faltering associate and start all over again to find a new physician to replace you in the practice. Make sure that by now you have reached peak levels of operational and marketing improvements to enhance profitability . . . inasmuch as the practice's value paid back to you by a buyer may be related, in part, to annual profits. Also in year six, think through what you're going to do after retirement. If you've been the average ophthalmologist with few nonpractice interests and few friends outside ophthalmology, are you cultivating the resources you will need to stay happily occupied after you leave the work-a-day world? Whether it's golf or a second business interest, it may take real time to develop the skills needed to master your postretirement passions.

Year 7

If you are transitioning a young physician from associate to partner, complete the myriad housekeeping details and

WHEN AN OLD
PERSON DIES,
A LIBRARY
BURNS DOWN.

Old African Saying



start his or her buy-in. Even after a couple of years as an excellent employee, there can be surprises. You may have been hanging your succession plan on unspoken assumptions about what your young physician would be willing to pay for your practice. Until the deal's inked (and even for some time after this), nothing is final about your plans. That's why it is critical that in your personal financial plan, you build in the assumption that the value of your practice when you retire will be little more than the residual accounts receivable and the salvage value of the tangible equipment.

Year 8

Incrementally reduce the practice's dependence on you for day-to-day clinical and management contributions. Now is the time, after you have a management staff and successor junior physicians who are up to the task, to make sure you are actively delegating. If you have been the managing partner of the practice, pass the reins, or at least assign your heir apparent to special projects and committee assignments that will prepare him or her for leadership when you step down.

Year 9

If appropriate, transition from being a surgeon to a non-surgeon, and even transition from being an owner back to being an associate-employee if you are in a larger group setting. Since equity in many practices is doled out roughly pro rata to financial productivity (as it should), it may be perfectly fair and reasonable for you to volunteer to sell part or all your stake in the practice back to your partners as your production drops back. This will top up your retirement kitty, relieve you of further divestiture uncertainties, and give the next generation some comfort that you're truly willing to let go.

Year 10

This is the year you retire from active practice . . . or maybe it isn't. Hopefully you will make this transition from a great career to an even more alluring retirement. After all, it's a lot more fun pursuing a "go-to" plan rather than a

GROWING OLD
IS MANDATORY;
GROWING UP
IS OPTIONAL.

Chili Davis



“get-away-from” plan. All too many surgeons itch for years to get away from a practice they began to detest long ago, only to find that they have graduated to a vacuum with much time and little stimulation. That’s why more people—in and out of ophthalmology—are deciding that working at something you love for all your life and never really retiring may be a happier path. If you plan to durably keep your hand in, launch off now into your next stage of voluntary, part-time, or emeritus work.

Succession Planning in Your Group Practice

Until July 3, 1996, an eye surgeon I know, let’s call him “Dr. North,” was the undisputed leader of his nine-physician practice in a mid-sized suburban community. North Eyecare started as a solo practice 22 years earlier. Under Dr. North’s strong leadership, driven in turn by his 51% ownership stake, the practice had grown to be dominant in the region. With an introduction like this, you know what’s coming next. On July 3, Dr. North was diagnosed with prostate cancer, underwent surgery and chemotherapy, and was forced to retire within a year. After 63 years of great health and prodigious energy, this vigorous physician was suddenly disabled, as was his group practice. Dr. North’s exceedingly strong leadership style over the years resulted in two parallel management problems that, in the end, could not be overcome. First, Dr. North had attracted new physicians to his practice who had been his colleagues, but certainly not his peers when it came to future leadership potential. Dr. North chose physicians to join the practice who were perfectly comfortable working in his shadow. Any candidate with leadership skills was rejected as being “too pushy.” Second, these physicians were kept in the dark about the finances and day-to-day operations of the practice. Even the practice administrator had taken a back seat to Dr. North’s strong leadership style.

Here are tips to help you and your practice avoid the kind of abrupt succession difficulties that North Eyecare faced:

- Select a managing partner, and rotate the job among partners every few years, if possible.

A NEUROTIC IS
SOMEONE WHO
INSISTS THAT
LIFE BE OTHER
THAN IT IS.

Anonymous



I AM INDEED RICH,
SINCE MY INCOME
IS SUPERIOR TO
MY EXPENSE,
AND MY EXPENSE
IS EQUAL TO
MY WISHES.

Edward Gibbon



- If you don't rotate managing partners, be sure to at least groom a successor for this position . . . even if your practice has only two physician owners.
- Make sure your practice has clearly drafted rules for how decisions are made. Small decisions (on the order of a few hundred dollars in impact) are often delegated to staff. Medium-size decisions can be carried by a simple majority of the board (e.g., three out of five). Large decisions (such as selling the practice, assuming new debt, terminating a physician) should require a supermajority (e.g., four out of five partners). Nimble, resilient practices actively delegate decisions to junior partners, associates, and staff, which reduces the organization's dependency on any one person.
- Give every physician in the practice—both partners and associates, even if they aren't in line to be managing partners—business tasks to perform.
- Prepare a written succession plan that describes the current operational authority for the practice and how you would like that authority to transition when the lead partner steps down. In addition, a written strategic plan and a detailed practice operations manual will make any transition or crisis much smoother.
- Recruit and empower a strong lay manager. Once your practice has more than five ophthalmologists or is over \$5 million in annual collections, you may decide that you need a higher functioning manager who anchors the practice's administrative authority, rather than a physician. But remember that the best practices, large and small, are managed by a strong lead physician and a strong lay manager who work together closely.
- Last, *anticipate!* Even the most energetic managing partner will wind down one day, whether slowly as in most cases, or abruptly, as in the case of Dr. North. Anticipating the inevitable will allow you to create the best possible outcome.

Grooming Your Practice for a Sale

Whether you intend to take the traditional route of divesting to junior partners or to an established local colleague . . . or simply close the doors, the price and terms you get for your

practice will depend on several factors. Here are eight ideas to help you groom your practice for a future sale.

- *Know the price you need to get and by when you'll need that price.* Review your retirement plan with professional advisors to see how far you really are from your economic finish line. If you need to net another \$500,000 and place it into passive investments to retire comfortably, your selling situation is much different than if you already have the resources to walk away from active practice. A review of your situation vis-à-vis the realistic market value of your practice may indicate that you will be compelled to work for several more years before selling out. Another important dimension: Do you want to (or need to) work in the practice after the sale? Your answer will influence the value of the practice.
- *Remember that the terms are often more important than the price.* As you calculate the price you think the practice is worth, be willing to soften your demands in exchange for a clean deal (high down payment, short payout, or even all-cash via third-party financing). Whether the new owner of your practice is a former competitor or a junior associate, you may get paid only if the buyer remains solvent and runs your practice well.
- *Build a history of large and increasing profits.* Your practice's intangible value in any brokerage event will depend more on profitability than on any other single factor. You can't do much to improve profits if you are selling out in the next three months without advance planning. But if you plan to sell in three to five years, my experience is that even the most troubled practice in the most competitive environment can boost or at the very least stabilize profits.
- *Lock in the stability of the key people.* After the surgeon, the greatest value in your practice is other key support staff. Because they may be nervous about their careers and may disrupt the practice if they leave, do whatever is necessary to have your administrator and core technical and business staff be well-anchored to the practice. Obviously, don't create any post-sale obligations to weak staff who would actually devalue the practice in the buyer's eyes.

THE ONLY
DIFFERENCE
BETWEEN A RUT
AND A GRAVE IS
THE DEPTH.

Bill Baras



- *Build up the practice's key operations strengths, and attack and eliminate the practice's key weaknesses.* These strengths and weaknesses underlie your practice's profit gaps, which will in turn directly influence the practice's appraised value.
- *"Manualize" the practice.* Once you've examined the practice's operational strengths and weaknesses, commit the day-to-day details to writing in a comprehensive operations manual for the practice. This documentation will demonstrate to buyers that your operation is well run; it's like showing a file of maintenance receipts to the prospective buyer of your sports car.
- *In most cases, keep your sale plans as private as possible.* Once word is out in the community that your practice is for sale, patients may drift away (not understanding that there will be successor physicians). If you are the glue holding your key staff together, they, too, may defect . . . leading to a lower practice value. However, this rule about privacy has a corollary—as soon as word gets out, be sure to communicate your plans clearly, openly, and often to all affected parties.
- *Hire a professional intermediary to value the practice, help groom and package it, and handle the brokerage process.* Probably the most powerful factor in optimizing the value of your practice and minimizing the hassle factor and emotional drain is hiring a trusted advisor. This can be a traditional practice broker who only gets paid a percentage of the sale price or a fee-only attorney, accountant, or consultant.

Expert Retirement Advice from One of the Masters

In the past 40 years, I've probably met about 10,000 ophthalmologists. Some stick in your mind for their clinical brilliance or for the size of their practice. And of course, a few wild ones you can't forget because of one outrageous act or another. But I remember retired ophthalmologist John T. Weisel of Medford, Oregon, a long-ago client, best for his smile. When we worked together, John was one of those happy people whose natural, resting facial expression was a generous grin. And when he wound up and actually smiled at you, he could throw off more sunshine than a

tropical vacation. I called him a while back to see how his retirement was coming along. Here's what he said:

"Most ophthalmologists, including me back then, don't pay much attention to what anybody says, but I'll tell you what I know. Everything, at this stage of life, now that I'm retired, depends on your partner, your health, and your bank account. What was my ophthalmology career like? I gave it my best shot, and we had a good run at it. But you also look back now, and you think, 'Gosh, I spent an awful lot of time there in the office pursuing my career at the expense of not doing anything else.' I didn't develop a lot of other skills or hobbies because I didn't have time for it. As I look back, I had a lot of fun, and I met and served a lot of nice people. But I do regret that I spent so much of my life doing one thing. With this in mind, you should start thinking about retirement the day you start work. That's not too early. How are you going to balance work and the rest of your life? Are you making enough time for the things you want to do along the way?"

"How do you know when it's time to retire? You kind of know when you're ready to go. Nobody has to tap you on the shoulder. You're psychologically ready to go, and you're ready to exit. But I can tell you, at least from my experience, when I was ready to quit, I simply stopped thinking about ophthalmology. This really surprised me. It really did. You know, I still read a few periodicals, but I haven't kept up with friends in the profession. It was a pretty clean break. I tried working part-time for a couple of weeks, tried semi-retiring, and it simply didn't work out. And it was so hard to switch from being a surgeon to being a medical ophthalmologist.

"If I had it to do over again, I think I would have had a little different attitude, a different perspective. I certainly would have been more thoughtful in my last 10 years of practice to decide what I was going to do after retirement. Along the way, I would have cut down the length of my working day during that time. But in our group practice, we got into this competitive game. It's the nature of the beast. You've got the young guys nipping at your heels, which gives you two things, two feelings. One thing, it stimulates you, and

HE WHO
LAUGHS, LASTS.

Mary Poole



the other thing is it aggravates you. But you know, that's the way it ought to be. And so you can't be upset about it, but it does have a profound effect on you, the young ones are all smarter, and brighter, and hungrier.

"I can say that when I practiced in partnership with a colleague of my own generation (Dr. John Retzlaff), life was more comfortable than when the next generation joined the practice. This is not meant to criticize the younger physicians who joined the practice as individuals. Their arrival simply changed the practice dynamics from a collaborative to a more complex practice environment. These were the new guys fresh out of school with all that 'new' knowledge, and we were the old guys who were not as current. It is important for these young fresh physicians who join the practice to add new enthusiasm, vitality, and continuity as the senior members begin to taper off. The demands of today's medicine dictate group practice; the solo guy is becoming extinct.

"The retirement of older doctors has been felt in our local medical community. We lose the close relationship we had with our peers. New doctors move to town who never heard of me, and the dynamics slowly change. This is manifested in referral patterns and our own personal medical needs. Looking back at the last few years of working, surgical complications, even the minor ones, became extremely stressful. 'Was it my fault? Could I have done better?' That sort of thing. Earlier, I had these same complications, but they were part of the game. You did your best and life went on. Especially in the last three or four years, any major complication was demoralizing. You approached each operation possibly with a little less confidence, even though you may still be at the top of your game. As you move toward retirement, you attract a lot of your personal friends, colleagues, and VIPs as surgical patients, so the stakes go up. Some of these were also difficult cases. You want desperately for every one of them to have a perfect result. Perhaps you also have more empathy at that stage of life.

"It wasn't that hard for me to quit. I was ready. I was tired of all the hassles, of the daily grind. I needed something to change and brighten my life. Still, looking back, it would

have been wise to schedule longer time away, quiet time, sabbaticals, to break the stress. Instead of the ‘carnival horse that hears the sound of the music,’ we keep hammering at the office. Long weekends are nothing. Two-week vacations are nothing.

“In the later years, you have earned the right to manage your own time. Make the deal up front with younger partners; that is the way it is going to be. Senior law partners seem to have more clout in this regard than senior physicians.

“The state of your marriage or partner is most critical for your retirement. If your spouse is comfortable and happy with you at home, it makes a big difference. On the other hand, some people in relationships were not meant to spend all that time together. (For better or worse, but not for lunch.) Dee Ann and I are fortunate. We both retired at the same time. We enjoy our family, our dogs, and our free time, and we do things together. We’re both totally committed to a healthy, low-stress lifestyle, moderation, exercise, diet. We have always been health nuts, but after retirement we went into high gear. There is now more time to work out.

“On the financial side, we have a professional investment management firm handle our assets. I thought that following the market would be fun and challenging. Quickly it became just a chore. Anyhow, the financial world is too complex for an amateur to be a prudent investor. You have to live on retirement assets the rest of your life. A good estate attorney, accountant, and investment team gives you the comfort and confidence to devote your time to other pleasures.

“I don’t ‘doctor’ anymore. I’m not ‘Dr. Weisel’ (unless making an appointment for my own care). I’m John Weisel now. All things considered, it was easy to make that transition. You’ll see when you get there.

“Our style of retirement is not for everybody. You certainly wear a different hat, not the doctor one, in every respect. You find that out in a hurry. Would I ever want to return

IT IS VERY DIFFICULT
TO SLOW DOWN.
THE PRACTICE OF
MEDICINE IS LIKE
THE HEART MUSCLE’S
CONTRACTION—IT’S
ALL OR NONE.

Bela Shick



to practice? Nope. Did I enjoy my ophthalmology career? You bet."

Sage Advice from the Oldest Worker in America

A few years ago, engineer Milton Garland, who had worked for the same employer for 78 years, was the oldest employee in America. At 102 years young, Garland told a news conference at the National Press Club, "I love the work I'm doing. My advice is to go into something and stay with it until you like it. You can't like it until you obtain expertise in that work. And once you are an expert, it's a pleasure. And once you like what you do, you don't want to quit doing it." Asked where he would be if he had retired with his peers 37 years earlier, Garland didn't hesitate. "I'd be in my grave."

Afterword

Why Medicine Costs So Much . . . and Should

There's an old, old tale still circulating about Morris-the-loudmouth-mechanic.

THE NATURAL
DESIRE OF
GOOD MEN IS
KNOWLEDGE.

Leonardo da Vinci



Morris was removing the cylinder heads from the motor of a car when he spotted the famous heart surgeon Dr. Michael DeBakey, who was standing off to the side, waiting for the service manager to come take a look at his Mercedes.

Morris shouted across the garage, "Hey, DeBakey! Is dat you? Come on ova' here a minute."

The famous surgeon, somewhat surprised, walked over to where Morris the mechanic was working on the car. Morris straightened up, wiped his hands on a rag, and asked argumentatively, "So Mr. Fancy Doctor, look at dis here work. Like you, I also open hearts, take valves out, grind 'em, put in new parts, and when I finish this baby will purr like a kitten. So how come you get da big bucks, when you an' me is doing basically da same work?"

Dr. DeBakey leaned over and whispered to Morris, "Try doing it with the engine running."

Postscript

Breathe Deeply. Enjoy the Ride.

A young ophthalmologist, on a much-deserved break from his patients, was jogging along a beach in Southern California, watching the sunset and fretting about his business. Looking ahead a few yards, he saw something small and shiny sticking up from the sand. He picked it up and saw that it was an ancient lamp. Remembering the story of Aladdin, he started to rub the lamp. With a “Whoosh!” out came the proverbial Genie, who stretched mightily, then pointed his finger at the eye surgeon saying, “For releasing me from the curse of that lamp, I will grant you one wish.”

The ophthalmologist, happy to be in California, but really wishing he were in Hawaii, said, “Genie, I have always wanted to go to Hawaii, but I am afraid of flying. I would like you to build a bridge from here to Honolulu so I can drive there.”

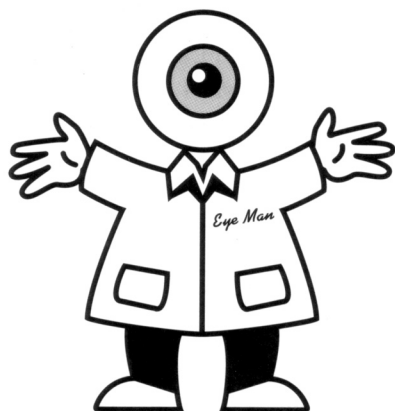
The Genie stroked his chin and frowned. “I am sorry, Master, but the ocean is too deep, the distance is too far. Even I, the all-powerful Genie, cannot possibly build such a bridge.”

The ophthalmologist, returning to thoughts of his practice, then told the Genie, “Very well. I understand. I only have one other wish. I just want to know, absolutely, positively, and with complete certainty that everything will be okay with my practice for the rest of my career.”

Whereupon, the Genie replied, “So, Master . . . would you like that bridge to be two lanes or four?”

* * *

The Moral of the Story: Although your nature as a surgeon compels you to know and control the future, this is impossible. More than 40 years of prowling the halls of science and medicine have taught me that despite Medicare cuts, managed care encroachments, and competition, chances are great that you and your practice will more or less thrive. Try as hard as you can to fight your basic instinct to be anxious every waking hour. Breathe deeply. Enjoy the ride.



APPENDIX 1

THE OPHTHALMIC PERSONALITY

*How to Harness the Strengths
and Overcome the Handicaps
of Being (or Working for)
Some of the Brightest Humans
on the Planet*

BY JOHN B. PINTO AND
CRAIG N. PISO, PHD

Introduction

For more than 40 years, I've ostensibly been a practice business advisor. But beyond the graphs and spreadsheets, I've been a keen student of the ophthalmic personality and really as much a "happiness" consultant as a business guru. What role does a surgeon's personality have on his or her business success? If we dare generalize, what are the roots of the typical ophthalmologist's personality? Most importantly, what are the drivers of happiness and career satisfaction for the ophthalmic surgeon?

A decade ago, with the very kind assistance and support of Drs. Herve Byron, John Corboy, and others, I started formally exploring the hallmarks of the ophthalmic personality. That work has continued ever since, deeply informing my consulting work and writings.

I am now joined in this arena by Dr. Craig Piso, a psychologist with broad experience advising high-level professionals and their organizations, with whom I share material experience with mutual clients. What follows below is a digest of our current thinking. Over the *next* ten years, we hope—through survey research now just getting under way—to start to objectify our impressions and provide ever-more-practical support for the profession.

Whether you're an eye surgeon, employed in an ophthalmic workplace, or the spouse of an ophthalmologist, we think you'll resonate with the insights we'd like to share with you below.

John Pinto

J. Pinto & Associates, Inc.

* * *

It's fitting that this series of articles on personality and happiness should start with an old quote from an even older and dearer pal: "My parents always held out to me how nice it would be if I did better, if I got better grades. And so I always thought I should win. If you're going to play, you may as well try to win, right?"

So said Dr. John Corboy, still famous in ophthalmic circles for building one of the earliest and largest ophthalmic empires in America, based in Hawaii . . . and for being a master of the business as well as the science of eye care. (And of late, for launching a brand new international eye meeting in the Far East.)

Corboy continues . . . "I learned that we may as well be as perfect as we can be or as perfect as we can make it, or what are we doing? To me it's incomprehensible to do less than the best that you can possibly do. Be as perfect as you can be, as your staff can be, as your practice can be. Always look for better."

His comments dovetail with what our clients told us anonymously:

"I must not have 'made it' yet because I'm still working too hard and I'm still not happy."

- Translation—"My work is not a source of joy or fulfillment in my life . . . it's certainly a way to generate the wealth that I expected would lead to a happier future life, but somehow haven't found yet."

"I'm really frustrated that people around here don't do what they're supposed to do."

- Translation—"Since I'm the brightest, best educated, medically skillful, and highest paid person here, everyone should respect me and do things my way. Which is, of course, the best."

"I'll be happy when I've saved up just \$2 million more, then I can slow back down and enjoy the 'good life.'"

- Translation—"I know in my heart of hearts that I could never make enough money to be fully satisfied or fulfilled, but this addictive, compulsive striving seems to keep me energized between bouts of depression, burn-out, irritability, and exhaustion."

"It's almost impossible to find competent, quality employees."

- Translation—"I'm such a perfectionist that no one (including me) can meet the unrealistically high standards that I set for myself."

"I can't understand why people make things so complicated and why it takes so long to get things done."

- Translation—"Everything should be as simple and straightforward as the surgeries I perform—logical, timely, predictable. Everyone throughout the company should behave more like I do. Then I wouldn't have to waste so much time dealing with 'people problems'!"

* * *

The Costs of Perfection

And so it goes. The result of perfectionism is wonderful for patients, and even pretty great from the perspective of most eye doctors. But taken to even slight extremes, the behaviors that create the outward hallmarks of the “ophthalmic personality” can lead to stressed staff, abused patients, and at least emotionally abandoned families.

Dr. Scott Diener, a former southern California psychologist now living and working in New Zealand, has worked with high-intensity surgeons. He has developed several educated theories about the makeup of upper-crust doctors that are in accord with our own field observations.

“What’s the difference between highly trained, highly stressed, and highly compensated surgeons and the general public?” Diener asks. “If you look overall at their history, they have dissociated from some of the normal dynamics in human life. If you go through medical school, a rigorous training where you have no life of your own for a very long time, there is really just one focus . . . and necessarily so. You don’t make it unless this is your total focus.

“I think this training, this focus, ends up acting as a filter so that only certain kinds of personalities come through. And probably the overriding personality characteristic would be narcissism. Now this is *not necessarily* the disorder in psychology that we formally call a personality disorder (which is, incidentally, far more common in males than in females.) But it’s a kind of light dose of a personality that will not accept criticism, that is highly perfectionistic, that really sees a world that revolves around ‘me’ rather than around others.

“And that’s not to take away some of the humanitarian qualities, but there is that ability to partially or completely dissociate. If you think about it, this *has* to be there to be a surgeon, especially an eye surgeon. You need it to be able to walk into any situation, and be effective. So I think that fundamentally there is this filter process that the medical community, and especially surgical specialists, go through that selects this kind of personality.”

Ophthalmology is perhaps one of the more rigorous filters, which is why some of these behaviors are more pronounced in eye surgeons.

* * *

*"Happiness is an imaginary condition,
formerly often attributed by the living
to the dead, now usually attributed
by adults to children, and by
children to adults."*

Dr. Thomas Szasz, U.S. Psychiatrist

The Dynamics of Perfectionism

Perfectionism is a driver of both personal and interpersonal unhappiness. For ophthalmic surgeons, perfectionism is a prerequisite for precise microsurgical excellence. Interpersonally, however, this leads to intolerance of the perceived failings they find in most others, especially among their nonphysician colleagues, as well as intolerance of the imperfection they eventually recognize within themselves.

The cognitive style of a perfectionist tends to be one that skews perception toward seeing everything as being black and white, all or none, and pass-fail with no middle ground or tolerance for ambiguity and grayness. Given that most office activities outside of the operating room are typically unpredictable and, therefore, more difficult to control, many ophthalmologists become impatient and critical toward what they perceive to be undisciplined, lower functioning workers who can't seem to do things "right"—a dangerous vibe to be projecting toward others in any venue—usually generating resentment and/or feelings of incompetence among staff.

The impossibly high expectations some ophthalmologists impose upon themselves is, at the same time, a source of addictive pleasure and emotional drainage, at least over the long haul. This is because surgeons do, in fact, demonstrate rare skills and talents almost daily, for which they are rewarded both tangibly (i.e., high earning power) and

intangibly (i.e., formal and informal authority, attention, praise, and followership by most fellow workers.)

There is an addictive aspect of such high performance and the accompanying reward cycle in terms of pleasure and tension reduction through performing. Additionally, many staff will find themselves unwittingly enabling the ophthalmologist's addictive and driving behavior, thereby reinforcing it and making it harder for him or her to slow down or to break free without experiencing emotional "withdrawal."

On the flip side of this pleasure-seeking, addictive cycle, which seems on the surface to bolster the actor's self-esteem, many ophthalmologists embody an all-too-willing inner self-critic that will abuse the doctor for even the slightest perceived weakness or flaw. Similarly, the affected physician will lash out at anyone who is judged to be less than stellar. This is an unconscious process of defending the integrity of one's own ego by finding a safer place to express what would otherwise be self-directed aggression (i.e., a defense mechanism known as "projective identification.")

Some over-controlled ophthalmologists seethe quietly in reaction to any "lesser" people they encounter, either stewing indefinitely or exploding one day as if it came out of nowhere. A seemingly out-of-nowhere explosion can precipitate a management or morale crisis in the practice because it is so out of character.

Eye surgeons who repeat this cycle of over-controlled seething followed by episodic uncontrolled outbursts can precipitate sanctions by their colleagues or institutions. In other practice settings, especially solo or small-groups, when this cyclic dysfunction is acted out, the culture of the practice becomes acclimated to and thus accommodating of this aberrant behavior, thereby making it almost impossible for others to feel safe with this physician, which cascades to high turnover, reinforcing the provider's frustration about an imperfect practice environment.

At the risk of attributing unpleasant characteristics to a small number of dear clients and physician friends, whom we in all other respects admire, we now understand that

perfectionism can be a fairly effective means of masking an underlying sense of inadequacy or other ego defects. Hard, perfectionist work performed to compensate for such ego defects, especially when these efforts are so highly rewarded by the modern medico-economic system we operate in, can easily evolve into “workaholism.”

The perfectionist’s striving to inflate his or her ego often produces painful, conflict-engendering interactions with others, including

- 1) a compulsive need to “win” at another’s expense, rather than seeking win-win relationships;
- 2) a preoccupation with self aggrandizement, rather than being altruistic or other-directed with genuine humility;
- 3) an inordinate need for control of others and situations, rather than empowering others and liberating the work environment.

* * *

Early Roots

Diener continues, “You have to keep in mind that this (in most cases) mild dose of narcissism is a long-term personality characteristic, something we can probably trace into early childhood. There is typically a decided influence, most often in the form of parents who are pushing for the child to succeed. I would again like to emphasize that this is not a ‘disorder,’ but a personality that has many positives, favorable factors that a mildly narcissistic person would not necessarily want to change.

“If this personality goes a little too far, however—and this is obviously found in some surgeons—what we find is a really disruptive, life-long pattern with relationships. We’ll see lots of ups and downs with relationships—marriages, friends, staff . . . lots of staff turnover. In most cases, the personality pattern of surgeons is not a disorder but a *trait*, allowing these doctors to function in an extremely demanding world. A full dose may be debilitating . . . but a half dose is invaluable.

"Clearly these highly filtered and screened professionals have highly charged, very emotional relationships. A characteristic I see is a kind of roller coaster fluctuation of feelings about a person, let's say an office assistant." Apparently, depending on which day you ask, a surgeon might think a medical assistant is either a super star or a lunkhead. There's no middle ground."

Diener says it's important to stress the positives of the ophthalmic personality. Patients probably prefer to have someone who is holding a blade to their eye to be a commanding personality. They want someone who's decisive, who can be demanding of themselves and others. You need someone who is saying to him or herself, even when a little out of touch with reality, "I'm the best and I'm in charge."

*"Happiness makes up in height
what it lacks in length."*

Robert Frost

More Nurture than Nature?

Diener says, "Interestingly, as women have come into the marketplace and become more 'professionalised' we have seen a lot more of these adaptive, narcissistic traits in women. Some of the highest functioning members of society seem to learn the skill of narcissism, and fortunately most pick up a half dose without over-learning the skill. I really do believe that narcissism is more a matter of nurture than nature. I don't think we'll ever find a gene for the trait."

Is there something truly different about ophthalmologists? According to ophthalmologist Dr. John Corboy, "You can err and be overly general because there are exceptions to all of this, but many of the people who find themselves in ophthalmology are very precise, very compulsive, because our field is one where you can measure everything. Your refractive error, your visual field, everything. In fact, it's often been said, 'If we can't measure it, you don't have it.' We like to play games late in our residency where we invite the patient in and we say to them, 'Don't tell me your chief complaint. I'm going to examine you and tell you what's

bothering you.’ The reason for this sort of audacity is that we think that everything can be measured. Perhaps ophthalmologists are the kind of people who lean toward that. Of course my father was an ophthalmologist, so of course I didn’t come to it because of any innate traits of my *own*, mind you, but because of *his* odd personality!

“I’m a neat-freak. I pick up all the time today because my mama used to say, ‘Pick up!’ all the time. That kind of attention to details pays off in our field. Ophthalmology is nothing if not infinitely precise. Your patient is rewarded for your compulsiveness and attention to detail. We’re talking microns, whether you zig or zag.”

The Value of Humility

Dr. Corboy continues: “At the same time, my mother gave me a great dose of reality. No matter what I achieved, my mother was quick to say, ‘Get off your high horse, mister.’ That echoed throughout my upbringing. I always felt that although I might be a god at the office, I was still just a person at home. The fact that the employees and patients worshipped me had no connection at home. My family didn’t give a hoot for that. They judged me for being home on time, being a pleasant dinner companion, being a good father who tucks the kids in at night. I never felt a hero at home. Everyone should have that humbling factor in their life, whether it comes from their mama or elsewhere. At the very least we as ophthalmologists should realize that we’re all standing on the shoulders of the giants in eye care who preceded us, and that very few of us are really anything all that special.”

What should a staff member or fellow doctor do when working with an eye surgeon who has perhaps too large a dose of the narcissistic trait? According to Diener, “Probably the most important thing has to do with how you go about challenging the individual and their authority. This is where you find the most abrasiveness and reactivity, when you challenge surgeons on any level. Fellow workers need to develop strategies that are supportive of the authority rather than challenging of the authority.

"If we go back to the example of dealing with doctors who run hot and cold on their feelings about the performance of a staff member, we'll hear them say, 'Our head tech, Susan, has to go!' The best way to deal with this overreaction, to get off of the roller coaster, is to first get focused on some of the positive things, and to second not directly challenge the surgeon's authority."

As an administrator or department head in a practice, be sure to investigate first, and challenge second. Centering on fundamental office rules or principles such as "patients come first" can help. Even the most brittle surgeons will ultimately succumb if they are gently assailed with the facts.

The Isolation of Living a Level Above

"Here's another point," says Diener. "It's a matter of carefully structuring the relationships between the surgeon and staff. It really is true that familiarity breeds contempt. The kind of office setting where everyone hugs and loves each other sounds wonderful, and it's something that doctors often try to sponsor to replace other unmet needs in their lives, but with this kind of personality such an environment is not long-lasting. Inevitably, if you look at the typical highly-strung surgeon's relationship style, you're going to have clashes . . . the teeter totter of over-valuation and devaluation. It can be very cyclic. So it often works best if you can set up the kind office where the staff are very bonded to each other, and have a good time together, but the doctors are at a level above. This is a reasonable structure."

Note that for many doctors, being above the team and aloof is very painful and isolating; they want to be part of the team that's having fun together.

"I've worked as a psychologist with a lot of high-level professional patients who perhaps have a larger measure of this narcissistic trait, up to levels of a frank disorder, and it's very lonely. They understand, 'Something is different about me. Why can't I keep these relationships? Everyone else seems to be able to keep these relationships . . . mine seen to go blasting off into outer space.'"

What should such doctors do? The answer may be at once frustrating and surprising. These high-demand doctors, in the main, are not in some way ill or in need of therapy or treatment, *per se*, unless as a surgeon they want to accomplish an improvement. First and foremost there has to be recognition among such doctors and their senior staff that these traits are helpful at some levels. If you eliminated these traits completely, the surgeon would lose critical talents at other levels . . . the decisiveness, the impulse to act. Staffers, spouses—even we consultants—simply have to recognize it. As for the highly strung surgeons themselves, it's important to accept the kind of personality they have, and acknowledge that it's largely okay.

Practice growth and development, from a small one-doctor practice to a very large group, presents challenges for the typical ophthalmic personality, but also interesting benefits. "Growth can often be very positive," says Diener. "The surgical personality does well with the command structure. It's very validating of the desired authority. The chief problem that can occur is that doctors find themselves doing what they had not quite intended, that is, having to manage a different mix and a much larger scale of resources. With a small office practice, the enterprise is very focused. With growth, there are competing demands."

Managing partners in such practices can draw on their natural ability and desire to command. But if that desire and ability is not present, doctors can find themselves the king of an unintended kingdom. You need to make sure that you don't work hard to get something that you really didn't want. We can vouch from the field that doctors who have built extremely large practices often question the scale to which they have grown.

Personality Co-Factors

What other personality traits come along with narcissism? "Anxiety is probably the most common," says Diener. "Other associated personality characteristics can include passive aggressiveness. The result can be the covert destruction of what has been built up, as by not attending to the details associated with a larger practice."

Perfectionism and the desire for control is a sword cutting two ways. In the transition from a small practice to a larger practice, there is an inevitable shift from direct doctor-owner control to control through subordinates. This results in less than perfection, which is difficult for most surgeons to witness in silence. Diener says, “I would set a larger practice up so that doctors with a strong tendency toward perfectionism don’t have to be exposed to the imperfections than attend growth.”

We’re talking about a personality that survives—and I would even go so far as to say thrives and has made it to the pinnacle—with perfectionism. It’s asking too much to change it. We do, however, need to isolate and let the managers manage. Exposure to all the normal little messes of running an ophthalmic practice can be extremely uncomfortable. If, as a surgeon, you’re reactive to these messes, stay out of the kitchen. Don’t purposely expose yourself to the most disturbing details.

However, this doesn’t mean that the doctors should be in the dark about the management facts and data of the business’s performance. Diener illustrates, “An old maxim of psychology is to go with the resistance. If we have a patient who likes to hoard towels, we fill their room with towels. Likewise, overwhelm the doctor with details, flood them. This can lead to a doctor who feels in control and happy.”

Surgical and Management Skills Differ

Surgeons are at some levels highly refined craftsmen. They’ve been filtered to be craftsmen. They’ve not been filtered to be managers, which is an entirely different skill set. They’re especially not conditioned to have their authority challenged. As one doctor we spoke with put it, “The most pressing thing is to not challenge me. That doesn’t mean accept all of my decisions silently. We need to simply work out new strategies for discussion to come up about issues. How we discuss is more important than what we discuss. I’m always going to want to make decisions. Bring me the facts and data. Let’s talk. Most important, don’t come to me and say, ‘You’ve got to do this or else.’ Come at me like that and you’re just setting up a scenario where I will show *you* the ‘or else,’ along with the door!”

Absolute contingencies don't work well. Try to select staff for your practice who are able to communicate at this level and are bright enough to understand this personality type. I don't mean that any staff member or spouse should ever tolerate frank abuse from a doctor, but you will help to deflect potential abuse by learning to communicate in a functional way. The doctors you work with need to develop trust and to know that decisions delegated to staff will be made with as much clarity as they would personally apply.

No matter what your frustrations are as a manager or other employee of an over-wound surgeon, being starkly confrontational in such settings does not work. You will lose every time, and ultimately you will be out of the practice. As a staff member, ideally you should choose to work for a surgeon whose judgment and position of authority you can respect. But even if this isn't the case, constant confrontation and struggles for control will work against you. At the other extreme, being a sniveling, sycophantic staff member means the talents of the whole team won't get used, only the talents and the judgment of one doctor at the top. It's a very delicate balance, obviously, between the extremes of head-butting confrontation and demurring.

Coping Skills

How can you cope if you find yourself in a practice with one or more surgeons who display behavioral extremes? First, it helps simply to be aware that surgeons are highly intelligent, and at least on some interior levels, very compassionate people who want to excel across a number of dimensions—financial, professional, and often, too, in their nonclinical passions and hobbies. So even with the narcissistic overlay, these are people who can deal with just about anything the world can throw at them. Most are highly sophisticated and highly competent—and highly confident. At some levels the world has to line up behind these individuals rather than the other way around.

It also helps to stand in the surgeon's shoes and understand that the medical business environment is very different, and far more stressful, than most businesses. If a toy company makes a defective toy that chokes a child, the

CEO doesn't get indicted. The responsibility is distributed throughout the company. For a doctor, reputation, personal assets, license, and the ability to pursue a career are on the line. Every day. At some levels, perhaps, anything less than at least a mild narcissist personality could not survive. Laid back folks just don't become eye surgeons.

Warning Signs

Diener describes three hallmarks that represent a dividing line between highly functioning, actually helpful, narcissistic traits and traits that are disabling. As a surgeon, ask yourself the following questions:

Do I see a pattern in my life of disrupted relationships?

Am I making decisions, such as staffing decisions, based on *feelings* about the staff rather than *objective information* about current and potential performance?

Am I mad at my head tech because she stood up to me and challenged me, or because her root performance is flawed?

"Don't get rid of the strength of narcissism that the filtering and conditioning of your surgical training has allowed," Diener says, "but temper your decisions and behaviors so you act in a way that is fact-based rather than emotionally based." This whole approach should feel appealing and comfortable to most surgeons, who after all are scientifically, objectively grounded. You can be the way you are, be highly functioning (and with this a little over-bearing.) It will all work out just fine so long as you understand that these traits can get you into trouble with the people in your life.

The paradox is that what puts a surgeon professionally on top, at the pinnacle, causes trouble in his or her relationships. On top of all the talents you've mastered as a surgeon, and all of the other nonclinical talents you possess, you *also* need to be able to buffer your overly judgmental and perfectionist tendencies when you interact with the world of mere mortals. The red flag should go up when you find you are making decisions based on emotions (positive

or negative) about a person, particularly staff. Develop an additional talent to let go and trust them to do their jobs. The average ophthalmic surgeon probably needs to be insulated from the details that annoy and distract. Make management decisions based on performance, not based on whether you like or dislike somebody. As one surgeon put it, "Every day I have to resist the temptation to slip into my old pattern of overvaluation and then devaluation."

By the same token, while avoiding rash personnel cuts based on feelings alone, don't keep staff who aren't performing simply because they stroke you and make you feel good. Always go back to the objective of performance.

"Happiness is always a by-product. It is probably a matter of temperament, and for anything I know it may be glandular. But it is not something that can be demanded from life, and if you are not happy you had better stop worrying about it and see what treasures you can pluck from your own brand of unhappiness."

Robertson Davies
Canadian Novelist

A Common Pattern: Compensating for Early Insecurities

(Perpetually) semi-retired ophthalmologist Dr. Herve Byron has long lectured and written on the personal challenges of being an eye surgeon. In his long career, he has become one of the most respected voices in the national community on this topic. He generously described a few years ago how his own path and early motivations still have much in common with those of his colleagues today.

"When I was five years old, I was a sickly kid, a kid with chronic ear infections, in an era without antibiotics. The treatment was mastoidectomy, a massive operation with a 30% mortality rate. My father was a physician, and he and the other doctors on the case thought a transfusion would help. My uncles were screened, and one was a match. I can

still visualize to this moment lying on adjacent beds in our living room, with this tube sticking into me. Suddenly the tubing broke, and there's blood squirting all over the walls . . . not a very security-engendering experience for a five-year-old. I was also a fat kid. In the public school you were supposed to climb the rope. I simply couldn't. My upper body was too weak. We had to jump over the horses in gym—forget it! This was my pattern. I went to the music class and everyone started to sing. The teacher came over to me and said, 'Herve, mouth the words but don't sing, your voice is terrible.'

"As I now see myself so clearly in hindsight, throughout my educational and then my professional, adult life, I was still this sickly, fat kid who couldn't perform in the gym and couldn't even sing! I've had to keep showing people that I have some value. So in high school I drove myself to being second in a class of 1800 students.

"Today, people ask me, 'Why are you still doing this, Herve? Why are you still striving?' Until a few years ago when I finally started developing some insights into what makes me tick, I really couldn't answer them. The anxiety about striving is long gone. Now it's just a matter of having fun. But for the first 25 years or more of my career I was compelled by those early, difficult experiences to show I had something to contribute.

"I've been through a lot of therapy and have talked to a lot of our colleagues, and the insight I've gained is that ophthalmologists are highly susceptible to depression. We're tightly wound. We have a great ability to use denial. We don't have great support systems. We have lots of quick relationships with patients—and we don't really get involved with them. If and when things fall apart in our lives, they go downhill rapidly.

Depression and Ophthalmology

"When I look out over an audience of ophthalmologists today, about 80% of them look depressed. No emotion. No reaction. Nothing. The tragedy and the danger is they

have no idea that they are depressed. Denial keeps us from getting help, unless we have a support system in place. There are a number of well-documented screens for this depression. Do you have trouble sleeping? Have you lost an interest in eating. Are there difficulties in your sexual life? Difficulty with relationships? Can you perform over eight hours in your office the way you used to? Can you make decisions clearly? Do you find you're withdrawing, not wanting to talk to people? Once I was medicated for my own depression, I could eat and sleep better, I could think and operate better. I wasn't going through anxiety crises every day."

"We're all so focused, and our obsessing, compulsing tendencies lead us to ophthalmology. When I was at the height of my surgical career I couldn't wait to get into the operating room. I couldn't wait to operate on difficult one-eyed patients, because I could walk up to the table with supreme confidence. It was a challenge I know I could handle."

Of course, all the striving in the world cannot overcome the inevitable transition from being a surgeon to being a non-surgeon, which can be terribly painful for doctors whose sense of self is so interwoven with their surgical acumen."

Byron continues: "At 62 or 63 years old, I found that some of the post-op results of some of the younger docs I was working with were better than mine. For a while I was striving to reach to the next level, but the bar had been raised so high. My neck was killing me, my back was killing me. I really was hurting myself physically to keep up. I decided it was time to quit, which was a very difficult decision to make. What else would be left? The trick is to find solace in the conversion from digital to cerebral skills.

"The even greater difficulty is making the transition from being a doctor to being retired. You must transition your skills into something that will give you satisfaction and add value to others and give you a compensatory sense of worth."

When making any transition . . . from your training to entering practice, from being an associate to becoming a partner, from surgical to nonsurgical and on into your retirement from medicine, get in touch with your *values* at each of these points. “After a lot of life,” Byron says, “you realize that time is irreplaceable. Take the time to enjoy whatever it is that you enjoy. You have to be flexible. You have to check over and over to make sure that when you are in transition, the new direction you’re taking is right for you.

“Next, you have to stop denying. Eye surgeons have got to be the best deniers in the world. In the face of total disaster, we’ll say, ‘Everything is great.’ We have to get in touch with our feelings. I’ve come to learn that every time my gut will make a better decision than my brain. If you are a man and have a spouse with good instincts, that’s a priceless asset. My dear wife Bryn can smell a bad decision or someone who’s faking it from a mile away.”

Male vs. Female Surgeons

Byron reports, “This leads me to what I think is the significant personality difference between male and female eye surgeons. They’re driven by different factors, I think. If I were many years younger and looking for an associate for my practice, I would choose a woman. They communicate better, they’re more driven in ways that I think males are often not when it comes to patient communication and care.

“Women are more pragmatic, realistic, intuitive, with far less denial than males. Male physician pilots have the highest incident of accident mortality. Female physician pilots have almost no accident mortality. It’s because women listen. When the tower says, “Come back,” they follow directions.

“Ophthalmologists need to know where their strengths and deficits are. It’s not enough just to be bright and creative anymore. You have to know how to find and motivate people who can sweat the details. I urge surgeons I speak with to be at peace with the reality of change.” You need to

be compliant to what's happening in the world of medicine today—that world is more powerful than you are.

“Also, communication is critical. If you're going to have people tolerate working with you, you've got to communicate. If you're interviewing a doctor to join your practice, look *first* to communication skills. It goes both ways; if you are a lay person in an ophthalmologist's life you have to become a good communicator. My advice is to know your doctor well enough that you can communicate without a confrontation. And most importantly, timing is essential. Don't confront at the end of the day when you're both exhausted. There should be a set time on a regular basis to do this.”

Soliciting Staff Feedback

Consulting in settings with poor communication has taught us it's helpful as surgeons to give colleagues, staff, spouse and even friends permission to give us feedback. If you're comfortable with this, ask them to be bolder than they might otherwise be. If you're the kind of surgeon who can invite openness, surround yourself with people who can give you intelligent feedback. If you're less willing to have blunt feedback, which is more commonly the case, select just one trusted member of your staff to be a private, on-site coach who can praise your positive personality traits and gently remind you to adjust traits and behaviors that can lower staff morale.

Here's another major theme we've uncovered in ophthalmic circles. Eye surgeons spend the first third of their lives being, by and large, exceptional when compared to everyone else around them. They are the best in grammar and high school, among the brightest in college, the achievers in medical school. Then reality hits for the newly-minted ophthalmologist, now living in a universe of about 15,000 other overachieving American eye surgeons: “Hey. I'm no longer the smartest or most talented person in my world. I'm just an average eye doctor.” Some doctors I know have a profound difficulty handicapping themselves against the members of a rarified world and being comfortable with an average ranking.

Dr. Corboy has some helpful perspectives on this. “The only thing that was acceptable to me is to be as good as I can be, because only then can I accept whatever results come for the patient. The guilt that would attend not being as perfect as I possibly can be is unacceptable. In the past I’ve had to get to bed on time, take a strict diet on surgery day, just because I had to, you know, just because every now and then you’ll have an unfortunate result, and at least I could say I was as good as I could be. There are some docs who obviously take that to the next extreme and say, ‘Well, what I’ve just done for this patient isn’t the best in the world that can be done.’ And they get very bent out of shape because of that. You have to let go of that and instead think, ‘Yes, there is a guy in Boston or Zurich who can actually do slightly better than me, but this patient can’t go to Boston or Zurich, and I *am* the best this patient is going to get.’ There’s always someone who’s better, taller, smarter, richer. You just have to let go of that. You get peace with that over time. And for some sub-specialty areas, such as retina, you never get peace with it, so that’s why we refer out the difficult cases. The whole goal is to take the best possible care of the patient.

“Well we all know people who have gone too far, who lost their family, or for that matter their sanity being overly perfectionistic with their practice. It’s probably healthy to want to be the best doctor in town. It’s probably unhealthy to want to be the best doctor on the planet. You can get too overwhelmed by perfection. You have to find a wholesome level of discipline, and then be gentle with yourself. You have to do the best you can and then let go.”

Generating Authentic Happiness

Here are a few prescriptions for any reader, but for ophthalmologists, in particular:

- Find an Appropriate Work-Life Balance . . . Just as a triangular stool must have three sturdy legs of equal length to support our weight, all of us need to create and maintain a healthy balance in order not to topple personally or professionally. We must constantly strive to equally prioritize career success, personal health, and

relationships with family and friends outside of work. It takes conscious effort to avoid becoming a workaholic. The more enlightened, proactive ophthalmologist recognizes the competing forces that make for conflict and is especially cognizant of the lure that “just a little bit more income” is a black hole of temptation whose gravitational pull can be irresistible and all-enveloping.

- **Seek Out Opportunities for Altruism and Service to Others . . .** It’s well established that healthy generosity and unselfish service to others are keys to greater life satisfaction. It must, however, be authentic and genuine, not merely role-played in order to gain something in the form of clinical research results or community recognition. Concretely, this means demonstrating genuine interest and compassion for others, combined with unconditional, nonpossessive sharing of one’s time, energy, and resources. For ophthalmologists, altruistic behavior can be shown daily within the office in numerous ways, such as mentoring less experienced staff, spending time “off the clock” to listen to another’s concerns, or donating services to the needy in the community. You don’t have to travel to the Third World to be a humanitarian.
- **Appreciation, Contentment, and Focus . . .** The happiest people you are likely to meet are those who focus on a glass that is “half full” and experience a deep appreciation for what they have. They make it a habit to recognize how fortunate they are relative to what could be, thereby becoming increasingly content with the positive equity in life that they find within it day-to-day. In sharp contrast, the people who bemoan what they lack tend to suffer varying degrees of misery, jealousy, resentment, and emptiness. This is more acute for individuals who see themselves as victimized by powerful external forces, over which they feel little or no control (for example, the current “economy”). Remember to “count your blessings” regularly to elevate your quality of life and emotional well-being. What you focus on tends to expand, so be selective about your focus and the lens through which you view your life.
- **Mindfulness and Presence . . .** An antidote to compulsive striving toward an idealized future is to become more mindful in each present moment, which, by the way,

is the only time that life is actually lived. Become more attuned to each moment and the opportunity within it as an end unto itself, rather than viewing time and the stuff that fills it as mere stepping stones toward some better future. This may require a shift of values—what you deem to be important. Instead of clinging to any perfectionist ideals and longings, outside the walls of the operating suite, learn to “go with the flow.” Embrace your own humanity with greater patience and compassion, which will naturally enable you to become more patient and compassionate toward others and their human frailties. Instead of working so hard to get somewhere, try to be where you are each moment.

Summing Up

Overachieving. Perfectionistic. Intolerant. Workaholic. Striving. Controlling. Being the absolute best. These undeniable ophthalmologist personality traits are admirable and completely essential when examined through the eyes of the patient about to undergo surgery. These same traits, carried to extremes or untempered by a dose of humility and self-effacement, can be profoundly galling to the rest of the people who orbit every surgeon’s life. And ultimately to surgeons themselves.

Perhaps one day in the distant future we will have a simple, painless test that will categorize ophthalmologists by various personality types. Perhaps we’ll invent an elaborate serum that can be slipped to the most abrasive doctors, without robbing them of the rarified talent so often found in greatest measure among the most difficult individuals.

Until that day, it will fall to those of us who have chosen to serve patients by serving our doctors to do the best we can with what we’ve got. And on the toughest days to simply say, as one might hear a long-suffering parent sigh about his or her mischievous children, “Bless their hearts, they can’t help themselves.”

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APPENDIX 2

STRATEGIC RESOURCE ASSESSMENT

HOW TO FIND WHAT'S MISSING FROM YOUR PRACTICE

Here's an easy test you can take to measure your practice's available resources and those needed for improvement. This exercise, done individually or as a group, will get you thinking about the critical bottlenecks in the practice.

Score each item on this 20-point list based on the following scale:

- 5 = We have 100% or more of this resource present in our practice; no more is needed for success.
 - 4 = We have *nearly* enough of this resource, but could use just a little more.
 - 3 = We barely have enough of this resource in our practice to survive in the future.
 - 2 = We have a little less of this resource than we need; this could eventually harm the practice.
 - 1 = We have a profound lack of this resource in our practice, and its absence will be fatal soon.
-
- 1. ____ Physician-owner boldness and willingness to take reasonable business risks
 - 2. ____ Physician-owner restraint and ability to avoid unnecessary business risks

3. ____ Physician-owner cohesion and teamwork among themselves
4. ____ Physician-owner leadership skills—the ability to set fair policies and inspire staff
5. ____ A business plan (even if brief and informal) describing the practice's realistic goals
6. ____ The discipline to stick to the business plan, and not be distracted by side issues and opportunities
7. ____ Management's operational abilities—the ability to turn policies into smooth daily functions
8. ____ Staff performance standards that are appropriate . . . not too high or low
9. ____ An adequate physical facility for current and anticipated operations
10. ____ Written protocols—an operations manual, policy manual, position descriptions, etc.
11. ____ Knowledge of our local marketplace, competitors, trends, etc., and proper management of external relationships (e.g., hospitals, referral sources)
12. ____ The proper team of external advisors (e.g. accountants, attorneys, consultants)
13. ____ An appropriate computer/information system that can be scaled up with the practice's future growth
14. ____ Marketing efforts, internally and externally, that fit with our growth and service-mix goals
15. ____ Knowledge of our economic facts and figures with appropriate accounting standards and reports
16. ____ Staff recruitment, training, and supervision protocols
17. ____ Staff number, skill level, and productivity (are we over-, under-, or "right-staffed?")
18. ____ Staff morale and willingness to follow the practice's leaders into the future
19. ____ Access to appropriate levels of capital, either borrowed externally or from ongoing operations
20. ____ A favorable reputation among our patients and in the wider community

Now add up your personal score (and the average group score if you're doing this as a group exercise). With 20 different resources, and with up to five points each, there's a maximum score of 100. Let's call this number the "Practice

Resource Score.” There is no objective scale that compares your practice to others, but this summary score can be a valuable internal reference of the practice’s fitness and ability to face the future.

Next, prioritize and estimate the dollar cost of the top three *needed* resources. Note that these are not necessarily the line items with the lowest scores, but those that *are most needed in your practice* at this time. Discuss the practicality, timing, and logistics of securing these three most critical resources. If one or all of these key missing resources can be feasibly secured, put down in writing a deadline for each item and the person responsible.

Some practice owners will chronically—and perplexingly—starve certain critical departments of the resources they need to function. For example, by lacking just one part-time staff member or a computer software upgrade, a practice’s billing department will struggle along, getting further behind each month, and miss out forever on some claims as the submission period lapses. Does anything akin to this happen in your practice, or are available resources spread appropriately based on each department’s and project’s needs?

Is there a significant gap between the practice’s needs and potential resource? Why have the needed people, capital, or expertise not been applied in this practice? Is management neglectful? Is there simply no money available? Is a lack of decisiveness holding everything up? Or have resource gaps simply not been recognized until now?

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APPENDIX 3

SCORING THE QUALITY OF YOUR *LIFE*

Chances are, the eye surgeons who are most drawn to this book on the business side of ophthalmology are competitive and financially driven. It's for precisely this reason I'd like you to consider the *quality* of your life, both in and out of the practice. Are there other, perhaps more important dimensions of success that your quest for practice financial success is edging out? This is a question I ask rather often in my consulting practice. A client's business project, which nearly always starts out as an economic evaluation, can end up being as much about global career or lifestyle management issues as about the narrow realm of financial management.

It seems obvious that intelligent surgeons would consciously seek what they perceive at any one moment to be a high quality of life. But at a preconscious level, the scale for measuring "quality" is more often drawn in units of dollars collected, profits kept, or cases performed. Surgeons with modest practices but loving families and admiring patients too often express to me a heavy regret at their disappointing careers. When we talk further, they overlook their global success and ask, "Yes, but who is doing the most cases in town? Who has the greatest market share? Whose stock portfolio is the most sizzling? Who takes the most exotic vacations?"

Every surgeon knows about quality and can distinguish a quality surgical case from a poor one. A quality diagnosis from the slipshod. A finely honed Swiss instrument from a back-alley knock-off. But few surgeons can identify the features of a truly quality life—*and then commit to living it.*

The most sentient surgeons I've known through the years, and certainly the happiest irrespective of their economic success, have developed their own metric of success and life quality. I've listed some of these for you below. And since this is a column about numbers, it's in the form of a scorecard measured with a maximum 100-point score. Give yourself from one to five points on the following scale:

- 1 = There is a nearly complete deficit of this in my life.
- 2 = I am significantly behind in this area . . . I could certainly use more.
- 3 = I have *just barely* enough of this in my life.
- 4 = I have a little more of this than most . . . but more would be nice.
- 5 = I have so much of this, I could easily share my excess with others.

- 1. ____ A loving relationship with a spouse or significant other, with an equal mix of durable passion, mutual interests, and a common history to reflect on with pride
- 2. ____ A deep knowledge that I have been an outstanding parent to my children
- 3. ____ A successful transition to an adult-to-adult relationship with my parents who are living, and a sense of appropriate closure with parents who have passed away
- 4. ____ Numerous friendships, deeper than mere acquaintances, in and out of my professional sphere
- 5. ____ The confidence that comes from expertise and accomplishment in my professional field
- 6. ____ A correspondingly deep expertise in at least one personal pastime or hobby
- 7. ____ An understanding of the inner operating workings of my practice in sufficient detail that I'm not held hostage to the unique knowledge of any one critical staff member

8. ____ The absence of professional jealousies or competitive battles that would make it uncomfortable for me to attend a local physicians meeting . . . my competition is “friendly”
9. ____ The incomparable good feeling that emerges from serving others voluntarily (as by mission trips, pro bono clinics, and the like)
10. ____ An opportunity to mentor one or more members of my staff and watch them grow
11. ____ The admiration and respect of professional peers whose judgment I respect
12. ____ An ample supply of relationships and outreach activities (with payers, doctors, patients, direct-to-consumer marketing, etc.) in the community that will continue to predictably feed patients to the practice . . . we’re free of worry about where our next patient will come from
13. ____ A fit, nimble body, somewhat younger than its actual age
14. ____ A sense that my mind is bold enough and my hands dexterous enough to master the latest surgical maneuvers
15. ____ Enough self-esteem to realize I won’t be devastated on that *inevitable* future day when my eroding manual skills demand I stop performing surgery
16. ____ A sense that I am still mentally sharp and that I haven’t lost my edge intellectually . . . indeed, a perception that my lifetime of learning is cumulative and I’m keener each passing year
17. ____ An inner, personal peace about the real purpose of life and enough time to contemplate and practice this in a form meaningful to me (as by religious or other practice)
18. ____ An up-to-date understanding of our personal financial condition, and the sense that we are slightly ahead of our expectations for this stage of life
19. ____ The habit of living consistently *below* our means so that any future wobble in the practice will have no material impact on our personal lifestyle
20. ____ A deep-seated perception of financial independence . . . drawn not so much from what has been

saved aside, but from an inner confidence of how great my earning capacity is, when compared to what little we actually need

* * *

What's your total score? How does it compare with the score you would give yourself in purely financial or surgical volume terms? Are you a high-volume surgeon with a high-grade economic lifestyle but a low-quality *life*? What are you going to do about that? Picking just one or two of the 20 dimensions above to work on may help you mesh your exceedingly successful business with a comparably successful life.

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APPENDIX 4

IS OUR PRACTICE GOING TO BE OKAY?

A (Relatively) Simple Practice Performance and Viability Index

Despite the lull in capitated contracting in much of the country, the slightly increased allowable fees for cognitive services, and the general boost in volumes, every eye surgeon today is (or should be) asking the same question: "Are we still going to be okay in the future? Will our practice survive?" Wouldn't it be nice to have a litmus test to answer that question?

Clearly, survival for every practice, in every setting, will be multifactorial. No single adverse factor today, such as working in a market overcrowded with providers, will necessarily spell disaster in the years ahead. Strengths in one area can offset weaknesses. The practice with a weak external marketing program can still thrive if internal marketing is handled well. The high-overhead practice can survive if patient volumes are sustained.

But the questions still loom from most surgeons I meet: "Are we doing OK?" and "Will we survive?" In response, I've worked up a coarse screening formula for general ophthalmology practices.

Just four simple, objective factors can be used as a gross screen of ophthalmic practice performance and to predict future practice viability as competition increases, fees fall, and utilization is restricted. These four factors, with the acronym SMPL, added together, may help you benchmark your general ophthalmology practice's global position:

S = *Your **Service** area's population-to-provider ratio*, expressed as the number of thousands of people per active eye surgeon. Divide the total current population of your service area (this may be a few city blocks in Manhattan or a 100-mile radius rural region) by the total number of practicing ophthalmologists. Then divide by 1000. The resulting number will likely be a figure between four and 75. (For example, Denver has about 8000 people per practicing eye surgeon . . . rural Mississippi has 50,000.) Locations with more potential patients and fewer competing physicians are favored.

M = *Your practice's average profit **Margin***. Divide the average monthly profit (after all operating expenses, including staff, rent, etc., but before MD/OD salary or pension and depreciation) by the average monthly collections. The resulting number will likely be in the range of 15% (in practices with low profits due to collection problems or excess debt) to 70% (in rural practices with high surgical volumes and very low overhead). Higher profit margins provide a cushion as fees erode. Use the whole number in the practice index formula on the next page (e.g., 15 or 70, not 0.15 or 0.70).

P = *Your practice's average per-doctor **Productivity***, expressed as the average collections per doctor-equivalent per month, in *thousands*. Divide the average *total* practice (clinic, ASC, optical) monthly collections by the number of "doctor-equivalents" (a full-time surgical ophthalmologist is one full equivalent; a medical ophthalmologist or optometrist is one-half of one equivalent). The resulting number will typically be in the range of 25 to 125.

L = Your practice's **Length** of operations. This is the number of years your practice has been in business, up to a maximum of 20 years

Pinto's Practice Performance and Viability Index = $S + M + P + L$
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Here's an example. A solo surgeon works with one full-time optometrist in her eight-year-old practice. The practice has a profit margin of 40%. The practice has \$81,000 in average monthly collections and serves a regional population of 396,000 with 21 other competing ophthalmologists. S is $396,000/22$, or 18,000, divided by 1000 = 18. M is 40. P is $81,000/1.5$, or 54,000, divided by 1000 = 54. L is 8. The Performance/Viability Index of this practice is: $18 + 40 + 54 + 8 = 120$.

Based on a wide variety of practices, and my evaluation of their potential for future success, here is the scoring range:

Low/Unfavorable under 110
Mid-Range/Acceptable 110 to 160
High/Favorable over 160

Please note that this screening formula is applicable to general ophthalmology practices and is somewhat less valuable when applied to pure subspecialty practices. In such settings, individual elements of performance (e.g., gross profitability, support staff labor productivity, profit per provider-hour, subspecialty market share) can be more useful benchmarks.

Rather than a one-time indicator of practice viability, you may find it helpful to periodically measure your performance/viability index to see whether your score is

improving. You may prefer to adjust the formula to better fit your own practice setting. Like an Apgar score for newborn infants or a capsized screening formula for offshore sailing vessels, this performance/viability index, or a customized variation of it, may be another useful way to ensure you and your colleagues can affirm: "We're going to make it just fine!"

* * *

I'd like to acknowledge and thank Dr. Herve Byron of New Jersey and Jay Slagle, CPA, administrator of Midwest Eye Care in Omaha, along with numerous other friends and clients, for their kind feedback and assistance in the development of this elementary practice screening formula. I would enjoy hearing from readers about how well this formula serves your practice, along with suggestions for improvement.

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APPENDIX 5

HERVE BYRON'S PRACTICE EVALUATION: A PATIENT'S CHECKLIST

Rating Formula

Every "yes" answer to the below questions adds one point to the total.

- 21 to 24 points = Excellent experience
- 16 to 20 points = Good experience
- 11 to 15 points = Average experience
- 6 to 10 points = Poor experience
- 0 to 5 points = Unacceptable experience

Initial Contact

1. Was the telephone answered by a human voice within four rings?
2. Was the receptionist polite, helpful, and knowledgeable?
3. Was an appointment made at a time and date convenient to you?
4. Were you instructed about what insurance information and medical data to bring with you at the time of your office visit?
5. Were you informed about the fees and what you will be expected to pay for this initial visit?

Initial Visit

1. Were you greeted promptly and with courtesy upon your entrance to the office?
2. Were you promptly given medical and insurance forms to complete?
3. Was the waiting room clean, well-appointed, and comfortable, with individual seats?
4. Were the magazines current, and were medically informative brochures available to take home?
5. Was your preexamination workup started within 15 minutes after you completed filling out the forms given to you at the front desk when you arrived?

Preexamination Workup

1. Was the staff friendly, compassionate, and professional in their performance?
2. Did they explain the purpose of the various tests?
3. Were the sites of the tests clean and orderly?
4. Was your privacy respected at all times?

The Physician Experience

1. Did your physician review your file and then ask you questions about the reason for your visit?
2. Did the physician perform a careful, thorough examination?
3. Was the time with your physician without phone interruptions or intrusion by the staff, and did your physician fully discuss the answers to your questions?
4. Was the prescribed treatment fully explained to you, with possible other options described?
5. Did your physician make you feel comfortable enough to trust his or her judgment and advice?

Checkout Experience

1. Were you personally escorted to the checkout desk and promptly helped by a staff member in a dignified manner?
2. Were you asked to pay what was mentioned in your initial phone call, and were you given a choice of payment options?
3. Did the checkout person volunteer to submit your insurance forms?

4. Were you given the prescriptions ordered by your physician and told how to use them?
5. Were you told when to return and given an appointment or told when you would receive a reminder card in the mail?

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APPENDIX 6

MAKING BETTER PRACTICE MANAGEMENT DECISIONS

DECISION: noun / a conclusion or resolution reached after consideration.

The New Oxford Dictionary of English

In ophthalmology practices large and small, hundreds of decisions are made each week. Even in the largest practices, most of these decisions are made by just one person, backed by years of clinical or clerical experience: "Should I work this patient into the schedule today or have him or her come in the morning?" "Is it time to operate?" "How should we code this visit?"

Only a few decisions are not made individually. These decisions, made by two or more people acting together, usually involve questions with bigger stakes: "Should we open a new satellite?" "Should we fire Dr. Edwards?" "Should we accept this new low-fee insurance plan?" Such decisions often involve matters of standing policy: "Should we allow patients to pick up their glasses without paying in full?" "Should we comanage cataract surgery with optometrists?"

Whether individually or as a group, we make so many decisions that we rarely stop to think about the *process* of decision making.

Obviously, making a decision is just the middle third of the three-part process of management:

Gather Information → Make Decision → Take Action

Inevitably, every manager (whether a surgeon-manager or a lay-manager) is stronger at one or more of these three steps and weaker at others. We all know managers who make decisions without enough information or who make excellent decisions without acting on them. Few physician groups get into internal struggles over the information they gather to make decisions, or even over how agreed actions are executed. Arguments are most often over what constitutes the *right decision*.

Remember that there is a great deal of ambiguity inherent in most practice management decisions. You can't always send the matter out for a quick lab study and write the proven prescription. It's rarely even possible to gather all the information needed to make a theoretically perfect decision. If you have a partner who keeps pushing for more data or more decision-making time, remind that partner that in most cases, the adverse consequences of an imperfect management solution are usually preferable to the consequences of a postponed decision.

Besides, the best decisions you make in your group practice are not all calculated and rational. There's a strong case for intuition, especially for those forks in the road where either choice you make is likely to be objectively satisfactory. Canadian philosopher Paul Thagard points out two key advantages to intuitive decision making: "One obvious advantage is speed: an emotional reaction can be immediate and lead directly to a decision. If your choice is between chocolate and vanilla ice cream, it would be pointless to spend a lot of time and effort deliberating about the relative advantages of the two flavors." Another advantage is that basing your decisions on emotions helps to ensure that you're taking into account what you really care about and are most likely to implement. "Decisions based on emotional intuitions lead directly to action; the positive feeling toward an option will motivate you to carry it out."

Decisions in your practice should be categorized and sorted by their economic impact. As a practical matter, most small economic decisions (on the order of a few dollars) can be made by *anyone* in the practice. The next tier of decisions, let's say those off-budget items costing up to around \$100 (more or less depending on the judgment of the individuals involved) can be made by department heads. Decisions on new expenditures in the $\pm$ \$500 range can certainly be made by your practice's manager or any thoughtful associate physician . . . if you don't trust them to make decisions like this, they're in the wrong position or your practice is on the ropes financially. Partners should be able to make off-budget decisions in $\pm$ \$5000 range (subject to retrospective review by the board, of course). This level of spending authority might be double or more for your practice's managing partner. Within the boundaries established by your annual budget, department heads, administrators, and managing partners will appropriately have actual financial authority much higher than these figures.

Now for the bigger issues. How do the highest-functioning partners make decisions? To start, they have formal—and frequently reviewed—partner or shareholder agreements that set down the rules for making decisions. These agreements, subject to input from legal counsel, should include the following:

- *Frequency of meetings.* Partner meetings should occur at least monthly, with the office manager or administrator present, concurrent with a review of financial and volume performance; it may be useful to hold a second monthly meeting for the physicians to concentrate on clinical quality assurance and protocols. A retreat or similar one- to three-day offsite meeting should be held annually to refine the practice's strategic plan, approve the next year's budget, and affirm tactical priorities for the coming year. Ideally, this meeting will be moderated by your administrator or an outside advisor.
- *Election of a managing partner.* Even in a two-partner practice, it's extremely enabling to name one person as the formal, managing partner in the practice. My preference is for the term to last two or more years and for this to be a position compensated with an honorarium.

- *Apportionment of control.* Will the practice give one vote to every partner, or in situations with different ownership percentages, will voting be proportional to ownership?
- *Simple majority decisions.* Whatever your group decides is a “small-” to “medium-” sized decision can be decided by a simple majority (e.g., three out of five votes). It is highly disabling in all but the most gentle settings for decisions to require 100% consensus; the simple adoption of majority and supermajority approval can lead to breakthroughs in making practice decisions and moving forward as an effective organization.
- *Supermajority decisions.* Some major decisions, such as removal/admission of a partner, deserve a supermajority (e.g., four out of five votes)
- *Entrepreneurial “safety valve.”* You may have one partner who by age, nature, or subspecialty training is more eager than his or her colleagues to buy new equipment, develop satellites, or launch new marketing campaigns. Rather than having such risk-takers leave the practice, you should, on a case-by-case basis, allow them to be “intrapreneurs.” As a simple example, a physician desiring a new \$500,000 laser that her colleagues are unwilling to buy might personally purchase this unit and lease it back to the practice at fair market rates. If she’s correct in her judgment, she gains and her partners are not exposed to the risk. The same arrangement can be made with facilities or staff.
- *Tie-breaking arbitration.* In practices with a potential for tied partner votes, especially two-partner practices, it would be appropriate to specify a tie-breaking mechanism, such as arbitration by an outside expert.

Here are 10 simple questions that can help you make better decisions, whether your practice is large or small:

1. *Are decisions being made at the right level by the right people?* Don’t waste time by letting what should be a clerk’s or a physician’s individual decision get bogged down in a committee. Beyond broad policy, there’s little need to involve physicians with the minutia of office management, such as how the phones are answered. Similarly, save clinical decision-making sessions for

the physicians and allied health professionals in the practice. The competent group practice administrator should have the last call on who needs to attend what meetings.

2. *Are decisions being made in the correct forum? Do you really have to meet to decide on which three lens designs are going to be stocked in the new ASC, or can you simply have the surgeons check off a ballot?*
3. *Is a decision we're about to approve ethical and legal?*
4. *Does a decision we're about to approve maintain the dignity of those affected?*
5. *Have the individuals likely to be affected by our decision been engaged in the decision-making process?*
6. *Will our decision increase profitability without reducing quality, or increase quality without decreasing profit?*
7. *Will our decision maintain or create new options rather than limit the practice's options?*
8. *Does our decision enhance our relationships with critical stakeholders: patients, payers, staff, hospitals and other institutions, venders, lenders, and fellow physicians?*
9. *When there are two equally acceptable options, are we moving ahead and making a decision, or are we allowing a "tie" to stalemate the practice's progress? If you're in a meeting and stuck in discussion, force a vote—even a nonbinding vote—to see how people line up. Or you can pass the decision to a committee for a recommendation. Don't let your meetings bog down.*
10. *Whenever we make a decision that forms the basis for a new clinical or business policy, is it memorialized in writing, communicated to all relevant staff, and followed up on periodically to ensure uniform compliance and continued relevancy?*

Some of the least frustrated physicians in America, those with solo practices, can hold their board meetings while shaving or applying make-up in the bathroom mirror each morning. For these physicians, decisions can be a rapid-fire amalgam of obsession, whim, and folly . . . and the practice can quickly recover from almost any error because so few people are involved. Decisions are ultimately more rational in a larger group practice . . . but much, much slower. For the largest practices, those with annual collections

exceeding \$20 million, the consequences of business errors are so magnified that it becomes prudent to insure decisions and hedge against error with outside board members. Whatever the scale of your practice, the decisions you make today about the *process* of decision making will determine your future success as ophthalmology undergoes what's shaping up to be a few tumultuous years.

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APPENDIX 7

LEADERSHIP SKILLS ASSESSMENT FOR LAY MANAGERS AND PROVIDERS

What follows are two simple tools to help lay leaders and surgeons raise their consciousness, celebrate their strengths, and pry into their weakest areas. Applied with a healthy dose of honesty, these self-tests lead to real improvements. A generation ago, superior lay practice leaders were not as vital to business success as they are today. The tempo and complexities of modern practice have accelerated beyond the command of the average eye surgeon who is still pursuing full-time patient care. Among managers, this hectic, high-stakes environment calls for more training, more oversight, more trust, and more—sometimes painful—personal insight into their strengths and weaknesses.

Part 1: Leadership Scorecard for Lay Managers

No lay manager I've ever met has a 360-degree skills set. True financial wizards commonly cast a not-so-great spell over staff relationships. Marketing geniuses don't often look so smart when implementing their terrific ideas. Administrators who are clinical perfectionists do not always have a flawless understanding of their practice's cash flow.

The following instrument can help you spot and fill the holes in your personal portfolio and your management team. Some attributes may be less applicable to your practice, and you can probably think of additional skills that

are important in your unique setting. Feel free to augment and customize this scorecard to make it more useful, and consider performing this assessment again from time to time to measure your progress.

Instructions

Your fellow managers in ophthalmology identified the following 20 attributes as characteristic of leaders in this unique setting. Rate your strengths and weaknesses on this scorecard to ascertain your strengths and the areas in which you may need improvement. Score each item on the following scale, in which 20 is the highest score:

- 5 = I have a very large measure of this attribute; no more is needed for real success.
- 4 = I have *nearly* enough of this attribute for success, but I could use just a little more.
- 3 = I have enough of this attribute to just barely get by as a leader in my practice.
- 2 = I have a lot less of this attribute than I feel I need.
- 1 = I profoundly lack this attribute.

[Important note: *If the managers in your practice are especially shy or insecure . . . or if the physicians are particularly predatory . . . allow people to take this assessment privately and share the results in a “safe” environment.*]

-
- 1. ____ *Direct job knowledge.* I could step in and perform the work I supervise.
 - 2. ____ *Delegation.* I’m good at knowing when and who to go to with a project.
 - 3. ____ *Action oriented.* I plow through my tasks and don’t procrastinate.
 - 4. ____ *Grace under pressure.* I am calm and clear in the face of confusion.
 - 5. ____ *Accountability.* I complete on time the jobs I promise on behalf of my department.
 - 6. ____ *Communication.* I am a better than average communicator; I listen especially well.
 - 7. ____ *Discipline.* I work every day to uphold the operational standards of the practice.

8. ____ *Tough love.* When it's called for, I am tough with the people I manage.
9. ____ *Fairness.* I am very tough, but I am also extremely fair.
10. ____ *Openness.* I am open to new ideas from my staff, and I encourage their suggestions.
11. ____ *Forgiveness.* I never hold a grudge for any error a member of my staff makes.
12. ____ *Adaptability.* I love change and embrace every opportunity to alter our protocols to improve.
13. ____ *Organization.* I am able to work well with many loose projects in the air at the same time.
14. ____ *Guardianship.* I see myself as a protector of the organization, patients, staff, and physicians.
15. ____ *Mentoring.* I have a lot of patience and a knack for passing along my knowledge.
16. ____ *Team playing.* I balance being a leader of my departmental team with being a member of the larger team called the "practice."
17. ____ *Sacrifice.* I am open to early and late hours, open to criticism, and open to the adverse consequences of making the occasional poor management decision.
18. ____ *Maturity and respect.* I publicly respect the decisions of the physicians and administrator, even when I may privately disagree.
19. ____ *Humility.* I readily admit my mistakes and work to correct them.
20. ____ *Personal energy reserves.* I consistently have abundant energy to get me through the week.

Total Score: _____

* * *

Now add up your score. With 20 different attributes worth up to five points each, the maximum score is 100. Although there is no objective scale you can use to compare yourself to others, this summary score can be a valuable personal baseline of your fitness to manage and help you identify areas in which you can improve. If your score is in the 50s or 60s, don't be too hard on yourself. Some of the sharpest managers are their own worst critics. It's interesting to have

a person you trust and respect fill out the same survey *about you* and then compare the two scores.

What comes next? Consider focusing on two or three areas for improvement at a time. In your own words, write down your commitment:

"I will work on my recently reduced sense of guardianship over our practice. My attachment to our practice has fallen recently after seeing that despite my best efforts, we keep slipping backward. I feel this happens because the physicians are unwilling to change and adopt the recommendations of our managers and advisors. Rather than resigning our practice to mediocrity and just giving up or quitting, I'll redouble my personal efforts and enlist the help of our most progressive partner to get the rest of my physicians willing to accept change."

It helps if you have a trusted peer in or out of your practice, professional help, or even a spouse who can give you feedback on how you're progressing. Over time, making small efforts to take care of the areas needing the most help will lead to a greater sense of control over the destiny of both your career and your physician's practice.

* * *

Part 2: Leadership Scorecard for Providers

Ophthalmologists often find themselves—sometimes abruptly—leading scores of people and multimillion enterprises without having any formal coursework in leadership and without the ordinary, incremental tutoring that leaders in most other business sectors get throughout their careers. Some physician-leaders don't particularly enjoy the mantle of authority that comes with owning part or all of a practice. Even those who like being boss sometimes lead quite poorly because they, themselves, have never been well led or have served as a protégé to a great leader. Few eye surgeons have the patience or time to become a formal student of good leadership. But given the increasingly provocative and heated-up environment, everyone leading others, in practices large and small, has the responsibility, each day, to polish their supervisory skills.

There are many reasons to become a better physician-manager. Being a good leader makes you a better judge of good leadership in others, so you'll pick better administrators and department heads. Being an engaged leader makes you less dependent on the comings and goings of the lay leaders in your practice. Great leaders gather to themselves great workers, staff who will pull hard and be satisfied with lower compensation just to be led by a thoughtful, rational, and inspiring individual. Given the expected trajectory of medical-economic change in the years ahead, good leadership may be needed for practice survival through the balance of this decade and the next. An increasing number of clinics are at a tipping point between success and failure, with the leadership skills of the senior partners making all the difference in whether the practice succeeds.

Instructions

Below is a list of 50 attributes that your fellow ophthalmologists have identified as important in being a leader in these unique settings. This list of attributes is by no means complete, and no physician-leader under the rank of "Dr. Saint" could be expected to score high on all of them. By rating your strengths and weaknesses, you'll gain insight into the areas in which you are quite strong and be on your way to making improvements in areas you feel may need improvement. Score each item on this 50-point list based on the following scale:

- 5 = I have a very large measure of this attribute; no more is needed for real success.
 - 4 = I have *nearly* enough of this attribute for success, but could use just a little more.
 - 3 = I have enough of this attribute to just barely get by as a leader in my practice.
 - 2 = I have a lot less of this attribute than I feel I need.
 - 1 = I profoundly lack this attribute.
-
- 1. ____ I am disciplined. I complete on time the duties and projects I promise my staff, patients, and family.
 - 2. ____ I don't procrastinate. I push ahead and get even the most unpleasant things done.

3. ____ I am a better than average communicator; I listen especially well.
4. ____ I am very tough, but combine this with being extremely fair.
5. ____ I am open to new ideas from my people and encourage their suggestions.
6. ____ I never hold a grudge for an error someone on my staff makes. I get over it, and life goes on.
7. ____ I love change and embrace every opportunity to alter our protocols to improve.
8. ____ I have the focus to be able to work well with many loose projects in the air at the same time.
9. ____ I see myself as a protector of the organization, the patients, the staff, and the physicians.
10. ____ People are attracted to work with me because I am much more often a giver than a taker.
11. ____ I am a great mentor. I have a lot of patience and a knack for passing along my knowledge.
12. ____ I am a team player. I balance being a leader with being a member of our larger team, which is called the "practice." When appropriate, I subordinate my needs to the needs of the team.
13. ____ I know when it's time to lead by gentle consensus and when it's better to put my foot down and simply be directive.
14. ____ I readily admit my mistakes to others and work to correct them.
15. ____ I consistently have abundant energy, more than enough to get me through the week.
16. ____ When we get stuck trying to make a decision, I am good at getting us back on track.
17. ____ Knowing that medicine is extremely stressful, I monitor my moods and their effect closely. I know when I need to apply stress-management tactics.
18. ____ I am good at setting reasonable workloads for myself and delegating or deferring everything else.
19. ____ I have written down a manageable list of measurable, core goals for our practice and reinforce these often with all staff.
20. ____ I avoid "mission drift" . . . I don't pile on new, conflicting goals. I avoid adding new goals until we've

- accomplished or formally abandoned old ones.
21. ____ I work hard to gather the facts, and I let these facts manage the practice.
22. ____ I review financial trend reports and volume performance graphs at least monthly.
23. ____ I keep a close eye on what is happening in our regional market and what my colleagues and competitors are doing.
24. ____ I avoid personal conflicts of interest and lead for the benefit of everyone in the practice.
25. ____ I am more than a figurehead. I am realistic about the time it takes to do the job right, and I put real time resources into this part of my job as a clinic owner.
26. ____ To avoid misunderstandings at home about the demands of my work duties, I have secured my spouse's durable acquiescence to my demanding professional life.
27. ____ In meetings, I speak little and listen much.
28. ____ I rarely vacillate or change my mind. When I do, I explain my reasoning clearly to others.
29. ____ When I anticipate resistance to a new idea or initiative, I touch base with senior staff individually before I bring it up at a group meeting.
30. ____ I can answer at least the following questions about all physicians I manage:
- Where they went to school and trained
 - The names of their spouses and children
 - Where their clinical interests lie
 - What their financial and volume performance goals are for this year
31. ____ I can answer the following questions about the senior managers of our practice:
- The names of their spouses and children
 - Where their future career interests lie
 - What their greatest strengths and weaknesses are
32. ____ I know every one of our staff members by name, and I know their position in our practice.
33. ____ I never break confidences. When told something privately, I do not divulge my sources, even indirectly.

- 34. ____ I don't make promises unless I know I can keep them.
- 35. ____ I know from experience that it's better to promise a "6" and deliver an "8" than the other way around.
- 36. ____ I struggle daily to be the most informed person in our practice . . . on many days I succeed.
- 37. ____ I am not afraid to motivate physicians and managers with an occasional sense of crisis. I use industry news, community gossip, and adverse financial trends to break through staff and physician lassitude.
- 38. ____ I have created a strong advisory board. The practice's consultants, attorneys, accountants, and bankers report to me, as does the administrator, when appropriate.
- 39. ____ I trust my gut feelings. I make really important decisions only after engaging in a few minutes of quiet reflection on this simple question: "Is this the right course?"
- 40. ____ I am humble. I consistently remember that "wins" belong to the team while "losses" are mine alone.
- 41. ____ People know there is no job in the practice that I would not be willing to roll up my sleeves and do.
- 42. ____ There is ample evidence that I enjoy my work. Even on the days I'm not enjoying it, I put on a brave face.
- 43. ____ I walk the talk. When I'm preaching practice cost containment, I simultaneously forego family expenditures. If productivity is lagging, I am the first physician who schedules extra patients in a day . . . and then arrives an hour early to see them.
- 44. ____ I never use my disproportionately great position and resources to bully others.
- 45. ____ When I have to reprimand or terminate someone, I strive to preserve that person's dignity.
- 46. ____ I arrive at the office earlier than is necessary for patient care to give myself time to touch base.
- 47. ____ I meet at least weekly with our administrator, even if briefly, and formally review progress. I allow these meetings to take as much time as my administrator reasonably needs to cover the company's business.

48. ____ I meet at least quarterly (and individually) with each physician in our practice. I know the specifics of where they want to head in their careers . . . and they know that I know.
49. ____ I have real empathy for the feelings of other people.
50. ____ I tell the truth, even when honesty results in temporarily hurt feelings.

Total Score: _____

* * *

Add up your score. With 50 different attributes worth up to five points each, the maximum score is 250. Although there is no objective scale you can use to compare yourself to others, this summary score can be a valuable personal baseline of your fitness to lead and help you identify areas in which you can improve. Consider focusing on two or three areas for improvement at a time. In your own words, write down your commitment:

"I will work on my ability to use positive rather than negative reinforcement with my technical support staff. Rather than blowing up on the clinic floor as I have been, I will write down my concerns and address them in a positive, upbeat way with all back-office staff at the end of each clinic day."

As is true for lay managers, it helps if you have a trusted manager, colleague, external advisor, or even a spouse who can give you feedback on how you're progressing. In the absence of a leadership coach, consider keeping a daily journal of your gains and losses. Even small, focused efforts in the areas needing the most help lead to outsized improvements, and you will have a greater sense of control over the destiny of your practice.

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APPENDIX 8

HELPING YOUR MANAGERS MANAGE: HALLMARKS OF SUPERIOR SUPERVISION

A Huey Cobra helicopter was just finishing up a nighttime practice run. The pilot was working on his low hover maneuvers at the air base when he tipped his tail rotor sharply backward, snapping off the tail boom. Without the tail—which keeps a helicopter from spinning around in circles—the helicopter took off like a pinwheel, sliding down the runway doing 360s in a brilliant shower of sparks. As the Cobra passed the tower, the following exchange was heard:

Tower: (urgently) “Sir, do you need any assistance?!?”

Pilot: (calmly) “I don’t know, tower. We ain’t done crashin’ yet.”

Sound familiar? Few business management environments are as vexing as ophthalmology. The simple, commonsense routine of running any business enterprise—being nice to the customers and getting paid for what you do—must rub shoulders with the immense complexities of third-party reimbursement and the even greater complexities of ophthalmic care itself. Every day can feel like a slow-motion crash landing. Like the helicopter pilot, the best practice supervisors need to be calm and serene, even in the midst

of disaster. Let's talk about the other attributes of great supervisors.

Departmental supervisors are middle managers who take direction from an office manager or administrator to translate the physician's policy decisions into daily activity. Most practices with only a few lay staff members can get by without mid-level supervisors. They only need one lay leader, the office manager. At practices with more than about eight or 10 on staff, the span of control becomes too wide for a single office manager and it pays to nominate supervisors for the natural departments: clinical services (the techs), patient accounts (billing), reception, marketing, optical, and surgical center.

Unlike your practice administrator or office manager, department supervisors are on the front lines of running your practice. The right supervisors can make any administrator look great. Poor supervisors will undermine the effectiveness of even the most outstanding administrator and can take down a practice much more abruptly than the helicopter in the story went down. At a series of client retreats, a group of experienced managers brainstormed about the attributes of great supervisors. Here's what emerged:

- *Direct job knowledge.* It's not absolutely necessary that a practice administrator know how to post a charge in the computer system. But it's essential that the billing department manager be the most savvy person in the practice when it comes to patient-accounts matters. Supervisors in most environments should be *working* managers. The chief technician should be on the clinic floor working up patients with his or her crew at least two or three days a week. The optical manager should be serving customers.
- *Delegation.* Almost all supervisors are brought up from the ranks. They know the job. And as working managers, they still spend most of their time *doing* the job. But they need to balance this with the ability to delegate. One of the most common complaints leveled at otherwise excellent supervisors is that they have difficulty

delegating. Your supervisors should continuously strive for a balance between doing and delegating.

- *“Action today” oriented.* Although every manager needs to keep an eye on the future, your practice’s supervisors should not be spending a lot of time pondering the long-term destiny of the practice. They should not be compiling endless, overly elaborate to-do lists, which commonly leads more to procrastination rather than organization. Instead, they should be executors, working with their teams to plow through the week’s tasks.
- *Grace under pressure.* Middle-management supervisors are squeezed in a four-way vise, pressured by patients, physicians, their administrator-boss, and their own staff to get things right. Like the helicopter pilot, great supervisors are understated, upbeat, and calm.
- *Accountability.* Too often, the pressure of pleasing so many parties at the same time can lead to making too many promises. Great supervisors are able to gauge the needs of the job at hand against their resources and be realistic about what they need in terms of time and staff to get the job done.
- *Communication.* It should go without saying that superior supervisors are great communicators, starting with being very good listeners. Although most supervision puts a premium on verbal communication, your practice’s department heads should also be able to write clearly. Any practice with more than a handful of staff needs to transition from being a purely verbal culture to one in which protocols and procedures are written down and memos are frequently distributed to keep everyone in the loop.
- *Discipline.* Supervisors bear and uphold the operational standards of the practice. If these standards are wobbly because of an undisciplined supervisor, the practice itself starts to melt down.
- *Tough love.* Holding staff members to the operational standards of the practice takes more than discipline. It requires the ability to be tough with the people you manage. If a staff member arrives to work inappropriately dressed, send him or her home, even if it means a 40-mile roundtrip and that the clinic will run behind that morning.

- *Fairness.* Staff, when they're being well managed, will always tell me something like, "Susan, my manager, is great. She's the toughest boss I've ever had to work for, but she's also the fairest." People do their very best work when they are supervised by someone who's very tough but who combines that with the ultimate in fairness.
- *Openness.* People love working for managers who are open to their ideas. People hate working for bosses who will only take their own counsel . . . or worse, will twist things around and take all the credit for the ideas of their staff.
- *Forgiveness.* All employees make mistakes. They're human. So they need to be redeemed after every mistake. Nobody likes to work under someone who holds a grudge for an error made last week. Unless the error deserves frank termination, everyone on staff should be able to erase his or her personal error scoreboard by at least the end of the week and start out the following Monday with a clean slate.
- *Adaptability.* Superior managers might as well wear a button that says, "I Love Change!" Rather than being rigid and bristling at the thought of policy changes or alterations in the routine, they welcome every change for the better and get their more resistant staff to support unpopular changes.
- *Organization.* The best supervisors I've met are working parents who have raised two or more kids. I'm convinced that if you can properly manage a few kids as a primary caregiver, you can organize the world just as well. Ask candidates for any supervisory position about their parenting style—you'll learn a lot about how they'll manage your staff and how organized and coordinated they'll be. I like to call supervisory applicants at home, at about 7 PM when things get especially hectic, to see how organized they really are.
- *Guardianship.* Even the most robust practices are still relatively fragile as business organizations go. The best supervisors see themselves as protectors of the organization, the patients, the staff, and the physicians. If they see something that's wrong, they act directly to correct it. If they think the practice is heading down the wrong path (e.g., wrong physician, bad office location), they speak up.

- *Mentoring.* Supervisors are coaches, cheerleaders, and mentors. Staff protégées are well served if their supervisors have the patience and knack for passing along their knowledge while creating a hunger for career development. Your practice's supervisors are the chief career advisors for each person they oversee. Every annual or semiannual written staff evaluation should include a section on career development goals that is signed off by both employee and supervisor.
- *Team playing.* Not only are supervisors the leaders of their own small departmental team, they are also members of the larger team called the "practice." Beyond technical skill, and leadership, your supervisors should have the ability to defer to the needs of the group. For a front-desk supervisor, this means not allowing warfare to break out between receptionists and techs. For the head of the marketing department, it's making sure that everyone is truly prepared for the new ad campaign that's premiering on Sunday so that the staff members are not slaughtered with calls and patients in the weeks that follow.
- *Sacrificing.* Sure, there's the glory . . . and the bump in compensation. But these rarely completely make up for the stress and demands of being an effective supervisor. Managers must be open to early and late hours, to criticism, and to the adverse consequences of making the occasional crummy decision.
- *Maturity and respect.* Every supervisor has the right to express an opinion. But sometimes, the organization and its board have to bypass opinion and make an unpopular decision. Mature supervisors publicly respect the decisions of the physicians and administrator, even when they privately disagree.
- *Humility.* In a world where you're generating dozens of decisions and requests a day, you're going to make mistakes. Managers (and physicians and administrators!) should readily own up to their mistakes, which will increase your staff's respect for them.
- *Personal reserves.* Ask your supervisors how much of themselves they're giving to the practice. Most will probably answer, "Why, 100% of course!" This is the wrong answer. If any of your supervisors have to give 100% of

their personal best to get the job done, they're working too hard. Adroit managers only give about 90% so they consistently have some gas left in the tank during crisis periods . . . which, given that this is ophthalmology, is rarely very far around the corner.

Consider sharing this list of ideal standards with your own supervisors. As a group exercise, customize it to fit your special setting and requirements. Then use the results to periodically assess whether everyone in an overseer capacity is living up to your practice's expectations.

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APPENDIX 9

HOW TO FIND AND REFORM OR ELIMINATE THE WEAKEST MEMBERS OF YOUR PRACTICE TEAM

In the words of that dearly departed ophthalmic management consultant, my old pal Bill Borover, "There are only three kinds of staff members and physicians: 'plus,' 'minus,' and 'plano.'" Indeed, every practice manager and physician-owner today must be extra skilled at "refracting" the quality of their staff. As ophthalmic management continues to become more challenging, just one negative or low-performing member of the team can be directly costly to the business and indirectly corrosive to staff morale. Many physicians and managers strongly resist reforming or removing these weak links in their business. Sit back and think whether you've been harboring any of the following in your practice:

- The physician in a group practice who holds himself apart from the rest of the team and refuses to follow protocols agreed to by every other provider.
- The tech who is sweet as pie to "her" physician but caustic with the rest of staff.
- The billing clerk who makes repetitive errors and passes on mounds of rework to her colleagues to clean up.
- The marketing and outreach coordinator who is too independent to be accountable for her whereabouts and productivity in the course of a work week.

- The surgical center manager who hides behind a smoke-screen of regulatory compliance or quality assurance to resist efforts to reduce operating costs and increase efficiency.
- The administrator who is more concerned with rescuing his career than growing the volume and quality of the practice.
- The optician who long ago stopped enjoying working with the public and is just going through the motions.
- The outside accountant who is kept on retainer not so much because of his competency as out of habit and because he's become a personal friend of the physician.

When giving lectures to groups, I commonly ask, "How many of you have at least one person in your practice today who shouldn't be there?" Almost every hand goes up. When I ask the follow-up question, "How long have you felt this way?" the typical response is measured in years, not months.

This resistance to reform or terminate weak players has many causes, the foremost of which is a reluctance to be confrontational or to rock the boat. Managers and physicians especially hate the thought of any near-term financial hiccups. The typical manager will say, "Dr. Nasty has always been that way, but we wouldn't dare let him go. He's responsible for covering a quarter of our overhead." Obviously, this same unpleasant physician may, in the long run, be the cause of high staff turnover rates and defection of patients from the practice. Here's a simple set of screening questions that can help you assess your personal tolerance for and response to underperformers. Answer them honestly and you'll be halfway to a stronger, happier practice.

1. *Do you have a clear "line in the sand" when it comes to performance and behavioral expectations, or are you inconsistent, applying different standards to various staff? Do you have pet staff members or physicians who receive extra-gentle treatment because their productivity is high or they are deemed the only people who know how to perform key tasks? Do these people know they're getting a free pass, and are they acting out accordingly?*

2. *Are you clear about communicating expectations, and do you let employees know when they have crossed the line? Do they know where this line lies and respect it, or do they play games, trying to see how long they can misbehave? Your staff will respond best to supervisors who are very tough, but fair.*
3. *If your practice has developed to the point of having middle managers, do they embrace the practice's standards? Or, do they work together as a group—a kind of unspoken trade guild within the practice—aligned against the interests of the physicians and patients . . . all to make their jobs more pleasant? If so, what have you done to convince this group that by serving the patients well, everyone wins?*
4. *Have you fostered a "consequential environment," one in which violations of practice expectations regarding policy (e.g., late to work, poor rapport with fellow workers, shoddy or inconsistent output) have a consequence? Or are you unconsciously rewarding the misbehavior of a few offenders while killing the morale of productive staff, who see their peers getting away with breaking the rules?*
5. *If you are an administrator or office manager, do the physicians back you up in disciplining staff, or have they made some staff untouchable? Have you been granted both the responsibility and the authority to take corrective action? Do you then apply the rules fairly to everyone, or do you shield one or more personal friends?*
6. *If you are a physician, do you grant yourself special allowances without regard for the impact your behavior (e.g., arriving late and holding everyone up) has on others? Or do you admit your errors and missteps openly in group staff meetings and work to improve your contributions to the team?*
7. *If you are the practice's managing partner, have you exerted your leadership on the toughest part of the job—counseling and censuring errant peers? Or do you let errors and omissions slide for the sake of harmony? A mollycoddling approach in this area is false economy, especially when dealing with younger associate physicians. It's better to come down directly with young physicians. If they can't respond to the imposition of group*

standards as an associate, it's better that they not be allowed to progress to partnership.

8. *Is it easy or hard for you to decide what the consequences should be for staff and provider misbehavior?* In larger practices, these should be spelled out in writing; they often take the form of progressive discipline, including things such as fines for chronic tardiness.
9. *Are your desires for the practice aligned with incentives for staff and physicians?* If you want a markedly busier practice, make sure financial incentives are in place for selected lay staff as well as for providers. If you are trying to trim costs, reward staff who come forward with ideas that lower costs without diminishing the quality of care.
10. *Are you honest about the cost benefit of keeping inappropriate staff on the payroll?* Many managers, especially those working in adverse labor markets and facing the chore of finding a new clerk or tech, take the easy way out and decide to live with weaknesses that will cost the practice dearly in the long run.

Too many practices wait for annual reviews to take corrective action. In the best practices, performance standards are clear and public, and vigilance is applied daily. Great performers are rewarded lavishly and publicly, while weak links are gently shown the way to the door.

As the children's ditty goes, "Every party has a pooper . . . that's why we invited you," and nearly every practice has one, too. No matter how strong your team, there is someone in your practice today who is the weakest link. One of the most important tasks you have as a manager or owner is to discriminate between those deserving removal and those deserving extra attention and loving, patient reform.

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APPENDIX 10

REVERSE ENGINEERING FROM YOUR PERSONAL FINANCIAL PLAN TO YOUR PRACTICE'S BUSINESS TACTICS

A number of years ago, one of our most sophisticated Navy surveillance planes was forced down over China. Although the U.S. personnel on board came home soon, Beijing held onto the plane, giving it back, largely disassembled, some time later. While all this was playing out on the world stage, the concern in military circles was that China would be able to “reverse engineer” our technology, from finished electronics goods to base components, and then replicate our sophisticated spy gear. That’s a good jumping-off point for what follows because if you’re at all wise, you should be doing some reverse economic engineering in your own practice.

When I start a typical consultation assignment, I often ask the client whether he or she has a personal financial plan—even though I’ve been asked to help with the business affairs of the practice. Why is this? Simple. Most eye surgeons have no written personal financial plan, and this plan, if intelligently crafted, can be a guide, in reverse, to what you should be doing with your practice. Unfortunately, most surgeons have diffuse goals, such as, “I’d like to make \$300,000 next year” or “I’d like to perform an average of 45 cataract cases per month and beat out Dr. Joe down the street.”

The few clients who have a basic set of personal financial goals have a wonderful reference standard from which we can work backward . . . “reverse engineer,” if you will . . . to find out what the practice needs to produce in profits today and in the future.

Here are the steps you should be working backward to get from the core hub of your personal goals to the outer rim of your strategic and operational business goals. Think of this as an archer’s target with a bull’s-eye and successive rings.

The “Bull’s-Eye”

What are your lifetime achievement goals? Said another way, perhaps less delicately, “What unfinished business would you like to get done in the X years of sentient, mentally sound, and physically active years you have left to live?” One common meditation in Eastern philosophy is to imagine each morning that this is your last day of life. Without being quite this stark, what more do you want to accomplish? What experiences do you desire? A few of your answers may be purely existential and have little or nothing to do with money. But most of your answers to these tough questions will require a defined capital base, if only for living expenses while you take the time to live out your dreams.

The Next Ring on the Target

Your personal financial plan comes next, something formal financial planners (ideally fee-only) and selected accountants do best. Let’s say you’re 48 years old and you’ve decided you want to retire at 55 so you can travel throughout the world on medical mission trips. Your planner ascertains that with only an extra \$50,000 in pretax income a year set aside for the next seven years, you’ll cross your finish line to financial independence. Your planner will also take into consideration the value you’ll be able to extract from the practice when you retire, which should be factored into how you conduct your practice business. If you’re a soloist and need to get the most possible from your practice’s sale in seven years, it may be appropriate to line up a succession plan, either with a partner-track

associate or perhaps through a purchase option agreement crafted with a larger practice in your service area.

Moving Outward: What Collections and Profits Are Needed?

Here's the last ring on the target. Assume you currently have a practice with \$1 million in collections and \$350,000 in profit before taxes. To make the numbers from your personal financial plan fit, you know you need to find an extra \$50,000 a year. There are several ways you can do this:

- *Forego \$50,000 in lifestyle dollars and shift the money to savings.* This is easier said than done in most middle-staged medical families. This is more likely a stage of family life, with teens or college students, when expenses are at an all-time high and nonessential costs have already been cut.
- *Trim \$50,000 in practice expenses.* This can be difficult in most settings. In our example, the practice is already at a quite-typical profit margin. Shaving \$50,000 off expenses may actually have a rebound effect and set into motion an unintended decline in practice revenue that more than eclipses your savings.
- *Work harder by seeing more patients.* This is often the most predictable and painless way to ramp up profits. At an average of \$175 or so in collections per patient visit in most settings, and with little or no additional overhead for marginal increases in volume, you only need to see another 286 encounters a year, or about six extra patients a week, to give yourself the raise you need.
- *Divert practice resources from market share growth or technology upgrades to profitability.* You may have been consciously growing practice revenue, and until now, gaining market share with external advertising and other efforts has been worth the cost. If you and your financial planner now have a definitive goal to focus on, it's easier to make an intelligent decision about whether to continue to divert resources to advertising or to bring these resources to the bottom line as profits. Should you upgrade your excimer laser or make due with the current unit? As long as patient care is equivalent, your financial plan should dictate the direction you take with discretionary purchases.

- *Practice more aggressively, upping the number of surgical cases you extract from a fixed base of clinical patients.* This is almost always possible, especially in a more mature practice with an older patient base. If you are a fee-for-service general practitioner and see more than 30 patient visits for every cataract surgery, some tuning up and boldness may be in order.
- *Work extra hard at a succession plan that will yield a larger gain when you sell.* This is something you should not plan on. Indeed, my usual advice to midcareer clients is to plan their affairs on the assumption that their practice will be worth nothing more than the salvage value of the tangible supplies and equipment, plus the residual receivables.
- *Go back and change one or more of the variables that went into your personal financial plan.* You can plan to work extra years and retire at 60 instead of 55. You can invest more aggressively. Or you can live on less after retirement. You might even get medical mission work out of your system, semiretire to the Sunbelt, and work well into your 60s and 70s part-time as a medical ophthalmologist.

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APPENDIX 11

MAKING A SMOOTH TRANSITION FROM SOLO TO GROUP PRACTICE

A surprisingly high percentage of ophthalmologists are still in solo practice, most quite happily. On the plus side, solo practice provides the satisfaction and serenity of absolute control. Solo surgeons don't have to consult with a colleague. They don't have to confront peers on difficult business or medical issues—they need only face down subordinates. Soloists can spend the company's profits as they see fit . . . the only financial negotiations are between the physician, the administrator, and the spouse. Soloists can come and go as they please. Meetings are pared to a bare minimum. "Bliss," some surgeons say.

This is not always so for physicians in group practice. For at least *some* physicians in *some* groups, two, three, or more physicians working together is not so much a trim commando squad as an armed gang, as likely to turn on each other as rumble with the local competition. Still, the economic and professional advantages of group practice are compelling and may trump your desire for independence. For instance:

- *High fixed overhead and expensive technology upgrades can be shared.* A significant proportion of new technology is quickly obsolesced, and the pain of buying errors can be split up.

- *Patients can be better served if several subspecialists are present.* Care is better coordinated, and a patient's needs can all be addressed at a single location.
- *It's much easier to afford superior management talent, along with top-flight accountants, attorneys, and other advisors, if the cost is borne by several physicians working together.*
- *With a partner, you have someone with whom you can share successes and commiserate about failures.*
- *The quality of care may be higher in group practices for two reasons.* First, each surgeon can learn from his or her peers, especially if periodic case reviews and chart audits are conducted. Second, two or more surgeons working together represent a kind of internal oversight, even if there is no formal case-review process.
- *As a member of a group practice, you have an in-house sounding board to help you improve your good ideas and a safety check to help you avoid following through with poor ideas.* (An ideal combination is when one surgeon is oriented to cost containment and the partner is oriented to revenue enhancement.)
- *There is greater practice security.* When a solo surgeon falls ill, the practice grinds to an immediate halt. A second or third surgeon can keep the company going until the downed partner is back in action.
- *There can be significant lifestyle benefits.* Call coverage is shared. It's even possible to arrange periodic sabbaticals, giving each physician a block of several weeks, or even months, off every few years. Two part-time surgeons can job share.

Many soloists are unsure about the timing of adding a second physician to the practice. It's critical to forecast the almost inevitable cash-flow crunch that occurs early on as you take on a new associate or partner. You must also have the patience and the cash reserves to take a personal pay cut for several quarters or longer. Imagine a solo surgeon with \$1.2 million in revenue and a 40% profit margin. Near term, especially if there are delays in gaining licensure or panel status, the new associate will represent all outgo and no income. It's typical for a general ophthalmologist-associate's first-year costs (including wages, taxes, benefits, relocation costs, insurance, staffing, other professional

	Month						
Parameter	Base	1	2	3	4	5	6
Number of MDs	1	2	2	2	2	2	2
Base collections	\$100,000	\$100,000	\$100,000	\$100,000	\$100,000	\$100,000	\$100,000
New physician collections	0	\$ 8,000	\$ 15,000	\$ 25,000	\$ 30,000	\$ 35,000	\$ 40,000
Total collections	\$100,000	\$108,000	\$115,000	\$125,000	\$130,000	\$135,000	\$140,000
Base expenses	\$ 60,000	\$ 60,000	\$ 60,000	\$ 60,000	\$ 60,000	\$ 60,000	\$ 60,000
New physician expenses, including salary	0	\$ 25,000	\$ 22,000	\$ 20,000	\$ 18,000	\$ 18,000	\$ 18,000
Total expenses	\$ 60,000	\$ 85,000	\$ 82,000	\$ 80,000	\$ 78,000	\$ 78,000	\$ 78,000
Profit for senior physician	\$ 40,000	\$ 23,000	\$ 33,000	\$ 45,000	\$ 52,000	\$ 57,000	\$ 62,000

support) to reach \$250,000 or more. In the early months, there will be sharp drops in practice profit, and the senior physician has no recourse except to reduce his or her salary or draw on loan proceeds to preserve income. The table above shows a typical, if markedly simplified and accelerated, cash flow in the first several months.

As you can see from this example, if the new physician's productivity can be accelerated (e.g., by pre-arrival marketing, strong outreach efforts), the senior physician has only a short-term drop in personal income, followed by a very sharp increase. Obviously, you don't want to stretch out the process. A senior physician making \$40,000 in the base month before the new hire's arrival will resent the young colleague who gets stuck at a "month two" level of productivity because it would result in a significant income drop for the senior physician.

For the same reason, you don't want to bring a new physician on board prematurely. Here are a few rules of thumb:

1. *Before you add a new physician to form a two-physician general ophthalmology practice, you should be personally seeing at least 20% more patients per month than you can comfortably fit into your schedule.* This typically translates to 600 or more patient visits per month for a general

ophthalmologist (inclusive of paid as well as post-op visits). Alternatively, you should have reached (but not yet exceeded) your comfortable personal patient volumes by growing total patient volumes at least 10% a year, and you should have a high level of confidence that this growth rate will continue.

2. *This level of excess productivity (or superior growth rate) should have been in place for at least the last six months before you make a hiring commitment.* From this, you can see that it's occasionally appropriate to begin the physician search process before you think you might need additional help, especially if you work in a less desirable market. It may take 12 to 24 months or more to find a superior candidate.
3. *Make sure you have significant financial reserves in place to carry you through the first few soft quarters after your new physician arrives.* Whether these reserves are held as retained earnings of the practice, personal savings, or simply a line of credit, you should have access to the equivalent of not less than six times your monthly salary and draws. Also, be prepared to curtail personal lifestyle costs temporarily if your new physician takes a little longer than expected to build his or her practice.

After the New Physician Arrives

Once you have transitioned from one physician to two, your new favorite saying must become, "I can live with that." If you enjoy a harmonious marriage with your spouse, apply the same tactics to your business "marriage." Even though you're the senior physician, take pains to ask your new partner or partner-to-be what he or she thinks about new practice initiatives or expenditures. Like an ex-bachelor, you can no longer do the ophthalmic equivalent of staying out late (not coming in on time for work), hanging out with friends (running behind in clinic), or spending money freely (buying a new laser without asking permission first).

You should accept that bringing on a fellow physician and becoming a small group practice will involve more than just near-term financial pain. Longer term, there will be other discomforts. Chief among these is additional meeting and communication time. Here's the line-up:

- *If you don't already hold general staff meetings, conduct such a meeting at least every two months; monthly is preferable.* All physicians should be in attendance.
- *If your practice is up to a size suggesting departmentalization, hold department meetings monthly.* At least one physician should attend at least every other technical department meeting.
- *Hold a monthly finance and volume performance meeting with the practice manager or administrator.* All partner and partner-track physicians should be in attendance.
- *Once a month, hold a meeting of physicians only.* In the early months, and perhaps durably, the physicians should review a cross-section of random charts to compare care pathways, referral patterns (both intra- and interpractice), return intervals, and utilization.
- *Arrange a social meeting of physicians every quarter or two, depending on everyone's temperament.* These meetings are most often dinners or similar outings with spouses; beyond mere enjoyment, they serve to deepen the bonds between partners. These social ties are not essential. There is no absolute requirement that physicians in a group be buddies in their private lives; indeed, too much personal involvement can cloud business judgment and create the opportunity for a personal spat (or spouse-to-spouse argument) to spill over into the business.

In most cases, as a practice transitions from a solo to a two-physician arrangement, the new physician will spend two to three preliminary years as a partner-track associate. During this trial period, he or she should receive personal monthly production figures (patient visits, surgical cases, collections, and average revenue yield per patient visit); ideally, these are graphed to make it easier to spot trends. In addition, I feel strongly that partner-track associates in good standing should receive some or all financial performance statistics for the overall practice. Unfortunately, some senior physicians elect to keep practice financials a secret until the associate is about to become a partner. This commonly results in an associate who is untrusting, disengaged from the details of the practice, and unfit to assume the fiduciary role of a partner.

As the senior physician, you should foster an environment of strategic intimacy. You and your new physician should openly discuss where you want to take the practice in the future, just as young couples discuss how many children they want to raise and what kind of home they dream of owning. Perhaps the second greatest source of partner discord, after financial squabbles, is when physicians disagree on where the practice is heading strategically. Ideally, you and your colleagues should collaborate on a written plan that includes the following:

- *Geographic span of the practice* (the boundaries of your service area).
- *Agreed scope of practice services and positioning strategy* (e.g., will you be known as a full-service provider, or a cataract boutique?).
- *Provider mix* (how many surgeons? medical ophthalmologists? ODs?).
- *Your current and future financial performance, out at least five years.* This section of your strategic summary should describe whether your development bias will be toward high market share (which will likely constrain profit margins) or high profit margins (which will likely constrain market share).

Make sure your new associate has nonclinical as well as clinical duties. Every physician, even durable associates who are not on a partner track, should devote five or more hours a month to staff education, outreach in the community, outcomes research, protocol writing, and similar activities. Every physician should periodically sit on various management committees and task forces.

Give your new associate reasonable control over his or her professional environment. It can be very helpful to give each physician in a group a dedicated lead or primary technician. Although every practice needs a degree of uniformity and standards, make sure you provide your physician with a chance to customize certain forms and protocols, especially those germane to his or her subspecialty expertise. Don't force your associate to adopt your surgical approach, and don't impose yourself as an uninvited

proctor. Presumably, you have selected your new colleague wisely and respect his or her existing personality, skills, and professional judgment. As in love and marriage, don't hold out hope that you're going to be able to change your partner-to-be, even if that partner promises to change.

Disclose early on, ideally when the initial contract is signed, what the buy-in terms are for partner-track associates. Spell out *provisional, nonbinding* terms in writing as part of the initial employment agreement. These terms should include: (a) when a partnership opportunity is likely to be first offered; (b) what segments of the practice will be sold (e.g., whether ASC shares will be offered or only shares in the professional corporation); (c) what percentage may be offered; (d) how the practice will be valued; and (e) whether financing for the buy-in will be carried by the practice or by a third-party lender.

I talk to hundreds of associate physicians every year. Most are happy. Those who aren't rank their chief complaints in the following approximate order:

1. *"I never really feel appreciated here; I feel like second fiddle."* Go overboard in expressing your appreciation for your associate and, later, for your partner.
2. *"I don't have enough voice in operations; I'm never consulted."* Obviously, your partner-track associate, and even your minority partner, has little or no legal control over the practice. But the wise senior physician picks associates whose counsel they respect, accept, and often implement.
3. *"The senior physician gets all the cases; I'm not being fed patients; instead, I have to fight for every new patient. The front desk knows who signs their paychecks, and so the senior physician gets most of the best new patients, while I get the scraps."* Few young associates are self-starters—they arrive on the job expecting to be fed, at least to some degree. This is solved by creating a written protocol for the entire office staff outlining how new and established patients are assigned. You can go further by doing consumer advertising to directly support your new physician and coaching help to introduce the

associate to the community and encourage him or her to make contacts outside the practice.

4. *"Every decision my physician-boss makes seems to be made with his personal benefit in mind. I don't trust him to make decisions that will be fair for all concerned."* This complaint is a little touchier to deal with because it involves the core personality of the senior physician. The best surgeons tend to have the greatest difficulties in this area. The best solution includes insight counseling for the senior physician, combined with open discussion, a lot of physician-to-physician face time, ongoing coaching for the senior physician, and regularly checking the associate physician's perceptions. Even after near-term improvements are made, ongoing vigilance is essential to check the inevitable backsliding.
5. *"Issues build up without ever being discussed."* The reason for this common observation is that most surgeons despise confrontation and harbor fears that a small confrontation will lead to an unpleasant, all-out battle. The solution includes providing sufficient meeting time to air issues and involving a third party (such as a strong administrator) in selected physician meetings to referee disagreements and gently bend the physicians toward an intelligent consensus on the most difficult issues.

There are compelling financial, quality care, lifestyle, and existential motivations for a solo surgeon to take on an associate or partner. At the same time, there are compelling and often deeply personal motivations to remain in solo practice. As many larger groups have found, there can be severe diseconomies associated with an ophthalmic practice with more than three to five partners. In the years ahead, as the next round of health care cost containment descends on eye care, I believe many heretofore happy soloists will be compelled to consider group practice. In addition, in the next decade, the baby boom generation of physicians who are approaching their retirement years will be seeking transitional physicians to slowly take over their practices. The concepts and strategies discussed here, if applied, will help you avoid the most common pitfalls of group practice.

APPENDIX 12

PINTO'S PRACTICE DEVELOPMENT DOCTRINE: FIVE EASY RULES TO HELP YOU HAVE FUN AND STAY OUT OF TROUBLE AS YOU GROW

In the winter of 1992, as the first Gulf War drew to a close, General Colin Powell published an article in *Foreign Affairs Magazine* setting forth the principles of what became known as a “when-to-go-to-war” doctrine. Powell set forth a series of relevant questions, including the following: Is the political objective we seek to achieve important, clearly defined, and understood? Have all other nonviolent policy means failed? Will military force achieve the objective? At what cost? Have the gains and risks been analyzed? How might the situation we seek to alter, once it is altered by force, develop further, and what might the consequences be?

Out of these questions came a series of determinants, which came to be known as the “Powell Doctrine.” These have been often quoted (if not applied) by military planners as the go/no-go trigger for proceeding with any offensive effort.

Having seen my share of ill-conceived ophthalmic battles over the past 30 years, I've been wondering lately whether a similar, useful set of orienting questions and an equivalent doctrine could be derived to help eye surgeons decide when they should proceed strategically.

First, borrowing from Powell, some orienting questions must be asked: Are the clinical and/or business objectives important? Realistically, the overwhelming majority of tactical decisions made by practices are driven by opportunity, not by plan. Physicians are more likely to acquire a competitor in a gleeful, impulsive pounce than with any thought about the longer-term consequences. The feeding frenzy for new, untried technology on the showroom floor can lead to financial indigestion six months later when they learn their new toy has improved neither the quality of care nor the profitability of the practice.

You must have the discipline to gauge the importance of any potential purchases or maneuvers in the context of common sense and your practice's strategic plan. When you're 58 and planning to retire at 62, you don't usually start building an ASC without a very good plan of who's going to buy it from you . . . although this might have been an excellent maneuver a decade ago. At the other end of the career spectrum, if you are 38 and your growing practice needs a nerve fiber analyzer, don't clutch on the decision. Even if you haven't paid your school loans and feel debt-adverse, technology that you need and that has been tested may be clinically and commercially important enough for you to risk taking on another lease payment.

Are the clinical and/or business objectives clearly defined and understood? One of the first questions I ask new clients is, "What's your clinical and surgical volume now, what's your revenue now, and where would you like these numbers to go in the next three to five years?" I've long since stopped being surprised that few surgeons have accurate off-the-cuff answers to any of these questions. What's more, only a few exceptional administrators know the answers by rote. Can you imagine directors of corporate divisions not knowing precisely the volume performance goals set for them by their CEO? Hardly. Any more than

you would expect a field commander to not know precisely what targets the Joint Chiefs had in mind.

You should also ask whether alternative clinical or business tactics have been considered. For example, consider the number of redundant excimer lasers languishing across the country now that case volumes have softened. If competitors in most markets had looked ahead and joined forces to develop cooperatively owned laser centers, they wouldn't be doing any more cases in today's depressed market, but they would be sharing high fixed costs over a much wider user base.

Here's another common example: A barely overworked solo ophthalmologist with a practice that has seen stable patient volumes for many years decides to bring on a partner to help with what he inaccurately considers to be a burdensome and ballooning workload. Without a concomitant ramp-up in patient recruitment *in an environment where more patients are indeed available*, the two physicians will end up splitting what's merely one surgeon's full practice and the senior physician will get nothing but a pay cut. In cases like this, it may be better to assess the ability to expand volumes and bring in an optometrist or medical ophthalmologist as a lower cost extender. Or it may be better to relinquish a subset of less profitable patients while decreasing overhead. Either tactic may better serve the senior physician's goal of removing the pressure of unacceptable fringe work and increasing his profit per unit time.

It's examples of such business disasters and successes over the years that led me to create the following five-point Ophthalmic Development Doctrine.

1. *You must understand and prepare for the cash-flow consequences of any proposed initiative before you act.* If such analysis indicates you may be treading financial water for a while, you must ensure in advance that you will have access to any needed capital. Here's a pertinent and common example: A two-surgeon practice hires a new subspecialist. There are immediate costs for marketing, equipment, and generally setting up a new nest

for the physician. Then problems hit. There's a clerical snafu and a holdup in securing a Medicare provider number. Credentialing for managed care contracts is slow in coming. In situations like these, especially in a low-profit-margin practice, carrying a new associate can make it hard to meet payroll for the existing physicians. The time to go to your banker to negotiate a bridge loan or line of credit is before you need the money.

2. *If you aim to make your business larger or more diverse, you must be prepared to manage the resulting complexities.* Even small, simple, solo practices have many moving parts and squeaking wheels. This enterprise complexity grows logarithmically with scale. You and your management team should master your current practice first. In the case of a merger or acquisition, you hardly have any standing to run another physician's practice if you can't yet master your own company.
3. *Every practice initiative should, within an acceptable time frame, be accretive to the net earnings of every owner.* That's just a fancy way of saying that your business decisions should be made with the aim of eventually resulting in more profit per hour per owner-physician. Let's take an example. In a five-surgeon practice, Dr. Smith's pod is going to be built out with two more exam rooms at a cost of \$75,000, charged evenly to the partnership. On the face of it, it seems as though Dr. Smith is getting a great deal and his partners are hosed—right? Wrong. If, in the next year, Dr. Smith uses these rooms to produce another \$300,000 in collections, both Dr. Smith and his partners will get a pay raise. Dr. Smith gets the money directly as a producer, but he and his partners also get an indirect benefit by having more of their fixed overhead covered. Following this rule doesn't promise that every physician will get an *equal* benefit from every development decision but that every physician will be better off in the long run.
4. *When developing, you must align the incentives for all the stakeholders in your practice.* Fair enough. As a surgeon-owner, it's reasonable for you to ask first, "What's in it for me?" But just after this you should also ask, "What do my partners get? What does my staff get? What does

the physician whose practice I merge with get?" If the incentives are markedly unbalanced, your plan may be destined to failure.

5. *Remember that health care is a local business. Don't overextend your supply lines to distant operations unless you have abundant capital and proven operational competence.* For most surgeons, staking out satellite operations more than 25 miles away without planting a homeroom physician in the subject market is becoming a very diseconomic business model as fees continue to erode and practice costs continue to rise. Try to have the discipline to keep remembering that success should be measured in profit per surgeon-hour (including travel time), not in cases per month.

Follow these simple rules, and you'll avoid the most common eye care business errors. That's critical in the increasingly challenging health care business environment of the future, when it's going to become all the more difficult to recover from mistakes.

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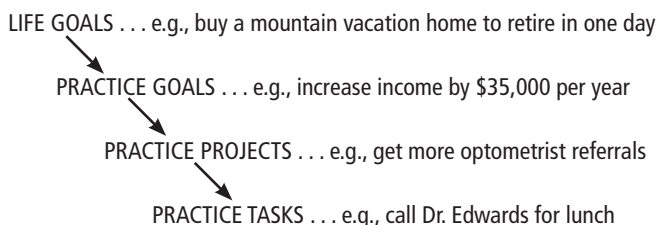
APPENDIX 13

GETTING THINGS DONE: THE ART OF PRIORITIZATION AND IMPLEMENTATION

As an ophthalmologist, by the time your formal training is completed, and after accounting for vacation time, you only have about 8000 workdays left to accomplish your professional mission. In these 8000 days, you must build a staff team, construct a business enterprise, refine your mastery over a complex body of clinical knowledge, and use this mastery to serve perhaps 30,000 different patients, all to improve the functional vision in about 60,000 eyes. That's it . . . just 8000 days. This works out to about one hour per eye over the panoramic span of your career, which is rather a nice way to think of things.

This time passes swiftly. If you're the average physician in your mid-40s, you only have about 4500 workdays left. In another decade, you'll only have perhaps 3000 workdays remaining. And by the time you finish reading this book closely, you'll have used most of *one* of those precious days.

What can you do to extract the most value from each of these fleeting days? First, you should prioritize in a way that flows downhill, from profound life goals to unremarkable practice minutia:



If you keep your eyes open to opportunity, hundreds of alluring new ideas will arise every year. But, you only have time in your life to seriously pursue a fraction of these ideas. How do you know which opportunities are important? You have to know your long-term goals, which provide a critical context for focusing the limited hours of your day and the limited days of your working life.

Consider the following scenario: You're a 48-year-old general ophthalmologist who dreams of owning a five-partner multi-subspecialty practice. You want to be the managing partner of this group and work hard in this role for 20 years if your health holds out. You want to continue performing cataract surgery and pass just about everything else along to your colleagues. These goals are consistent with the following actions:

- Go to national meetings and sit in on courses related to being the managing partner of a group practice.
- Direct your administrator to strengthen her financial training so that she will be ready for managing a larger organization.
- Become good at delegating to middle management staff in the practice.
- Call a recruiting firm to cast a net for your first partner-track associate.
- Hire a personal trainer to increase your energy levels.

The following actions would *not* be consistent with your goal of owning a larger group practice:

- Go to national meeting and take courses related to medical retinal care. (You'll be delegating such cases in the future, remember?)
- Direct your administrator to learn how to scrub into surgery as a backup for your lead scrub tech. (Such work

would be a distraction to someone who is going to run a larger business for you.)

- Handle detailed projects instead of delegating. (You’re going to be too time-poor to do everything well by yourself.)
- Fail to follow a diet and exercise regimen that will keep you vigorous well into your 70s.

Were your actions during the past week, day-by-day, consistent with the outcomes you desire? If not, align your actions and your goals to the greatest possible extent. Before reading further, fill out this simple grid:

Actions I Have Taken in the Past Week	The Larger Goal I Hope to Accomplish Through This Action
<i>Example: I visited an old friend from my residency (who performs cataract surgery faster than I do) to learn how I can shift from 2 cases per hour to 3 cases, with the goal of making it financially viable to develop a modest ASC.</i>	<i>I would like to have my own surgical center one day and can't afford this unless I'm more efficient surgeon.</i>

Were the activities you wrote down in the left column in accord with the goals you wrote in the right column? If not, what does this tell you about how you’re prioritizing your time? Do you need to adjust your goals (perhaps defining them formally for the first time in years) or better direct your actions to match your goals?

Sometimes the focus of your time and attention is not driven by your desires alone but is bounded by practical realities. Let’s say you would love to develop an ambulatory surgical center. You’ve bought every book on the subject and go to every possible course on ASCs. You have hired

a few consultants to review the prospects, and you get the same answer each time: “You can’t develop an ASC because (1) your case volumes are too low to support it, (2) your market is so small that you’ll never build sufficient case volumes, and (3) state regulations prohibit the development of private ASCs. In light of these facts, it would be foolish for you to keep attending ASC courses, reading ASC how-to guides, and hiring advisors. Adjust your dreams: Find another kind of practical ancillary service (an optical shop perhaps, or an augmented diagnostic testing pod), and put your energies into these more achievable goals.

Managing Your To-Do List

You don’t gulp down an entire steak dinner in one bite; instead, the meal is divided into discrete courses and each mouthful is cut one at a time. Practice projects should be carved up the same way. Once you have prioritized the outcomes you desire and developed a list of projects, break down each project into its component parts.

You can use one of many computer programs to automate your to-do list. Microsoft Project is a robust program designed for projects with hundreds of sub-routines . . . as would be the case if you’re a general contractor building a new office tower. Microsoft Outlook, is a much simpler program, packaged with Microsoft Office, that allows you to arrange projects by initiation date, departmental area, or responsible party. Perhaps the simplest and most familiar approach is to use Microsoft Word to create the table below.

Sample Action Grid			
Action (Dated)	Who (One Person)	Deadline	Progress Notes (Dated)
Replace the worn carpet in the Akron main office Oct 2	Susan	Nov 20	Oct 15—carpet samples reviewed and order placed Oct 30—installation scheduled for Nov 13 Nov 10—date pushed back due to work to repair flood damage

Here are a few simple rules for using the grid:

- Date all action items and make sure they are written as a complete thought and so someone from outside the practice could understand what you have written. Use a simple subject–predicate format.
- Each item should be assigned to one person, not a committee.
- The deadline should be a specific date in the calendar, not “spring.”
- If an item is approved but tabled, enter the a date in the “tabled to ____” deadline column.
- Enter all progress notes and date *by each responsible party* on a networked or central/open-access personal computer at least 48 hours in advance of regular management meetings. Use the grid as both the agenda and the minutes of the meetings.
- Move highly confidential items to a separate grid.
- Remove completed items to a separate archive file, and have the practice’s managers review them periodically to ensure that completed projects require no further action.

Whatever system you use—from a worn-out legal pad to a dedicated computer program—it’s critical to foster an *accountable* environment in which each action item’s “owner” feels truly responsible for his or her line items and there is a formal consequence for not performing the task. By starting with a clear understanding of the desired long-term outcomes for your life and practice, you and your staff will spend more time on purposeful activity and less time on busywork that, each day, robs you of the precious hours you need to accomplish your dreams.

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APPENDIX 14

RETINAL PRACTICE PERFORMANCE BENCHMARKS

General ophthalmologists, especially in surgically oriented anterior segment practices, have invested significant resources in benchmarking their financial and volume performance against the performance of fellow providers. Much less benchmarking has been performed in retinal practice settings, which is in line with the generally slower pace at which the other vanguard practice management tactics are adopted by these subspecialty practices. There are several reasons for this:

1. Retinal practices enjoy a much higher profit margin than general ophthalmology practices. As a result, they have been understandably less concerned about the nuances in their cost of doing business or individual physician productivity.
2. Retinal practices have been arguably under less threat of fee reductions than general ophthalmologists and have enjoyed a material volume and earnings boost since the advent of injectable treatments. (Try not to think about what's destined economically when frequent injections inevitably yield to less frequent dosing options.)
3. Retinal practices are somewhat more complex and can have a higher diversity of patients and procedures. There are more new procedures and clinical maneuvers to master every year. This means there is less time for the average retinologist to think about the business

details of the practice, much less the administrative minutia of comparative benchmarks.

4. Retinal surgeons, while at least mildly competitive with their in-town colleagues, tend to be less adversarial in their relationships than cataract and LASIK surgeons; thus, they have less motivation to compare their practice with others.
5. Retinal practices tend to be insular and are not comfortable sharing confidential practice performance data with other practices.
6. There are many fewer retinal surgeons—and retinal practice managers—than generalists, so the odds are less that someone will take the time to ask benchmarking questions.

There are only one-tenth the number of retinal practices compared to general practices, so my client benchmarking data set in retina is proportionately smaller. But after decades of work with a few hundred practices, here are some comparative guidelines, whether you own or manage a single subspecialty retina-only practice, or have a retinal department embedded in a multi-specialty practice.

We conventionally describe retinal practice collections as either gross collections (inclusive of drug collections) and net collections (omitting drugs). As drug reimbursements have climbed, most benchmarking is reasonably indexed to net collections.

Net collections per full-time retinologist are wide-ranging, from \$1 million to \$3+ million. Drug collections commonly double this figure. The typical collections for drugs wind up providing a c. 5% mark-up.

Profit margins typically range from 40% (in high-cost urban settings with high managed care penetration) to over 60%. As might be expected, the 60% margin practices are more often rural and suburban than urban.

My average retinal surgeon client comes in at annual pre-tax earnings of about \$800,000, but there are notable exceptions. Retinologists in less efficient multi-specialty

practices, where high producers can end up subsidizing low-yield pediatric and other providers, may only earn \$400,000 or less working full time. At the high end, I've served numerous hard-working retinal surgeons who earn more than \$2 million before taxes.

We typically see retinologists who work in retina-only practices ending up more harmonious, happier, and financially more productive. Unlike their colleagues who work in multi-specialty practices, they don't have to argue as hard for technology investments, nor are there as many call conflicts. It can be especially challenging to work as a solo retinologist, given the rigors of on-call duty, and the cost of buying high-end equipment for use by just one doctor.

Interestingly, optometrists are not often included as providers in a retinal practice, although in my limited observation, they have much to add, both in terms of reducing surgeon fatigue from routine clinical patients, and in increasing net income per surgeon-hour.

There can be wide divergence in clinical productivity from one retinal specialist to the next. The typical provider averages about 450 visits (including post-ops) per month. A few rarely exceed 375, and hard workers often hit 600 or more.

Even with the advent of more longitudinal drug injection treatments, new patients are the lifeblood of every surgical practice. The typical healthy practice sees 20% of total visits as new patients. The new-patient percentage will be low in practices who follow patients closely and return them reluctantly to their referring physician. New-patient percentages are higher in settings in which referred patients are returned rapidly. As expected, practices with the lowest new-patient ratio tended to have the lowest revenue yield per patient visit.

The net collections yielded per patient visit are similarly wide ranging. In the average practice, the figure (again, net of drug) exceeds \$250.

Lay staffing dynamics in a retinal practice are nearly the same as for a general practice, with the exception of tech staffing. Whereas a general practice will typically have 1.0 or less tech hour per patient visit, 1.3 tech hour is needed in retina due to the presence of older/slower/sicker patients, more testing, and more help with injections. Because the average net revenue yielded per patient in retina is higher than in a general practice, retinal labor typically costs about 25% of cash flow (compared to 28–32% in a general practice.)

The average retinal specialist enjoys a significant income premium for a few extra years of fellowship training, a somewhat more taxing clinical life, and added on-call responsibilities. Remarkably, if one divides the extra training time into the lifetime earnings premium, one sees an extra \$3,000 or so in lifetime earnings for every hour spent in one’s fellowship years.

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APPENDIX 15

PRACTICE PERFORMANCE BENCHMARKS

Practice Performance Benchmark	"Within Normal Limits" (All figures are for a general ophthalmology practice, except where noted.)
Practice revenue growth rate (collections this year, minus collections for the prior year, divided by the collections for the prior year . . . e.g., a practice that collected \$1 million last year and \$1.1 million this year enjoyed a 10% growth rate)	3% to 5% should be the baseline goal, which means that in an environment with slowly eroding fees, efficiency, and productivity must materially exceed fee reductions to hit growth targets. Young and aggressive practices should aim at 10% growth rates; mature practices can do just fine with zero net revenue growth.
Profit margin (profits before any MD/DO salaries and draws, divided by total collections)	30% to 45% (can be 15% and still "normal" in an HMO-driven practice and as much as 60% in a high-volume LASIK, retinal, or cataract referral center practice)
Cost per patient visit (add up total annual practice costs before all optical or contact lens costs, depreciation, MD/OD payroll, and any exceptional cost of sales such as injectable drugs; divide by the number of patient visits per year.)	\$70 to \$120 (you can see from this how accepting panel status with the wrong low-fee vision plans can kill profitability)
Overall lay staffing efficiency . . . the number of "man-hours" per patient visit (avg. monthly core lay staff payroll hours—omit optical and CL staff—divided by avg. monthly patient visits)	Wide-ranging from 1.5 to 3.0; typically averaging about 2.5 or lower in an efficient general practice . . . as an interesting contrast, it takes Toyota about 30 man-hours to build a car.
Staffing cost ratio (lay staff payroll, benefits and taxes divided by total practice collections . . . in some settings, where ODs are cast more as "super-techs" it can be more appropriate to count their costs with lay staff costs . . . just be consistent in tracking monthly)	25% to 32% (can be as low as 15% in a high-volume surgical practice and as high as 38% or more in a primary care oriented practice or a practice in an adverse urban location)
Average lay staff costs per FTE (fully-burdened lay staff costs inclusive of wages, salaries, taxes, and benefits divided by the number of FTEs)	+/- \$45,000 (will be much higher in urban centers with higher average wages and somewhat lower in rural practices . . . also, some practices choose to hire a small number of top-flight staff, rather than a larger number of average workers)

Facilities cost ratio (rent or mortgage payments, utilities, taxes, and basic repairs divided by collections)	4–6% (can reasonably range to 10% or more when in a new facility that the practice is still growing into)
Patient visits per exam room hour (total patient visits for the year divided by the number of exam room-hours per year, which is calculated by taking the number of fully-equipped exam rooms times 2080 nominal hours available to see patients per year)	0.7 to 1.1 is the typical range.
Collections per exam room per hour (the number of active exam rooms times 173 hours, divided into the average monthly practice clinical/surgical collections—omit ASC and optical revenue) . . . this is a compound benchmark analogous to a metric used by airlines to measure the ticket revenue paid per passenger mile.	+/- \$150 . . . but for resource-sparing practices and those with high surgical densities, the figure can range far higher.
Marketing cost ratio (creative, production, media, printing and other costs, but not internal marketing staff costs, divided by collections)	3–12% (rises much higher when launching new services such as elective plastics or LASIK). An old-line, established practice with no further growth aspirations can get by on 1% or 2%.
Refractive surgery cost per lead (with a “lead” defined as a caller who is not just checking price but is interested enough to give a name and contact information, and to make a screening appointment or receive practice information in the mail)	Extremely wide-ranging. Global cost per lead (all marketing costs divided by all leads) should be at or under \$150 for an established LASIK practice. Cost per advertised lead can approach \$500 and be “normal.”
Annual collections per FTE staff member (divide collections by all non-MD FTEs) . . . [This can also be expressed as collections for lay staff payroll hour.]	\$110,000 to \$225,000+ (up to twice this amount in retinal, LASIK and co-management oriented practices)
Tech efficiency ratio (tech total payroll hours divided by patient encounters)	0.8 to 1.0 (can be somewhat higher in a practice that delegates more care to lay staff, or a practice with trainees or a hub-spoke practice with lots of travel) LASIK practices are typically at 1.1; retinal practices at 1.3.
Reception staff efficiency ratio (check in/out; include call center staff, operators and medical records staff; omit time spent posting charges, if this is currently a front desk task; take staff total payroll hours divided by patient encounters)	+/- 0.5 (this is highly influenced by the payer mix of the practice, and where charge posting duties reside)
A/R ratio (this month’s ending A/R divided by the average monthly gross unadjusted charges over the past three months)	1.3 or under (note that this can vary widely based on service mix, patient base, and fee schedule applied)
Gross collection ratio (collections divided by total charges)	50%–85% (varies depending on both fee schedule and accounts management efficiency)
Net collection ratio (collections divided by allowable charges)	95+%
Percent of total receivables out over 90 days	14% or lower for the typical general/geriatric practice; half of this in a practice with a significant cash-and-carry trade (elective plastics, LASIK, optical).

Patient accounts staff efficiency-I: annual collections divided by department FTEs (all staff doing posting, charging, collections, etc.)	\$800,000 to \$1.2 million for the average general ophthalmology practice \$1.5+ million in LASIK and retinal practices.
Patient accounts staff efficiency billing department payroll hours (all staff doing posting, charging, collections, etc., divided by the additive product of the total patient visits [inclusive of post-ops] and the total surgical cases)	+/- 0.3 hours
Surgical counselor efficiency (counseling staff hours per month divided by the number of major cases per month)	With 173 payroll hours in a month, the typical FTE counselor can transit 50–150 cases per month . . . that comes to 1.2 to 3.5 payroll hours per major case (wide-ranging based on facilities used, scope of counselor responsibility).
Optical sales ratio (Optical sales divided by total medical, surgical, optical sales, excluding any ASC revenue)	15%–25%
Optical cost of goods sold or “COGS” (frame, lens, and lab costs divided by total optical sales)	30–40% (can be higher with premium stock)
Optical remake rate . . . what portion of jobs done have to be redone, largely due to refracting or prescription writing errors?	Under 5%
Optical 2nd pair sales rate . . . in what percentage of sales transactions does the patient buy 2 or more pair of glasses?	20+%
Optical staff efficiency total annual optical sales divided by number of dispensing opticians (omitting the lab staff)	\$200,000+
Optical sales per patient visit	\$15–\$65 (very dependent on the style of practice and mix of surgical vs. primary care)
Core clinic collections, omitting optical, per average patient encounter (monthly total collections divided by monthly total patient visits, inclusive of post-op visits); also referred to as the “average ticket”	\$150–\$225+ (can be much higher in surgically-dominated centers)
New patient ratio (new patients divided by total patient visits)	10%–20% Younger offices will obviously have a much higher ratio of new patients. Higher percentages than this baseline for an established practice may indicate poor continuity of care and recall protocols, which should be audited for gaps before spending on external marketing.
Collections per provider per year (inclusive of medical fees, surgical professional fees, ancillary testing, optical, but omitting ASC collections) Often useful to think in terms of “doctor equivalents” where a DE is one MD or DO, or two ODs.	The typical general ophthalmologist should be aiming for \$800,000+; retinal surgeons routinely hit \$1.5+ million, net of drug collections. Optometrist annual collections should be in the \$450,000+ range, inclusive of optical sales.

Patient visits per DE per month	Optimally lies at 550+ in general ophthalmology, but 450+ is a reasonable goal for a subspecialist practice.
Percent of allotted schedule template that is filled . . . that is, if a doctor's half-day session allots 30 visits, what percentage of these slots are actually filled at the start of each day, before cancellations and no-shows?	100% is obviously the target, but with work-ins can be higher.
No-show rates (the percentage of a day's scheduled appointments, after prior reminder calls have been placed, who do not show up that day for their appointment). A clinic with 100 filled appointments, and 10 missing patients that day would have a 10% no-show rate . . . this figure should be averaged over time, and by location and provider.	5% or under is optimal in a general practice. Rates hit 10–15% in pediatric offices or settings with a higher percentage of Medicaid patients. Compared to live calls for appointment reminders, no-show rates can be twice as high when automated calling systems are used.
Profit per surgeon-hour	A key metric. Wide ranging . . . may be as little as \$50 or over \$600. This is one of many dimensions of efficiency where ratio analysis is often best applied as an internal standard, rather than trying to match external benchmarks.
Surgical yield (total patient visits divided by the number of major surgical cases . . . better used as an internal reference than comparing to external benchmarks)	Highly variable depending on practice mix; 15–30 is WNL in a typical cataract practice; often under 10 in a co-management center. 25–50 is common in retinal care.
YAG ratio (YAGs divided by cataracts)	35%; can be 45% in mature practices.
Premium IOL rate (all premium lens including toric divided by all cataract surgeries)	+/- 18% at present, and generally rising; 25% and higher is routinely achieved in motivated settings.
Percent of maximum ASC capacity utilized	At 3+ cataract cases per hour in efficiency centers, it's not unreasonable to aim for 24+ cases per day. Working four days per week, 48 weeks per year in a multi-user center, this means a two-room ASC could transit 4600+ cases per year, although most such centers rarely exceed 50–80% of such maximal capacity.
Established patient growth rate (established patient visits this year, minus established patient visits for the prior year, divided by the established patient visits for the prior year . . . e.g., a practice that saw 5000 established patient visits last year and 5500 this year enjoyed a 10% growth rate)	Highly variable, depending on practice type. Should be higher (5+%) in a general practice with a higher ratio of ongoing care. Low for co-managing cataract surgeons where many patients return to their referring doctor. Can be a negative rate for a surgeon nearing retirement.
Annual support staff separation rate (Divide the number of lay staff employee voluntary and involuntary departures you have experienced in the last 12 months by the average number of staff members who have been employed by your practice during the same period. Then multiply that number by 100 to express it as a percentage.)	Highly variable, depending on the market, provider behavior, employment practices, and management's skills. The U.S. private industry rate is about 37%. This figure is only about 15% in government service. In a stable practice, a mid-point between these two is reasonable and typically seen in well-run centers . . . about 26%

Quick or “acid test” ratio. A measure of a practice’s liquidity and ability to meet its obligations. Obtained by subtracting goods inventories from current assets (such assets should be inclusive of the recoverable portion of the A/R) and then dividing the resulting figure by the current liabilities.	1.0 or higher; the higher the number, the stronger the practice. Is commonly much higher than this in established practices.
Debt Service Coverage Ratio or “DSCR.” Classically used in real estate to score loan applications. A measure of the cash available for debt servicing (interest, principle, equipment lease payments). Divide the practice’s annual profit available for owner compensation by the sum of annual principle repayments, interest, and lease payments. Indicates the “safety margin” of an enterprise or a proposed initiative.	Typically 1.0 or higher when applied to a pure real estate evaluation, and may be in the range of 2.0 for a new practice launch . . . is more often 3.0 or higher in established practices. This metric can be used to gauge the safety of a single transaction (for example, the purchase of a satellite practice) or look at the overall position of the practice. If tracked over time, can indicate a strengthening or weakening business position.

Benchmark Components: Conventions Defined and Discussed

Patient Visits: A patient visit, by convention, is a patient seen by a “provider” as defined below (an MD, DO, or OD professional.) This includes compensated visits as well as uncompensated post-op visits (when seen by a provider) and omits patients seen by a technician only (as for a pressure check or visual field exam). It omits surgical visits. As a matter of convention, it does not count those few patients per month who may drop in for a minor clinic procedure with the doctor if they do not also receive an exam on that day, nor does it count the infrequent ER or admitted patients seen in the hospital.

New Patients: Patients seen for the first time by the practice. They may be difficult to calculate perfectly, because a patient not seen for more than three years, for reasons of billing conventions, is typically charged out as a new patient.

Collections: Cash basis collections received and deposited.

Profit: Free cash flow, after all cash-basis business expenses (omitting depreciation, but including optometric provider wages/taxes/benefits), available to pay wages, taxes, benefits, and dividends to owner and associate physician (MD/DO) providers in the practice, along with any undistributed, retained earnings available for reinvestment or debt reduction.

Lay Staff: All non-MD (non-DO), non-OD workers in the practice. This would include foreign-trained physicians working as techs due to licensure issues. When counting lay staff, estimates may be necessary for outsourced services (e.g., billing services). Cleaning and building maintenance staff are not included, nor are on-call individuals charging professional fees (attorneys, accountants, consultants, etc.) Although techs, FA specialists, testing staff, and others often provide care to patients, with little or no supervision, these are “lay” staff and not “providers.” By convention, when counting techs or billing staff or reception staff, the cohort supervisor’s time should also be counted. (Example: A billing department with three billing clerks plus an additional working supervisor, all of whom work 40 hours per week, should be seen as having four FTEs in the department).

Provider Staff: Ophthalmologists and optometrists only. (Too few NPs or PAs are employed in ophthalmology to have created a standard convention for these providers.)

Payroll Hours: Compensated work hours, whether regular time, overtime, paid sick leave or vacation time. Typically, 2080 hours per year (40 hrs x 52 weeks) or an average of 173 hours per month.

Lay Staff Full-Time-Equivalent: An employee working an average of 40 payroll hours per week.

“Reception” Staff: All staff who are responsible for answering incoming calls, making appointments, pulling/filing medical records, scanning documents, and checking patients in and out. As a matter of convention, material time spent posting charges or window payments and time spent supporting the billing department by securing preauthorization and insurance verification should be apportioned to “billing” for the purpose of determining the practice’s labor utilization benchmarks.

“Billing/Patient Accounts” Staff: All staff who are responsible for authorization and pre-certification work, posting charges and payments, submitting primary and secondary claims, generating billing reports, and handling collections work.

“Technical” Staff: All staff who are responsible for escorting and working up patients, taking histories, providing special testing, scribing, or chair-side assisting.

Doctor Equivalent: A matter of convention used for many years at J. Pinto & Associates, Inc. A “doctor equivalent” (DE) is a surgical provider working full time (or essentially full time, e.g., 4.5 days per week). A medical ophthalmologist working full time or an optometrist working full time are counted as one-half DE, not because they are somehow less-worthy professionals, but because their output—in both volumetric and economic terms—is commonly about half that of an ophthalmic surgeon. There are obviously wide variations in this area. Some ODs produce more than some eye surgeons. So it’s often reasonable for practices to develop their own internal conventions and apply these consistently going forward.

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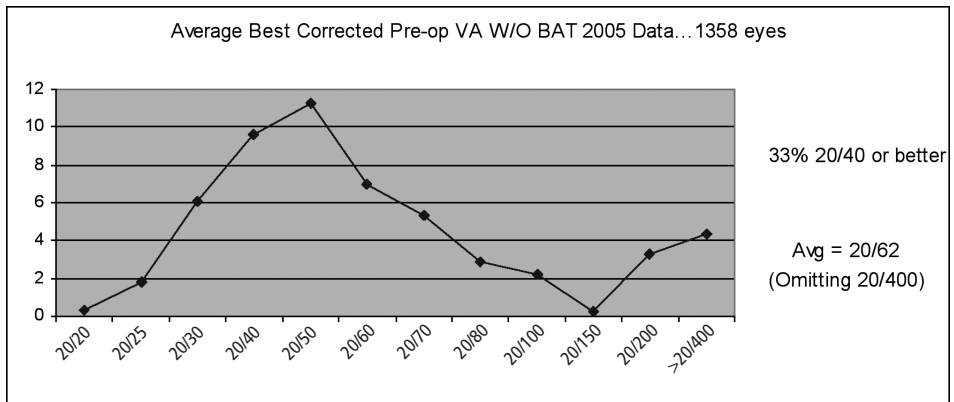
APPENDIX 16

PINTO'S SURGICAL ASSERTIVENESS INDEX

In 2005, with much support from Drs. Richard Lindstrom and Elizabeth Davis, I reported client data showing the typical preoperative, pre-Brightness Acuity Test (BAT), best-corrected visual acuity (BCVA) distribution curve, and the average figures for two key statistics:

- The percentage of eyes with a pre-op/pre-BAT BCVA of 20/40 or better
- The average pre-op/pre-BAT acuity of these eyes (omitting those eyes of 20/400 or worse, as a matter of convention for the study)

Back then, I looked at 1358 eyes operated by 25 different client surgeons . . . about 54 eyes each. The resulting distribution curve was as follows:



One-third (33%) of these eyes were 20/40 or better pre-op/pre-BAT, and the average Snellen acuity was 20/62 omitting the 20/400 and worse eyes.

For several intervening years, after this first study, I applied these same calculations to selected new clients and generated the same, basic distribution curves for scores of individual surgeons. In the early years, aside from the occasional high and low values, subsequent surgeon data have been very much in line with the 2005 study. Most clients had about a third of their patients presenting with pre-BAT cataracts that were 20/40 or better.

This benchmark has been a useful coaching tool. When the graph has been shifted sharply to the right (for example, when a client has a profile showing an average pre-BAT BCVA of 20/70) my typical advice has been for the surgeon to visit with a trusted colleague for some peer-to-peer insight on how to become a less reticent surgeon.

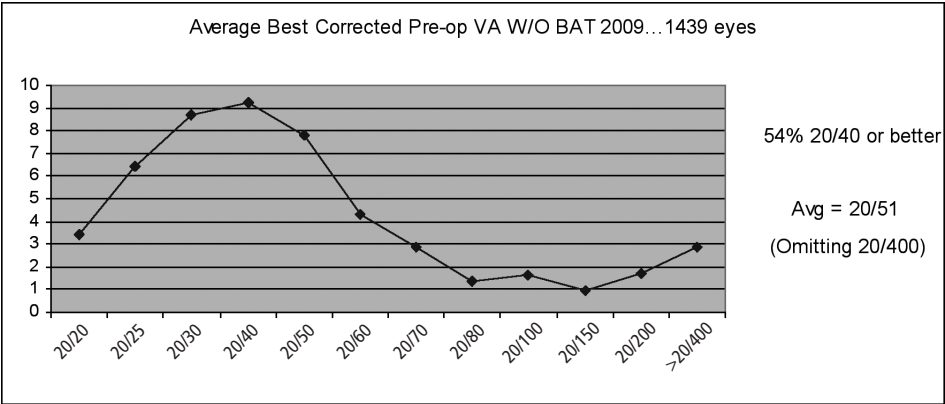
I've applied the same urgings for peer-to-peer discussions—in the opposite direction—for left-shifted surgeons, those whose pre-BAT BCVA profiles can be 20/45 or lower. In such settings where the client surgeon appears to be vastly more aggressive than average, I also recommend a redoubling of history taking, testing, and charting caution.

Is Something Changing?

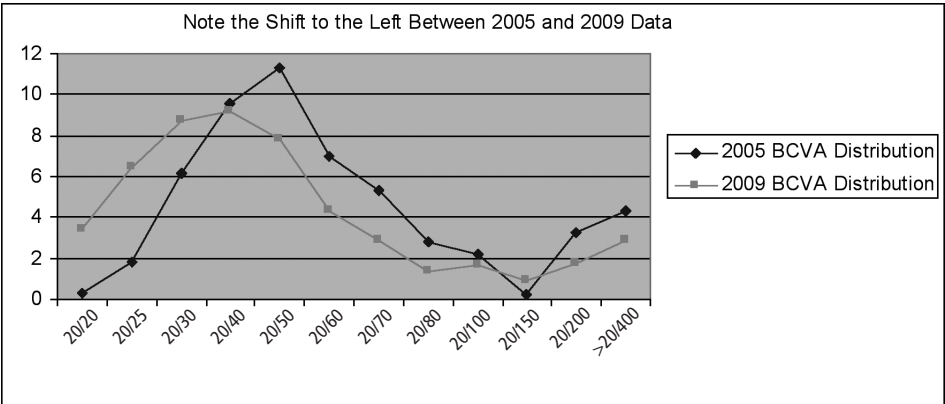
Interestingly, I've observed of late that MOST client surgeons are "left-shifting," becoming on average as assertive in their case selection as the highly *aggressive* surgeons from 2005.

Here are the most recent results from late 2009 averaging the data from 28 client surgeons (an entirely different cohort from the 2005 study).

This time around, I looked at 1439 eyes . . . about 51 eyes per surgeon. The resulting average distribution curve was as follows:



Compared to the 2005 study, 54% of these most recent eyes were 20/40 or better pre-op/pre-BAT, and the average Snellen acuity was 20/51, omitting the 20/400 and worse eyes. Here are the two curves superimposed and combined into one graph:



And here is another way of looking at the data from the two timeframes:

	2005 Data (1358 Eyes)	2009 Data (1439 Eyes)	Variance Percent
Percent Pre-op/Pre-BAT BCVA at or under 20/40	33%	54%	Up 64%
Average Pre-op/Pre-BAT BCVA (omitting eyes 20/400 and worse)	20/62	20/51	Down 18%

Unless this material graphical shift to the left is an artifact of the admittedly limited sample size in both studies, these data appear to signal a discernable change in surgeon behavior toward greater assertiveness in the recent years. This shift, which has continued to a somewhat lesser degree in the years since the 2009 re-study, is certainly in line with my subjective impression from visits to hundreds of practices. Something very interesting and not so subtle seems to be going on.

As an “ophthalmologistologist,” I’d propose that this shift to the left could be driven by several possible factors shown below, alone or in combination:

- Rising surgeon confidence . . . resulting from lower complication rates, better methods, better tools, and better education
- A continued diffusion of “best practices” knowledge in the profession . . . over the last 40 years, cataract care has inexorably shifted from “Wait as long as you can” to “Proceed whenever the patient is really ready” to “Let’s just get on with it; the patient’s lifestyle enhancement is going to be terrific.”
- Rising surgeon-to-surgeon competition . . . “If I don’t help this patient today, my colleague down the road will operate on her tomorrow”
- Greater demand from baby-boomer patients . . . who are not only better informed and more finicky about their vision, but are increasingly concerned about future Medicare cuts
- Ever-rising economic pressures on surgeons . . . if true, this is validation of the observation that utilization rises when fees fall, which will continue to null efforts to contain healthcare costs.

* * *

Irrespective of the cause, this finding is helpful to report here for at least two reasons. First as a placeholder for subsequent studies, and second to teach you and your administrator a simple approach to measuring whether YOUR practice is more or less conservative than those of your peers these days.

My interest in 2005 was driven by clients who would ask, “Am I a sufficiently assertive cataract surgeon? How do I stack up with other doctors?” That interest abides. The methodology I developed at the time was very simple—and I’ll acknowledge here, probably less elegant than could be derived by better minds. Here it is for your own in-practice use:

1. Pull the last 50 cataract cases you have performed. Don’t throw the data off by skipping cases you feel are unusual. We want a straight series of consecutive cases.
2. Simply write down in two columns the patient name or number (for subsequent reference if you’re interested) and the corresponding preoperative BCVA before any brightness acuity testing.
3. Count the number of cases in each acuity category, and graph these counts as shown above.
4. Average the pre-BAT BCVA of these 50 cases, omitting those cases where the vision is 20/400 or worse. The resulting figure will probably be more than 20/45 and less than 20/70.
5. Determine what percent of the 50 cases present with 20/40 or better vision before surgery and without BAT testing. The resulting figure will typically be well under two-thirds.
6. If your curve is shifted materially to the left, you’re a more aggressive surgeon and you may want to make sure your history taking, documentation, and testing substantiate your case selection. If your curve is right-shifted, you’re perhaps a less aggressive surgeon and there may be an opportunity to help your patients by being a little more assertive.

* * *

Here are a few additional observations in this interesting area:

- Providers in competitive urban markets (where the population-to-provider ratios are low) tend to have a lower average BCVA than noncompetitive markets.

- Higher volume surgeons have a much lower average BCVA than low-volume surgeons.
- Surgeons working together in the same practice will commonly cluster—whether high, low or in the middle—with each other.
- Younger surgeons have a higher average BCVA (and are more conservative) than mid-career surgeons . . . and older surgeons tend to become more conservative once again in their 60s and beyond.
- Conservative surgeons, with a higher average pre-op BCVA, once exposed to their personal BCVA profile, often “left-shift” to become more assertive. Similarly, surgeons with much lower average pre-op BCVAs, who one may politely call, “very self-confident,” will often right-shift toward the mean when they see these data in black-and-white.

* * *

As I wrote in 2005, patterns of surgical aggressiveness or passivity tend to cut across the full span of clinical and surgical services. So if through this exercise you find yourself to be a little less assertive in your cataract patterns than others, examine your utilization of other patient services, as well. You may find that your use of special testing or return-to-clinic intervals could use an update.

#

APPENDIX 17

THE TWIN BRIDGES PROTOCOL: A PROPOSED METHODOLOGY TO MEASURE AND IMPROVE CATARACT SURGEON SKILLS

All eye surgeons are strivers and achievers. After years of striving to be the best student in high school . . . and then to be among the top few graduates from university . . . and then to hold their own in medical school and postgraduate training, it seems appropriate that the most striving and confident surgeons would be clamoring for a cataract “report card.”

And yet, so far as we have been able to determine, no consensus has been developed around the best approach to measure cataract outcomes or a surgeon’s comparative surgical performance versus his or her peers. Interestingly, a search of the Internet reveals many fewer U.S. citations than international ones.

America has some of the finest medical training programs in the world and likely graduates the planet’s best prepared eye surgeons. That said, half of the cataract surgeons in America perform below the median of their peers.

I describe below the results of a modest pilot study to try to compare the peer-to-peer outcomes of a small cohort of

cataract surgeons and also propose a simple “surgeon scoring” methodology for the profession to adopt and hopefully improve upon over time.

This study resulted from efforts over several years, working in collaboration with selected client practices and an advisory group consisting of Drs. Dick Lindstrom, Lisa and Amir Arbisser, Paul Koch, and Trevor Elmquist, to develop a simple cataract outcomes screening tool.

The “Twin Bridges” name for this project is attributed to an Old Wild West town in the middle of Montana, where most of the advisory group first started discussing this project during annual client fly fishing sessions.

We believe there could be several potential applications of the “Twin Bridges Protocol” once it is fully developed beyond our early efforts. The Protocol can be used:

- to augment a practice’s ongoing quality assurance activities.
- to screen surgeon job candidates.
- to screen out associate or partner candidates who are not passing internally agreed upon surgical outcomes standards.
- as part of the vetting process for merger-consolidation activity.
- to provide doctors nearing retirement with objective evidence that it may be time to discontinue operating.
- to provide surgeons with objective skills verification for their personal development.
- to validate new surgical maneuvers, equipment, or implants.
- to establish the basis and starting baseline for any needed peer-to-peer surgical performance coaching.
- to use favorable data in a practice’s patient communication to give candidates for surgery confidence that their doctor is objectively better than average.
- to use favorable data to verify to payers and professional referral sources the quality of care.

That said, everyone who has been involved with this project understands that significant controversy could arise out

of this initial, exploratory effort—which may be why similar efforts to grade surgical outcomes and skills have been so scant in the past. The potential controversies with our efforts are manifold.

In its present format, as you will read, the “Twin Bridges” methodology is simple and highly reductionist—nothing more than averaging just two percentile metrics: the percent of a surgeon’s cases resulting in the patient’s one-month postoperative spherical equivalent being 1.0 diopter or less divergent from the preoperative planned spherical equivalent . . . and the percent of cases achieving 20/40 or better Snellen BCVA at one-week post-op. (A third measure recommended by the advisory group—the percent of patients not needing a vitrectomy—was originally employed, but skewed nearly all scores sharply upward. The vitrectomy rate in this 34-surgeon, 1700-case cohort was just one-tenth of a percent).

The benefit of the approach we used is simplicity and the ready availability of this data in nearly every surgical patient’s chart. As a result, adding surgeons to the data pool will be easy as our exploration of this metric continues. However, by being this reductionist, we are probably shaving points from some surgeons and adding undue points to others. In particular, it would be fair to criticize the Twin Bridges Protocol because we only assess the outcomes of uncomplicated cases; the Protocol doesn’t measure a surgeon’s mastery in handling complicated cases.

* * *

Our Methodology

Fifty case cataract data sets were received from 37 surgeons; 34 of these had data forms completed sufficiently to be used in this study. All data were masked as to surgeon or practice of origin. The cases submitted were limited to “qualifying” eyes defined by the following parameters:

- Cases selected were those where pre- and postoperative vision was NOT compromised by corneal, vitreous, or macular pathology (examples: Corneal dystrophy,

macular degeneration, visually significant diabetic retinopathy, epiretinal membrane, etc.).

- All patients with a diagnosis of glaucoma were omitted.
- Cases selected were all orthodox, senile cataracts, in patients 55 years of age and older, NOT coded as complex cases (66982), and NOT implanted with a premium/multifocal or toric IOL.
- The only cases submitted were those where the postoperative care was provided by the practice's internal providers; comanaged cases where the post-op care was provided by an outside/referring doctor were to be omitted.

It was decided that a simple 100-point scoring system would be ideal (like the familiar "Parker" points for wine, which perhaps reveals a bit too much about what we're doing besides fly fishing in Montana.)

From the raw data, we generated each surgeon's score as follows:

- An "A" value was calculated by measuring the percent of 50 cases with a spherical equivalent at or under 1.00 diopter from the pre-op plan at one month.
- A "B" value was calculated by measuring the percent of 50 cases with best corrected visual acuity at or better than 20/40 at one week.
- The total "Twin Bridges" score was simply the average of these two percentile values.

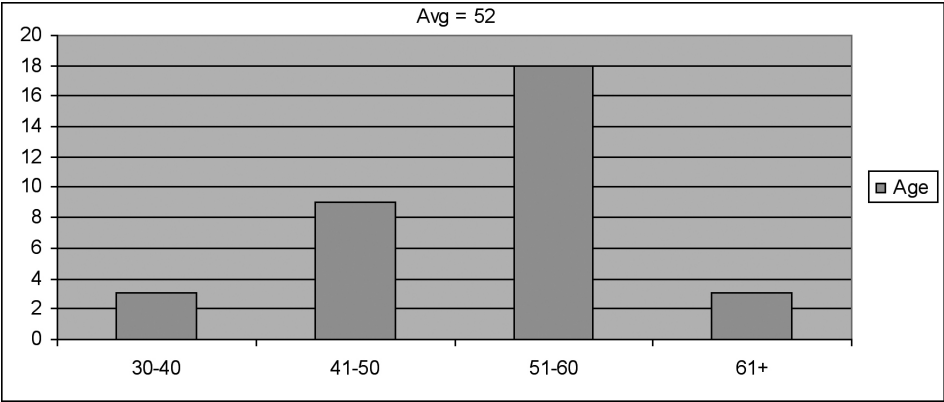
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Preliminary Results

Surgeon Age

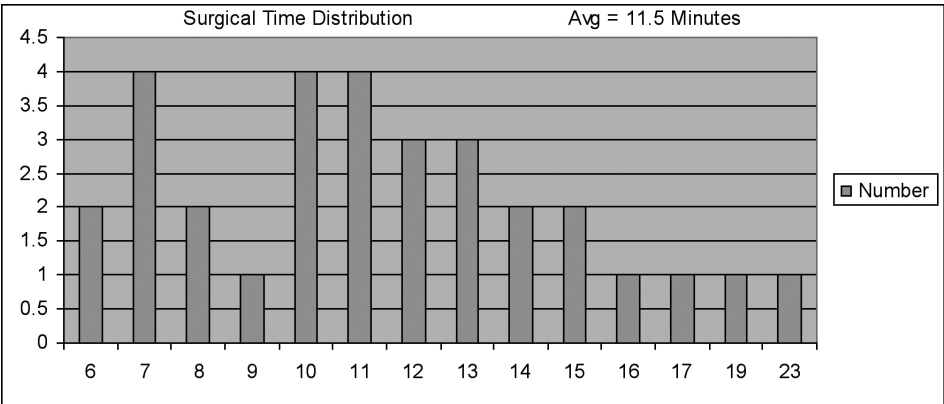
The 34 surgeons in this cohort ranged in age from 37 to 61. The average age was 52. It is not unusual today for eye surgeons to remain active until their early 70s or later. (As a side point, this is in line with the distribution curve of eye surgeons in America, who—like the baby boom generation—are clustered within a decade or so of retirement. This, plus the fast-rising demand for ophthalmic services, and the material reduction of residency slots, are all

leading us to an era when the country will be underserved. For the typical practice, this will lead to benefits, such as more patients to see . . . but also to more difficulty with surgeon recruiting, and real challenges to practice succession planning.)



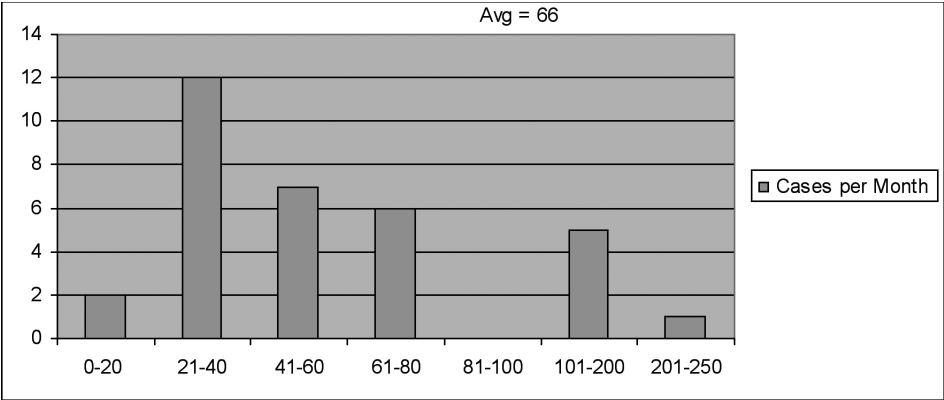
Distribution of Surgical Times

Thirty-one surgeons supplied intraoperative times. Most reporting practices provided a finite time in minutes for each case; a couple of practices submitted an average time. The average surgical time was 11.5 minutes. The fastest two surgeons averaged six minutes, the slowest surgeon 23 minutes. The average timeframes are in line with observed contemporary goals to be generating three or more cases per hour in the OR.



Case Volumes

This group was wide-ranging in monthly volumes, from 15 to 240 cases. The group average was 66 cases per month. So as a cohort, even when looking at median figures, this group could be considered to be more experienced than the typical eye surgeon in America. One might expect that when this study is expanded, we will see somewhat lower Twin Bridges scores with less seasoned doctors. Interestingly, as you will see in the data below, high monthly volumes do not necessarily result in the highest scores when applying the Twin Bridges Protocol.



Twin Bridges Scores: Range and Distribution

Scores ranged from 86 to 100 points. The average score was 95.6 points. Two of the questions we have are whether this is too charitable a scoring approach and whether it might be better to raise the bar such that average scores are a bit lower. It's fun to think about this in terms of the Parker system for wine, a 50 to 100 point scale:

96–100: An extraordinary wine of profound and complex character displaying all the attributes expected of a classic wine of its variety

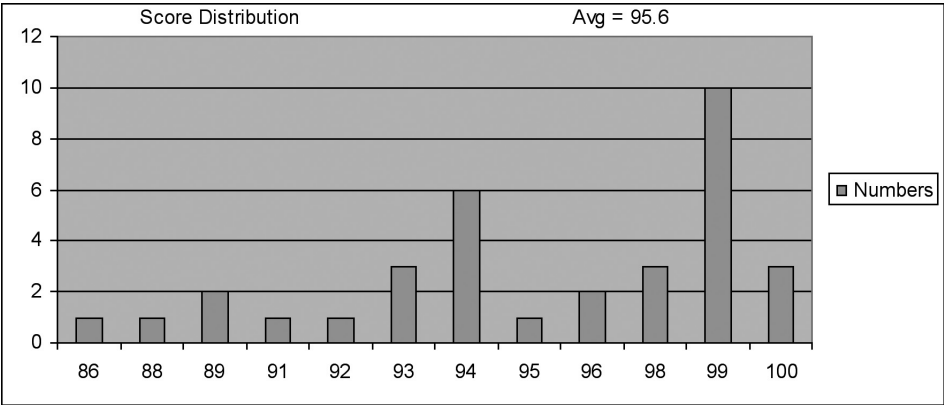
90–95: An outstanding wine of exceptional complexity and character

80–89: A barely above average to very good wine displaying various degrees of finesse and flavor as well as character with no noticeable flaws

70–79: An average wine with little distinction except that it is soundly made, in essence, a straightforward, innocuous wine

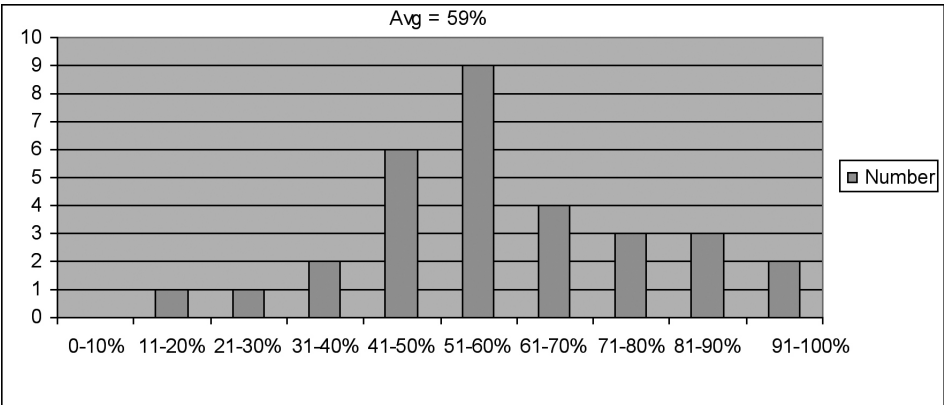
60–69: A below average wine containing noticeable deficiencies, such as excessive acidity and/or tannin, an absence of flavor, or possibly dirty aromas or flavors

50–59: A wine deemed to be unacceptable



Surgical Assertiveness Distribution

Several years ago I developed and published in OSN a method for scoring surgeon assertiveness by taking the percent of cases, pre-op and pre-BAT, with a BCVA of 20/40 or better. Five years ago, the average figure was 33%. In an early 2010 OSN update of the 2005 baseline study, the average came in at a significantly more assertive 54%, which is in line with observations in the field during client site visits. For this Twin Bridges study cohort of surgeons, the wide range was 16% to 94%; the average at 59% was slightly more assertive than this year’s update study.



Correlations Between the Twin Bridges Score and Surgeon Parameters

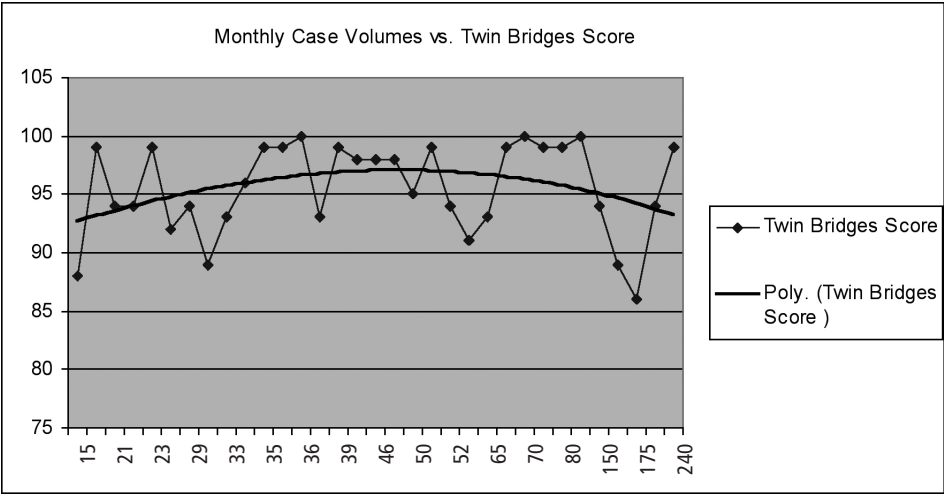
While the number of surgeons and cases reviewed for this pilot study are not yet enough to draw firm conclusions, or to control for the key variables, the following graphs suggest potential correlations between the Twin Bridges score, surgical time, cases per month, and surgeon age.

* * *

Monthly Case Volumes vs. Twin Bridges Score

In looking at the left half of the graph below, we see what we would expect: If you do more surgery you get better at it and your score improves. However, if we look at the right half of the graph, we can seemingly reach only one of three conclusions: 1. either higher volume surgeons are doing poorer work; 2. we are not appropriately scoring surgical quality; or 3. we don't have enough data points yet to draw any conclusions.

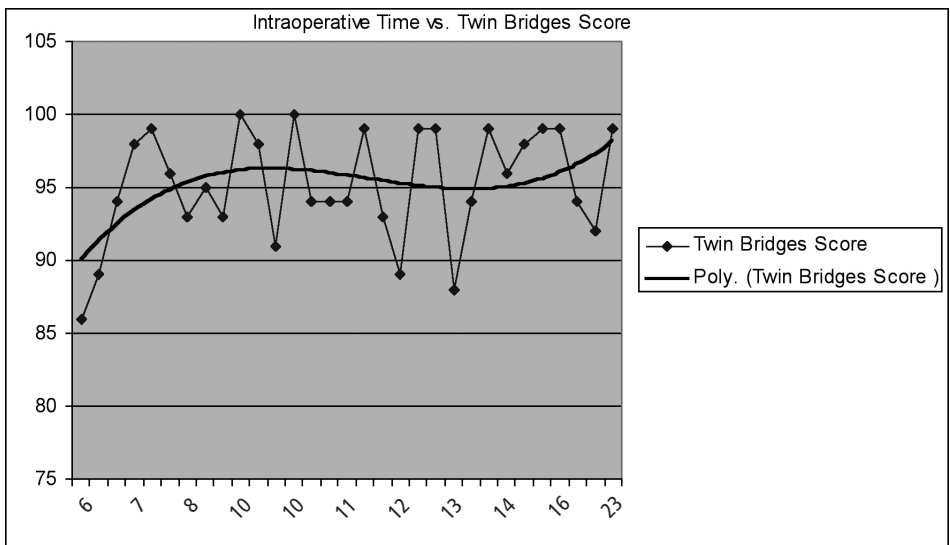
Holding the data at arm's length, and applying my experience with surgeons and surgeon behavior as their workloads increase, I believe what will emerge as this study expands and matures is that as a surgeon becomes more volumetrically successful, up to about 100 or slightly more cases per month, his or her outcomes continue to improve, but that after this—whether due to fatigue or rushing, perhaps—outcomes start to erode.



This is fairly sensitive territory, especially among those surgeons who aspire to higher volumes. Your impressions and feedback would be most welcome.

Intraoperative Time vs. Twin Bridges Score

As a layman, I have often heard moderately paced surgeons castigate their faster colleagues, saying that the latter's increased, brusque pace makes for sloppier or at least less gentle work. It's interesting, even in this smaller data cohort, to see this opinion potentially objectified in the graph below.

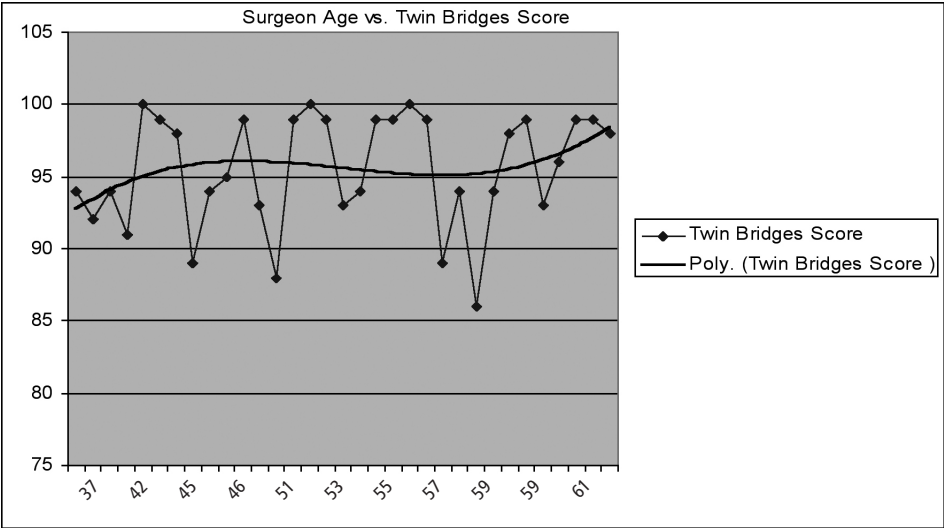


The slowest 10 surgeons had an average Twin Bridges score of 95.8; the fastest 10 surgeons had an average score of 94.3. Given the compressed nature of the present scoring system, where all but five of the 34 surgeons measured had a score of 92 or higher, these differences feel material. However, additional data points will be needed to validate this early impression.

Surgeon Age vs. Twin Bridges Score

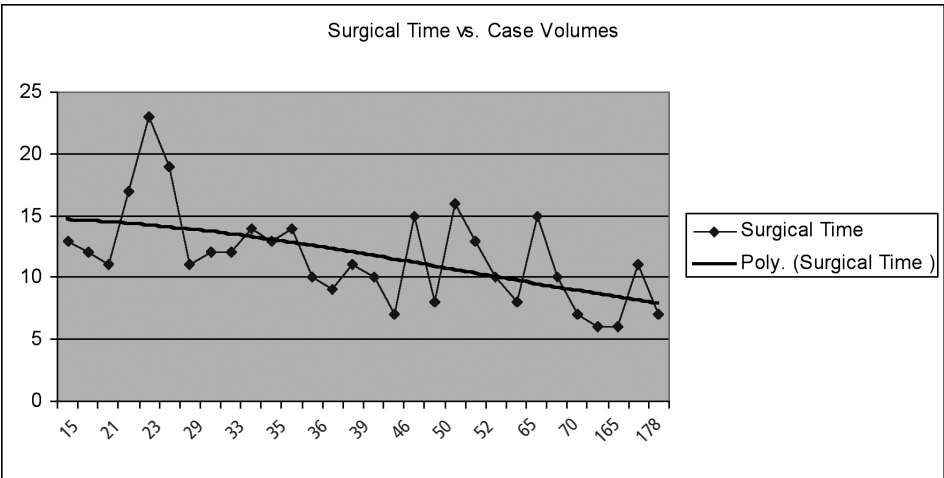
Unfortunately, when looking at age vs. score, we don't yet have sufficient data sets to control for case volumes or intraoperative time. However, by expanding the height of the y-axis in the graph below (and squinting rather hard) it seems possible to recognize that the generational

middle-third of surgeons have slightly better (and less volatile) scores than younger surgeons, and that older surgeons are holding their own just fine. This will be interesting to return to when more data is available, especially from surgeons in their 60s and 70s, who are increasingly common to see.



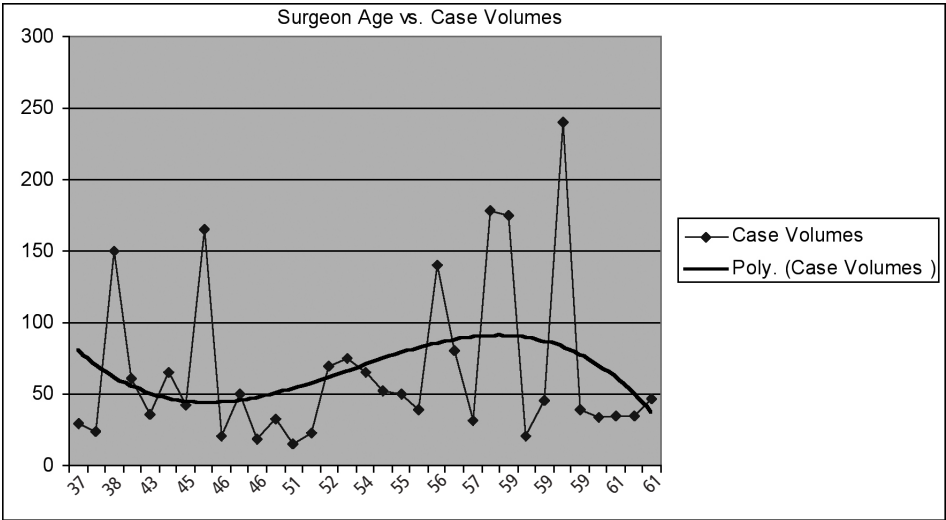
Intraoperative Time vs. Monthly Case Volumes

Practice makes perfect. Or it at least makes *faster*. The graph below shows a strong correlation between monthly volumes and surgical tempo.



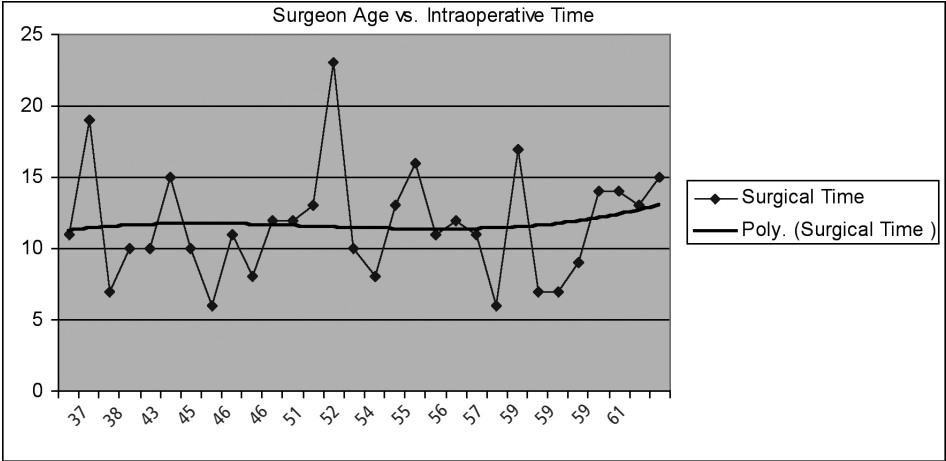
Surgeon Age vs. Monthly Case Volumes

No surprises here. As might well be expected, surgical volumes rise as careers mature and then perhaps decline again.



Intraoperative Time vs. Surgeon Age

The overall tempo for this cohort of surgeons was faster than surgeons on average. In this small group, however, there appeared to be no meaningful correlation between age and tempo; there were relatively faster and slower surgeons at every career stage.



**The Top 10 and Bottom 10 Surgeons
in This 34-Surgeon Cohort**

One prefers to think that all surgeons are above average. All are certainly trained, licensed, and vetted daily by ordinary market forces. Subject to a lot more work to be accomplished, one might perhaps be able to say with some assurance one day that the best outcomes are generated by providers who are a bit slower (More cautious? More gentle? More tissue sparing?), just a bit older (More experienced? More conservative?), and performing somewhat more moderate case volumes. We shall see. For now, here is the breakdown:

**The Bottom 10 Surgeons (based on their
Twin Bridges Score *only*)**

- had an average Twin Bridges score of 90.8.
- had an average age of 49.2.
- averaged 76 cases per month.
- had an average intraoperative surgical time of 10.2 minutes.
- had an average pre-op BCVA of 20/40 or better comprising 55% of cases.

Of the six surgeons performing more than 100 cases per month, three are in the bottom 10 group and one is in the top 10 group

**The Top 10 surgeons (based on their
Twin Bridges Score *only*)**

- had an average Twin Bridges score of 99.3.
- had an average age of 51.3.
- averaged 60 cases per month.
- had an average intraoperative surgical time of 13.9 minutes (n = 7 for this avg., due to data gaps).
- had an average pre-op BCVA of 20/40 or better comprising 60% of cases (n = 7 for this avg., due to data gaps).

* * *

In Conclusion

Everyone reading this Appendix is a professional of one kind or another. As a professional consultant, I would probably be a little defensive if someone came up with a 100-point scorecard for the way I advise surgeons. The professional practice administrators reading this might similarly resist any effort to pin a national numeric grade on their job performance. Seen in this light, cataract surgeons reading this report could, quite reasonably, be in a mood to throw rocks at it.

However, we are entering a likely durable era of health care cost constraints, one where *fee-for-service* may increasingly be replaced by *fee-for-outcomes*. We could anticipate that cost containment efforts in the future may include payer policies allowing only the most necessary surgery by only the most competent individuals. There are certainly precedents in other advanced countries for only a subset of trained surgeons to be allowed to operate.

Ophthalmology has long lent itself to numbers. Visual function is graded numerically, as are many eye diseases. We hope that this modest study, for all of its limitations, will stimulate readers to join us in considering methods that are robust, accurate, reproducible, simple to calculate from pre-existing chart data, and believable by surgeons. Far better that ophthalmology should develop these measures bottom-up than that the profession one day should have such measures imposed top-down.

I would like to express my deep appreciation to the surgeons and administrators of participating client practices, and to the surgeon review group for their most generous efforts to date. That said, please consider any errors, omissions, or oversights in this preliminary report to be mine alone. We look forward to your comments and suggestions for improvement. With your help, and a bit more effort, I'm hopeful we will be able to derive a concise, simple approach to fairly and simply evaluating cataract surgical outcomes.

APPENDIX 18

SIGNPOSTS OF SURGEON CAREER AND LIFE HAPPINESS

BY JOHN B. PINTO AND CRAIG N. PISO, PHD

What makes a good ophthalmic practice great? Depending on the observer's professional discipline or position—doctor, manager, staffer, or patient—it may be many things, such as:

- Objective, measurable clinical outcomes
- The patient's subjective experience . . . was the practice caring?
- The level of technology and technical sophistication
- Staff composition, training, and teamwork
- The physical plant, its layout and accommodations

But perhaps, seen through the eyes of our practices' surgeons, a "great" practice is simply one which affords **each doctor** with an overall feeling of personal happiness, security, pride . . . in short, "satisfaction."

Even though we have never before benchmarked surgeon happiness or satisfaction, it's entirely appropriate for managing partners, practice administrators, consultants, and others to study the satisfaction of the surgeons we serve, work to increase their sources of potential happiness, and limit susceptible sources of frustration and unhappiness.

We think that what follows is potentially important and could change the way you interpret and manage your enterprise.

In the view of happiness experts, the model of life satisfaction is linear and additive. A person's overall satisfaction is the sum of satisfactions in those areas of life deemed important by the individual. Said another way, if we think that those dimensions of life we value most (such as our work, our play, our relationships) are going especially well, life is satisfying. Looking more narrowly within the confines of a practice, a doctor who values, let's say, a great lead tech, high profits, and a comfortable personal office—and who achieves these things—is going to be a happy doctor. Or perhaps not, as you'll read.

America's ophthalmologists have many reasons to be satisfied with their professional lives and practices. They have successfully mastered one of the most rigorous educational gauntlets in the world. As physicians generally, and eye specialists in particular, they enjoy a high level of societal respect. Ophthalmologists are highly mobile, able to take their talents nearly anywhere in the world and earn a top-tier income.

There are several other reasons that ophthalmologists should feel good about their lot in life, including:

- Incomes put almost all ophthalmologists in the top few percent of American wage earners and a fortunate few surgeons in the ranks of international entertainers and sports figures.
- Most patients get predictably better after treatment, and you can objectively measure when they don't.
- Most patients can be treated in a way that is virtually pain-free.
- The pace of new clinical and surgical development in ophthalmology is brisk, but not so daunting as to overwhelm the average provider.
- The comparatively strong economic output of ophthalmology allows the profession to respond more effectively to every new regulatory burden than in other medical domains.
- There is an abundance of ancillary services and products that can be offered in an eye clinic—ASCs, optical shops, elective/cosmetic services, etc.—which at least until now have been able to more than mitigate the effect of falling fees.

- The ophthalmic work style is relatively kind, with minimal after-hours call. Eye care is not very physically demanding; unlike orthopedics, it's common to see ophthalmologists still practicing actively into their 70s.

Of course, opposing these drivers for feelings of well-being are several well-understood counter-drivers, including:

- America's health care payment systems, and particularly the rising cost of Medicare, are under considerable scrutiny and likely slated for downward adjustments . . . so even if one is confident about there being lots of demand for eye care, one's reasonable expectation is that net surgeon revenue per hour of work or unit of service is bound to decline. This will leverage incomes sharply lower in an environment of rising practice costs.
- There is an underlying feeling of competitive threat among some ophthalmologists that optometry's growing provider base (the number of new optometrists graduated per year is about three times the number of new eye surgeons) and widening scope of care will encroach on the ophthalmic franchise.

After many decades spent studying the business and profession of ophthalmology, we decided it was time to more rigorously examine the question, "How Happy and Satisfied Are Ophthalmologists Today, and What Are the Determinants of This?"

* * *

We employed a standardized "life satisfaction" test, the "Quality of Life Inventory" (QOLI; developed by Michael B. Frisch, PhD and distributed by Pearson Assessments, www.pearsonassessments.com) to poll surgeon-owners of practices belonging to the Large Practice Interest Group, a subset of JPA clients.

The QOLI is a written survey instrument which asks respondents how satisfied they are with various segments of their lives (eg: work, health, friendship, etc.), and how important each of these segments is in their lives. The QOLI instrument is 16 questions long, and was augmented in

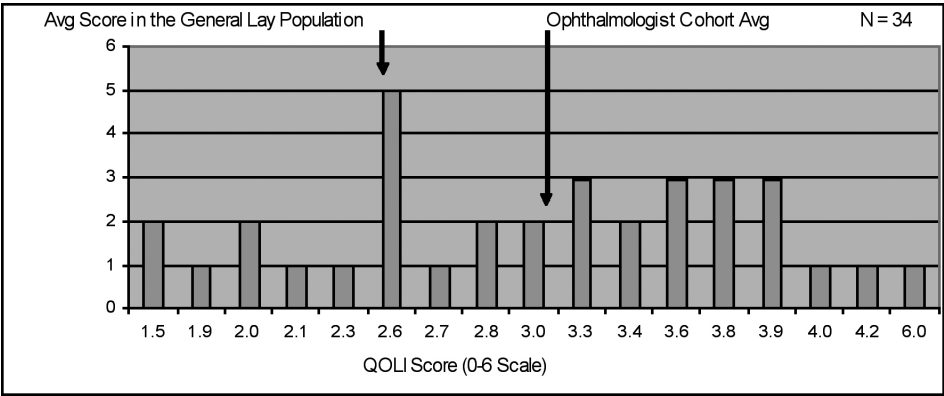
our study by an additional section asking about their lives and practices to help us try to correlate satisfaction with such things as age, career stage, subspecialty interest, practice volume, or income.

A total of 34 surveys were returned. Due to this limited sample size, and the potential for adverse selection (as by happy doctors volunteering to participate more readily than dour ones), we applied our best efforts to draw what are, at this point, no better than impressionistic conclusions regarding the results and their meaning. Future efforts to increase the cohort sample size and control for variables will be interesting to pursue.

* * *

The Results

The average age of respondents was 49. There were 33 male responses and one female. The average QOLI instrument raw score was 3.1 on a 6-point scale. This compares favorably with members of the general public taking this instrument, whose average is 2.6.



Applying the instrument’s cutoffs for “High, Average, Low, and Very Low,” 35% of respondents had a High level of life satisfaction, 59% fell into the Average category, and 6% (two individuals) were Low.

These “Low” individuals were interesting in that they both wanted to retire somewhat sooner than average, in their early 60s, and had lower satisfaction with the nonwork “Play”

aspects of their inventory. If they had taken this instrument as part of a personal counseling program, their professional counselors might likely have followed up these findings by working their clients up for suspected depression.

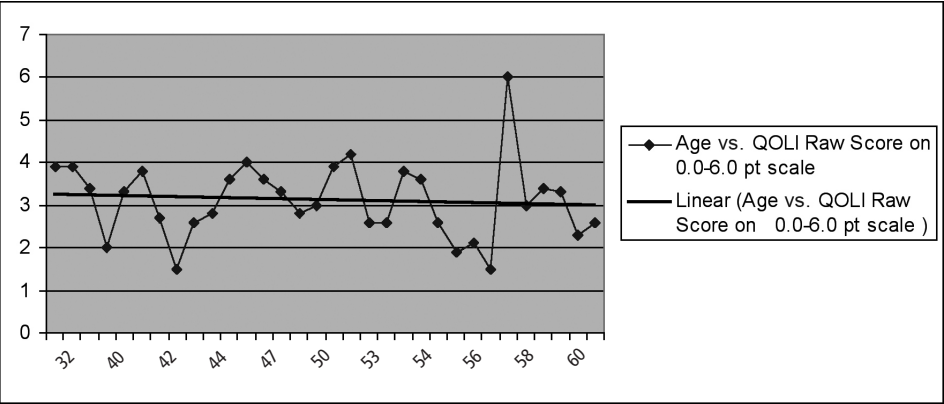
The ophthalmologists responding to this survey are materially more satisfied than baseline members of the general public used to normalize the instrument. The most satisfied doctors appear to be those who manage to live on smaller percentages of their personal incomes, those who have very busy clinic volumes, those driven by feelings of self-esteem, and those who intend to have a much longer career span than the rest of their colleagues who filled out this instrument.

The available data suggest, but certainly do not confirm, that the somewhat less-satisfied doctors are those whose happiness is more financially derived, those in higher income brackets, and those who describe themselves more as leaders than followers or peers.

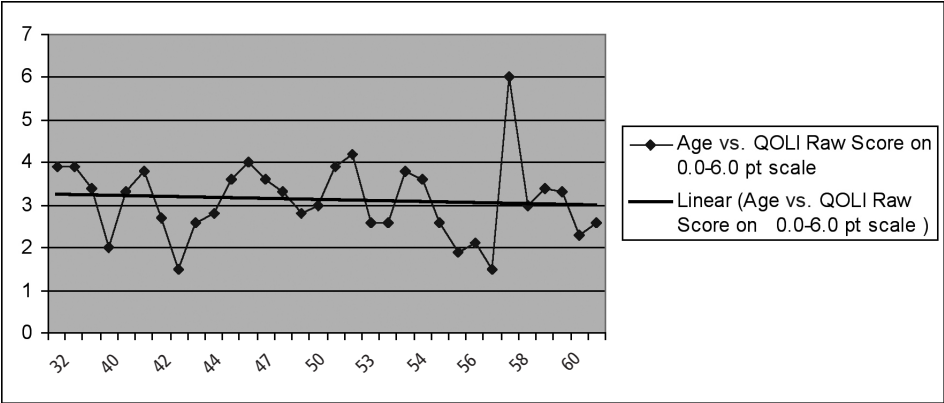
Although the small sample size involved here allowed no reliable conclusions, there appeared to be little correlation between a doctor's age, surgical density (in terms of visits per case), his or her progress in saving for retirement, or personal collections. A mixed picture arises with vacation time taken and one's personal profitability (individual income as a percent of personal collections).

1. Age vs. Satisfaction

There did not appear to be a meaningful correlation between age and one's overall quality of life score. Is there

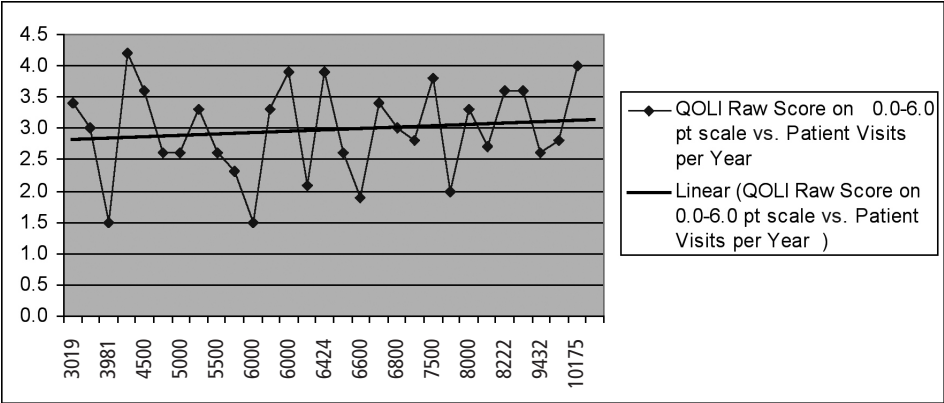


even a “happiest half” of one’s career? If so, it didn’t emerge in this data. Given the typical ± 35 -year career span in ophthalmology, the younger half of this cohort reports about the same satisfaction as the older half.



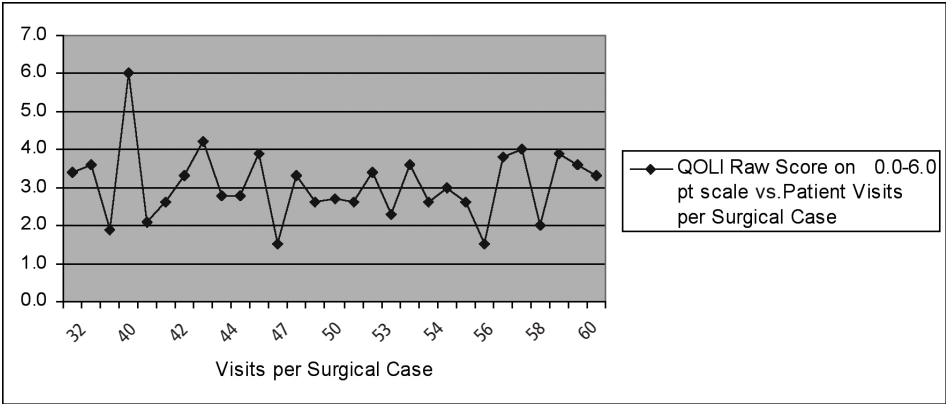
2. “Am I Busy?”

It appears that clinically busy doctors may be slightly happier . . .



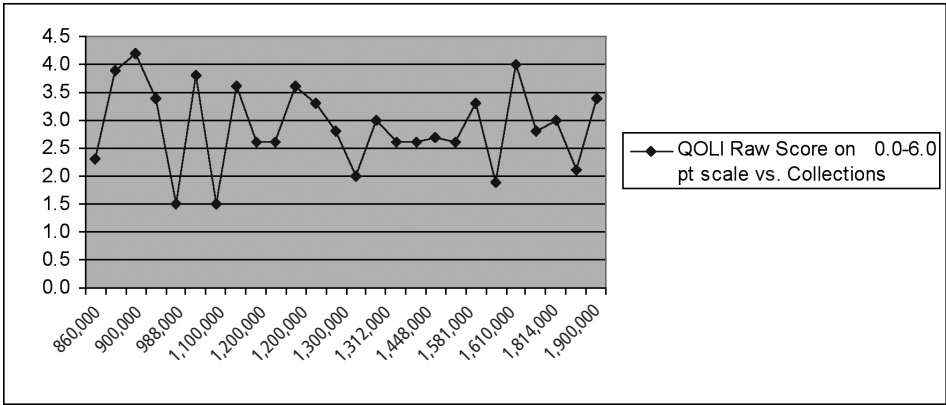
3. Surgical Density

The surgical density of the practice (the number of patient visits transited to generate each surgical case . . . typical figures in general ophthalmology are ± 25 . . . the LPIG cohort is a much more surgically dense group) seemed to not correlate with satisfaction in this sample.



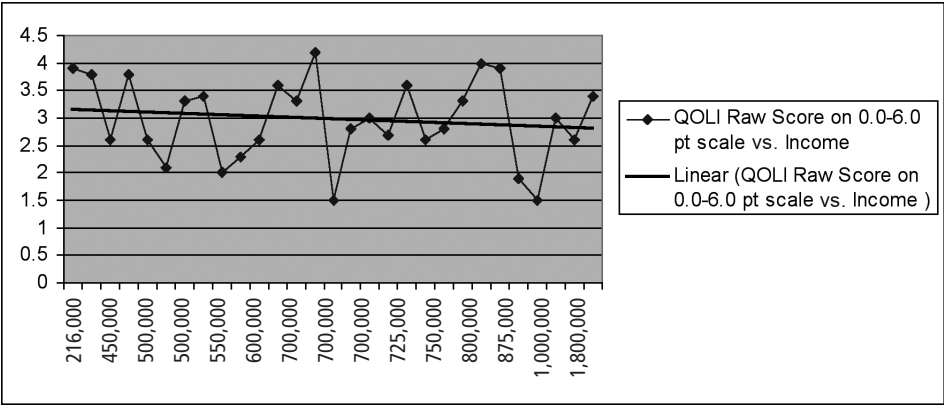
4. Annual Personal Collections

The average cohort annual revenue production per doctor was just under \$1.4 million. There was no material correlation between the level of revenue production and happiness. The 10 most economically productive doctors had essentially the same average satisfaction scores as the 10 least productive doctors.



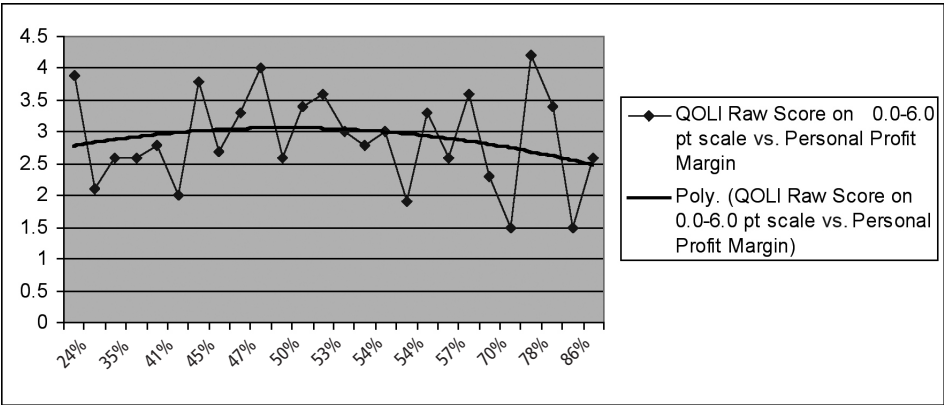
5. Reported Personal Pretax Income

The average respondent's reported income was \$722,000 per year, just over twice national averages for ophthalmology. There appeared to be a very mild negative correlation between income and QOLI Raw Scores. Doctor who earned a little less were a bit happier.



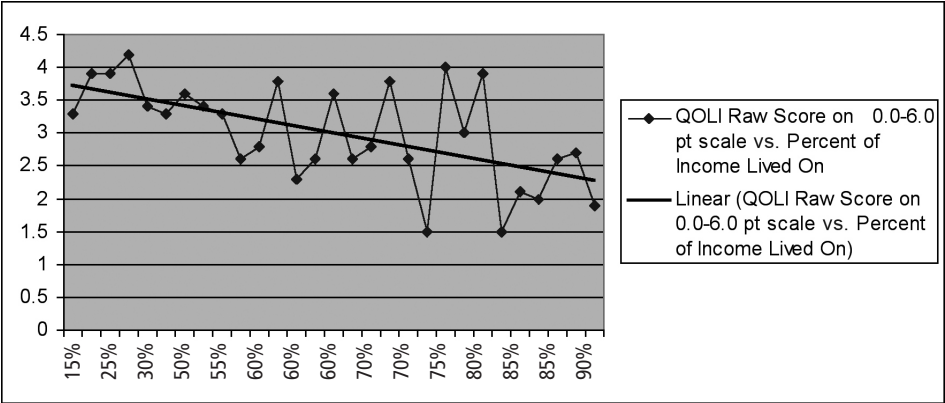
6. Personal Profit Margin

Of course, one of the most sought-after advantages of being in a large, LPIG-scaled group practice is the ability to hire top management talent, aggregate ancillary services, and build a team of durable associate providers who can provide practice owners with passive income. The best measure of this is to ask, “What percentage of a provider’s personal collections do they enjoy as personal income?” In comparison to a world where the typical consolidated profit margin is now under 40% in most settings, the reporting LPIG cohort for this study enjoys on average a 55% personal profit margin. The correlation between each provider’s personal profit margin and his or her QOLI score was mild, but interesting. One can imagine how the more stressed out surgeons at both ends of the profit margin continuum might be slightly less satisfied than those in the middle of the pack.



7. Percent of Personal Income Lived On

The most interesting and strongest correlation in this project was between the percentage of their income respondents said they believe they live on and their QOLI score. Those who live on a smaller fraction of their income appear to be—as might well be expected—a lot happier.

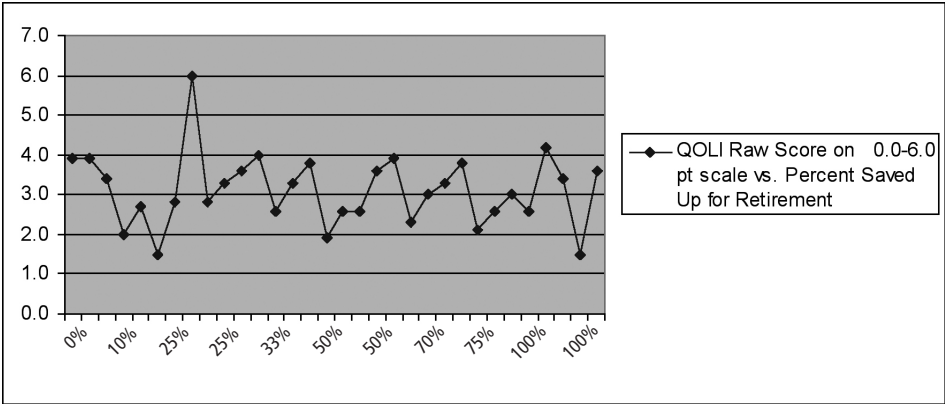


8. Leadership vs. Happiness

The average QOLI score for all respondents was 3.1. The 23 respondents who reported that they were relative “leaders” in their groups had an average score of 3.0. Five respondents who described themselves as “peers” within a group had an average score of 3.2. Three “followers” had an average satisfaction score of 3.3. If these averages held up with a larger sample size, it might be in line with common sense: leaders are those who are agitated enough to want to do more and be better and take control of their environment . . . which does not necessarily comport with greater happiness or satisfaction. As they say, “It’s lonely at the top.”

9. Savings for Retirement vs. Happiness

Although there should be an obvious relationship between the percentage of total income one lives on and how far down the track you are in saving for retirement, when we try to correlate savings levels vs. satisfaction in the graph below, there is no apparent link. Those who report that they have saved at least 100% of what they need for retirement have essentially the same QOLI score as those who believe they have only saved 50 percent.



10. What Drives Doctor Happiness Most?

When we examined the weighted scores for four key dimensions: Self-esteem, Money, Work, and Play, we found that

- “self-esteem” came in highest with a composite score of 3.6.
- “work” came in second with a composite score of 3.3.
- “money” was third at 2.9.
- “play” was last at just 2.4.

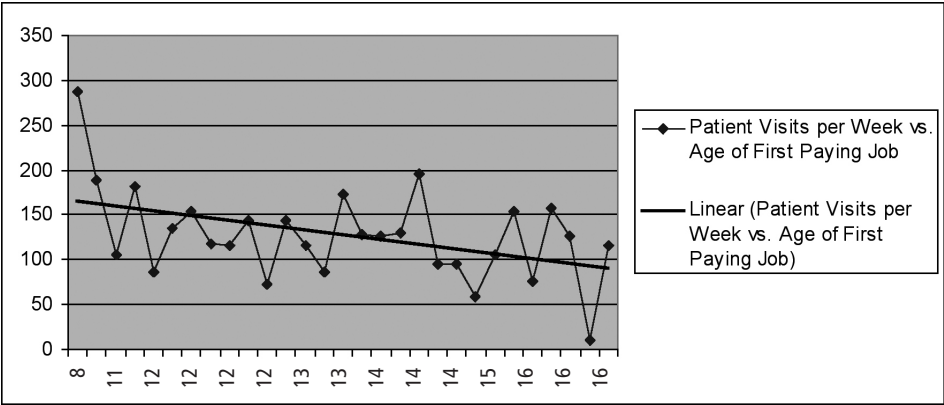
One might infer from this that although surgeons enjoy a favored income, they derive more happiness and satisfaction from the self-esteem and innate day-to-day work of medicine than they do from their paychecks. This correlates with numerous lay worker studies which have shown that one’s raw wage is well down the ranked list of job satisfactions compared to such things as coworker and customer relationships, and a sense of mastery over one’s career skills. Inasmuch as few surgeons do a very good job with work-life balance, the low “Play” scores are not unexpected.

11. What Drives Happiness More, the Work One Does or the Money That Work Earns?

In terms of raw *importance to one’s happiness*, on a 0 to 2 scale, respondents gauged “Money” at 1.3 compared to “Work” at 1.5. Work seems to come in first, while the money may be secondary, based on this report. (Again, a large caveat here associated with the small sample size.)

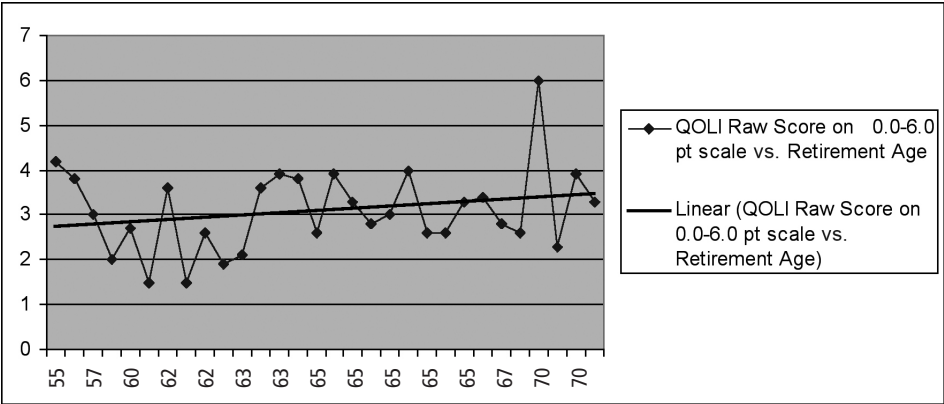
12. Work Ethic & Intensity Today vs. Age at First Paying Job

Here was a sideline finding that, while not in the realm of “satisfaction,” aligns with our experience as advisors to doctors. The average respondent started his or her first job at 13.3 years old. Anecdotally, our experience has been with both lay and professional ophthalmic staff that the earlier one starts working, the more likely that individual is to be more hard-charging and “workaholic” as an adult. This impression seems to be borne out by the data (although this analysis is not controlled for current age of the respondent . . . perhaps ophthalmologists of an older generation simply tended to go to work earlier).



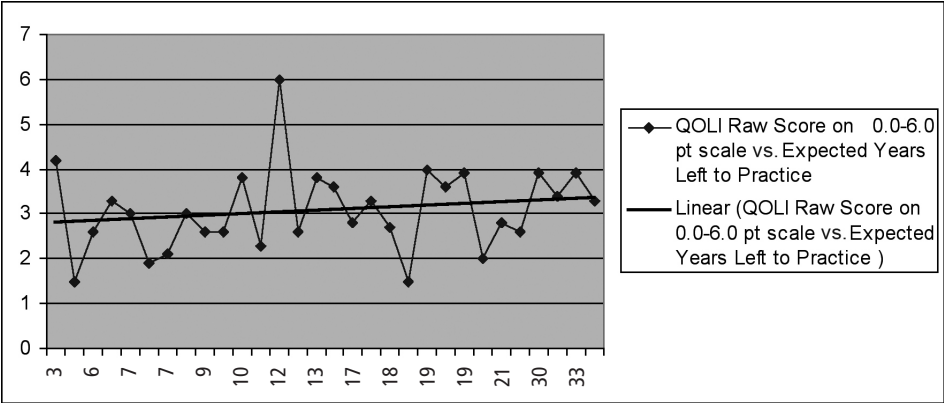
13. Planned Retirement Age vs. Happiness

The average respondent believes he or she will retire at 64 years of age—somewhat earlier, of course than when the typical ophthalmologist actually hangs it up. Respondents who report a later planned retirement had a somewhat higher QOLI score. This makes intuitive sense—those who are planning on retiring later probably love their career and their scores are somewhat higher as a result.



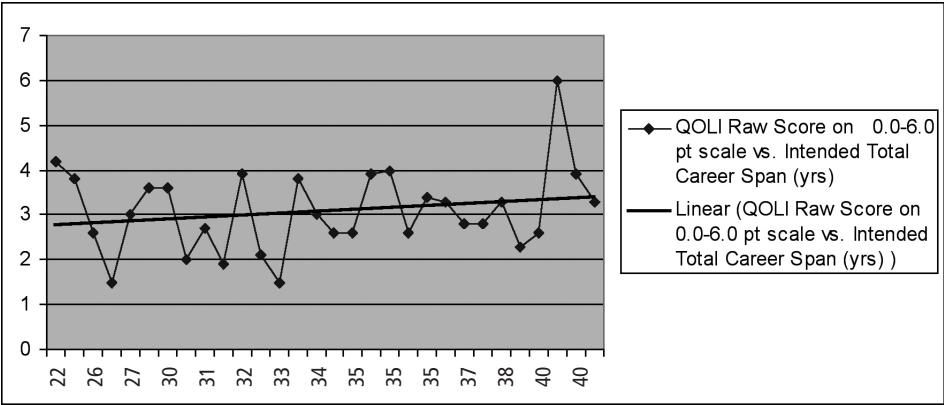
14. Expected Years Left to Practice vs. Happiness

Although the data is necessarily soft and we are unable to control for age or revenue production given the small sample size, those doctors closest to retirement do not appear to be as happy or satisfied as their colleagues with a longer career run stretching out ahead.



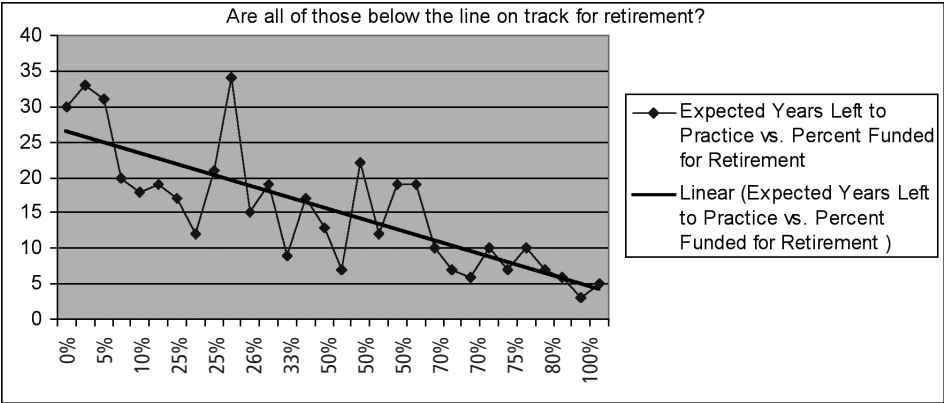
15. Intended Total Career Span vs. Happiness

The typical ophthalmic career span today, from residency graduation to retirement, is +/-35 years. We took the number of years each respondent had worked as an ophthalmologist to date and added to this the number of years he or she intended yet to practice, to derive an "intended total career span." The average was 34 years. Based on the graph below, it appears that those who are thinking about a relatively short career span (those wanting to retire much earlier) have a lower level of satisfaction than those who are expecting a relatively long career.



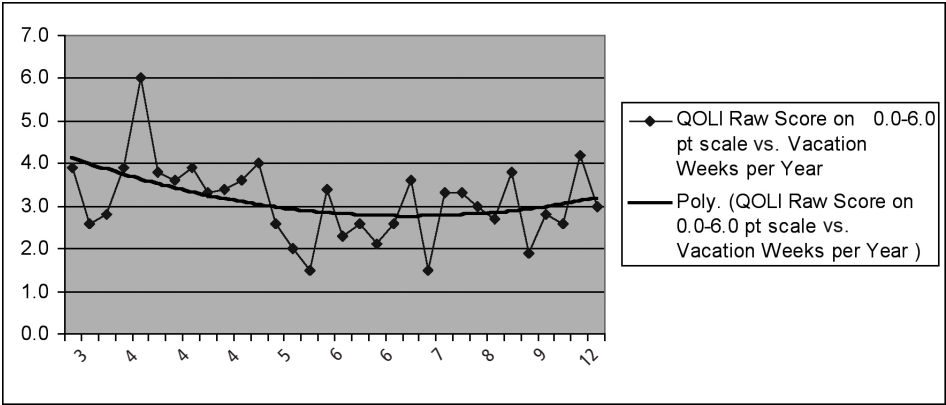
16. Years Left to Practice vs. Economic Preparation for Retirement

There were remarkable variations in the reported preparation for retirement. Many doctors who were well past the half-way mark in their career were only a third of the way (or less) toward saving up for their retirement. (Keep in mind that these are the respondent's impressions only. In the majority of cases, when a client's retirement portfolio is professionally examined and compared to his or her planned postretirement income, retirement funding levels are much lower than the client expected them to be.)



17. Vacation Time vs. Happiness

The average respondent took off 6.4 weeks of vacation in 2008. It is interesting to note in the graph below that taking this average amount of time off may not correlate with the greatest satisfaction. Of course, as with many aspects of this modest, informal study, it's difficult to tease out



the chickens and the eggs. Are those who take very little time off doing so because they are so happy with their day-to-day lives, and don't need a break? (Perhaps this graph could be used by numbers-driven administrators and managing partners to coax their doctors to take *less* time off for greater happiness!)

18. Clinical Interests vs. Happiness

To the extent ascertainable by the small sample size, there was no apparent difference in satisfaction between practice interest domains—general, retinal, pediatric, and refractive. A much larger cohort of data would be required to determine variance in this area.

19. Practice-to-Practice Comparisons

We looked for differences between those LPIG practices which sent in three or more responses. The resulting average figures from each practice are shown below. Remember that “2.6” is the normative average of this instrument applied to the general public. Each of these practices is a longstanding client of one or both authors; the lower QOLI score of “Practice E” aligns with our impressions of the interpersonal challenges present in this setting.

- Practice A: 3.5 (n = 6)
- Practice B: 3.2 (n = 3)
- Practice C: 3.0 (n = 3)
- Practice D: 2.8 (n = 4)
- Practice E: 2.5 (n = 5)

20. Marital Status

While not in the least statistically meaningful, only two of the married male respondents reported that they were *not* married to their original spouse; as a subset of two, their raw QOLI score averaged just 1.7, while the “married to original spouse” cohort averaged 3.1. Although not being statistically significant, it is interesting to note (and daring to report should our spouses see this) that the two unmarried respondents averaged QOLI scores of 3.9.

* * *

Interesting Additional Comments Made by Respondents

Many respondents provided written comments (provided below), which taken together add an interesting context for the results discussed in this series.

TIME: Very few eye surgeons—and certainly very few of the caliber seen in the typical large practices used in this study—do a great job with balancing work and life. The selected comments below get at the conflict inherent in devoting time to become and stay an expert, and the allure of workaholism in any fee-for-service environment.

- “I never get enough time off.”
- “I don’t get enough time to relax.”
- “I always feel behind and never have time to be creative.”
- “There’s not enough time to pursue personal interests, hobbies.”
- “I would like to trade income for more play time, but am afraid of what would happen if I did this.”
- “Although an MD, I don’t have time to tend to my own health or exercise.”
- “I have more interests than time.”
- “There is not enough time for friends, exercise, spouse, children, hobbies. Just working.”
- “Time is the major constraint on my creativity, play, and learning.”
- “Time, time, time, time, time.”
- “Not enough time. Not enough time. Not enough time.”
- “Not enough time to exercise or willpower to eat right.”

RELATIONS WITH OTHERS: Most male eye surgeon clients have reported anecdotally to us through the years how they believe that they have fewer (and shallower) friendships than nondoctors. The comments below resonate well with this impression. The drivers for this seem clear: a) limits on raw time to find and nurture relationships; b) the large income and intellectual disparity between most physicians and most nonphysicians; c) little time for hobbies, which would allow one to rub shoulders with those having similar interests; and d) a professional life with thousands of patient-acquaintances, dozens of lay support staff; but, in most cases, few economic or educational peers at work (contrast this with the typical corporate environment, where executives commonly have scores of peers with whom friendships can be cultivated). Consider the comments below in the context of research indicating that by far the greatest predictor of happiness is intimate relationships.

- “Not many friends”
- “I have a problem getting along with others.”
- “I don’t get along well with others in my practice.”
- “Constant bickering with partners makes long-term planning a challenge.”
- “Partner discord prevents us from coming up with a plan to help our community.”
- “Relationship issues with parents, siblings are upsetting.”
- “Most of my friends live around the country, not in my town.”
- “I feel professionally isolated only working with docs in our group and not with the wider community.”
- “Nonphysician friends don’t understand me.”
- “The friends I have are self-serving and not genuine.”
- “I have few friends of high quality and longevity.”
- “I find it hard to make friends in our community.”
- “Little or no contact with my siblings for many years.”
- “Like most men, I don’t feel I need a lot of close friends.”

SECURITY AND VALIDATION: It’s ironic that eye surgeons, being among the most fiscally secure and societally admired professionals, should harbor some of the feelings

expressed below. Whether reasonable or not, these feelings ARE valid to the individuals who have them, and can create a challenge for the executives, staff, peers, and advisors who work with such individuals. As we've described elsewhere, the underlying insecurity which commonly drives ophthalmologists to attain professional greatness doesn't go away when the pinnacle is reached.

- "I've worked so hard to have what I have; but it's not 100% safe."
- "We are the only business where we are paid by our enemies."
- "My spouse/family don't appreciate why I work so hard to secure the future."
- "I'm not financially ready for retirement, but I'm sick of working."
- "It's frustrating not having my high-producer status better rewarded by partners."
- "Deep down, I'm afraid to try new things, like new surgeries."
- "Payers and patients devalue the quality of the work I do."
- "Getting harder and harder to save money."

GENERAL COMMENTS:

- "When it comes to learning, I've become lazy."
- "The days are getting repetitive . . . not enough that's new."
- "Coming from a humble background helps me appreciate what I have now."
- "I was once very creative . . . now stuck in a rut."
- "I don't think much about the future . . . I'm more here-and-now oriented."

* * *

Closing Thoughts

As happiness expert Bill O'Hanlon frames things, happiness can be boiled down to a simple "SOAP" acronym:

Social Connection

Optimism

Appreciation

Purpose Greater than One's Self

We have all met doctors who work in financially and operationally awful practices, but who manage to go through life quite happy and satisfied. And—with a great deal of frustration—most of us know (and have worked for) eye surgeons who have fantastic practices but who are quite unappreciative, unoptimistic, and discontented.

We welcome your feedback on this modest, first attempt to give you new tools to help your managers and providers flourish.

Practical Pearls for Consideration

1. Just because a provider has a great practice in volume terms, don't assume that he or she is happy. As a practice executive or managing partner, speak to your providers often enough to identify their unique perspectives, the influence of their outside life on practice happiness, and to gain insight on how more data or operational adjustments might improve their daily experience.
2. Consider using an instrument such as the QOLI or a practice-focused cognate of this tool you might develop on your own to track provider and senior staff happiness over time.
3. Because of the strong correlation between personal financial prudence and happiness, urge your providers to get competent assistance with family budgeting, retirement planning, and asset management. In the highest-functioning settings, partners will all use one financial planner and share the results openly to ensure that contemplated practice development initiatives are not

unduly burdening any partner. This is especially important guidance at a time when medical incomes may be softening.

4. Encourage balance and boundaries. When a doctor is paid by the visit or surgical case, and as practice profits inexorably erode, it's easy to creep into workaholism, robbing time from other dimensions of one's life. If finding balance is a chronic challenge that is adversely impacting the clinic, urge the affected individual to seek professional counseling assistance. Like alcoholism, workaholism is progressive and can ultimately be fatal—if not in a literal sense, then certainly to a provider's relationships and happiness.
5. Because a lack of personal friendships is a long-understood phenomenon among many male ophthalmologists, don't rely on accidental encounters to make new friends. Start a hobby and join a local interest group. Join a sports team. Launch a rotation dinner with a few compatible couples. Become involved with your hospital's management team. Orbit a local community cause. Lean on your spouse to be the social engineer in your family. In group practices, use a regular journal club or board meeting, held over a relaxed social dinner, to create deeper interpersonal ties. At the very least, get a dog.
6. Regarding "Time," recognize and accept that you will NEVER have more than 24 hours in any given day, about eight hours of which must be devoted to regular sleep hygiene in order to sustain basic physical vitality, mental sharpness, and emotional well-being. The happiest and most productive physicians, long term, take personal responsibility for the choices they make, including how they spend their time 24/7. Remember, you don't "have" to do anything . . . everything you do is by choice (under your power), for which you and only you are responsible. You will have more time freed to do more of the things you desire by saying "No" to other things, recognizing without resentment or regret that we can't have or do it all. With balanced planning and execution, you can "Have your cake and eat it, too" . . . by simply taking smaller bites.

7. Addiction can occur with positive stimulation of the pleasure center of the brain and the accompanying negative rebound effect of withdrawal. Ophthalmologists must recognize the inherent risks of becoming addicted to their work. Factors that can predispose a person to workaholism in ophthalmology are: 1) tremendous earning potential matched with feelings there is never "enough"; 2) low self-esteem, which is temporarily (but never satisfactorily) uplifted via recognition, a position of power, and material affluence; and 3) an external "Locus of control," wherein a person feels driven, rather than being the driver of his or her life, thereby becoming vulnerable to external pressures or rewards without a sufficiently strong inner compass to resist temptations to act compulsively. The most driven people tend to abdicate responsibility for their unhealthy behavior, often with a sense of being victimized without having control or another recourse. Here's a useful metaphor: People with a healthy, realistic sense of personal power (and responsibility) are more like the "Wind" than the "Weather vane" . . . they drive themselves with a sense of freedom, influencing their world and others around them, while less powerful people ascribe to a sense of passivity, helplessness, and spinning in reaction to forces and people . . . they simply turn as the winds blow. Therefore, become the "Wind," living powerfully with free choice and emotional independence fueled by strong core values and self-determination.
8. Write your long-range vision and plans for "Success" in your life, including but not limited to your career (which is a dramatically important but not exclusive source of reward and fulfillment). Crafting and living by such a plan requires maturity and effective self-management. Try to plan your life outcomes as deliberately as you plan for clinical and surgical outcomes. Remember that the happiest people will often say confidently and without regret, "I could be making more money, but paying the time toll to do so doesn't fit my goals and priorities. I'm doing what I want to do, and I have all that I need. In the choices and trade-offs I've made, I'm right where I choose to be."

APPENDIX 19

IMPROVING PRACTICE BOARD MEETINGS

Every high school physics class, when the syllabus comes to the concept of “entropy,” should be taken on a field trip to the nearest ophthalmology practice to observe a typical doctors board meeting.

Dr. Where-Is-He? arrives 20 minutes late. Dr. Bored spends the entire time going through her mail and signing off charts. Dr. Gotta-Go leaves half-way through the proceedings to see a patient who could have been scheduled later. Dr. Eager Beaver introduces seven perfectly acceptable ideas, except that they have absolutely nothing to do with running a medical practice. The long-suffering administrator counts the minutes but dares not bring order to this random chaos for fear of being chastised.

It’s been about 40 years since my last physics class, but I still get to go on board room field trips regularly as a consultant to practices throughout the country. From these, I’ve abstracted a primer on how to conduct your practice’s board meetings more effectively. Here’s a 21-point list.

1. Advance preparation is key. Board members should receive a package of materials at least three days in the advance of the meeting, and have clear instructions from the board chairman on expectations. These expectations can be laid out in a cover letter describing the key theme of the meeting.
2. If you are the chair of your practice board, it’s likely that you’re either an administrator or the managing partner of the group—you’re not the king of the world.

All the same, both you and your board members should take the mantle of your office seriously. Don't be shy to set high expectations going into the meeting, such as: "In the next week, I would like each of you to: a) talk to your techs about their feelings on the uniform changes; b) read the chapter I distributed on budgeting; and c) study last year's financial statements for at least three potential cost savings." You'll garner more respect if you are clear and reasonable in your requests and if you thank board members abundantly for their efforts.

3. Set the tone for each meeting. If practice performance has been excellent, and it's time to celebrate, then introduce a little levity. Hand out personalized trophies to each board member, or bring in a singing telegram. If you're in the midst of a real crisis, assert your leadership and start the meeting with a short speech outlining your optimism that the challenge will be overcome.
4. Work from a written agenda . . . and if you have the habit of running out of time at every meeting, set time limits for each item.
5. Although it should be obvious, make sure that in making up each board meeting agenda you are devoting prime time to priority topics. Put the most important matters at the top of the agenda.
6. If your group tends to ramble, a little spoon feeding may be in order. Prepare Issue/Decision sheets. These are simple, one-page documents on which you have synopsized the open issue, the relevant facts, and either your firm recommendation (in the form of a formal motion) or a punch list of potential options.
7. You should insist on wide participation by all attendees, and not run the board meeting as a policy speech or classroom lesson. When you report on quarterly practice performance or progress with a project, go around the room asking for comments. When you reach an impasse, table the discussion for another time or send the issue to committee for its recommendations.
8. Despite any personal feelings or excitement in the heat of battle, respect the chair's authority to direct the discussion.

9. The chair must be fearless in defending his obligation and prerogative—granted under the authority of the board—to direct the meeting. Any chair who finds himself not being respected by those in attendance at board meetings should wrest back control of the proceedings or offer his resignation.
10. Every board member should ideally be in attendance at every meeting; create a stiff fine system for those who miss more than two meetings in a row.
11. There should be no side-bar discussions; only one person speaks at a time, and only when acknowledged by the chair.
12. Once a vote is cast, the decision is final (subject of course to re-votes based on new information). It is highly destructive to the operational integrity of the practice for dissenting board members to subsequently turn to lay staff and in effect say, “Well, I know that’s the new policy, but I’m not doing it.” People who can’t live with group decisions should not work in groups.
13. Remember your fiduciary responsibility as an owner . . . board members need to vote wisely for the betterment of the *practice*, not their personal interests.
14. As chair, know the patience and tolerance levels of your board members. Some members may be inexhaustible and willing to sit through a five-hour meeting. Others may fidget after 50 minutes. Take formal breaks and mid-meeting stretches to keep the blood flowing.
15. Make sure your room is chilly and ventilated enough to keep members alert. Serve caffeinated beverages and light snacks. Expect that sessions over a filling dinner will tend to be somewhat less effective (though great for periodic morale boosting).
16. Be disciplined. Start and end on time. Be intolerant of late arrivers, chronic interrupters, distracters, and early leave takers.
17. If you have new participants, have nametags for everyone.
18. Bring middle managers and line staff in to report periodically on issues in their areas.
19. One of the biggest errors I see at client board meetings is this: Doctors will bring up an important issue, discuss it robustly—but probably for longer than is

necessary—and then the conversation trails off without any resolution. Remember that it is the chair's job to open, direct the flow of discussion, and drive toward resolution with each item on the agenda. Consider this step-wise process to help you get closure on each issue raised:

- a) Framing: The person introducing the subject should frame it up in a simple sentence or two, such as: "Our lease rates in the Morristown office are scheduled to rise sharply. We have an opportunity to accept this, lease alternate space, or consider building a new office."
- b) Facts: Present the facts and data related to the issue . . . this might include a timeline, budget figures, contingencies, legal impediments, etc.
- c) Comments and discussion: Allow time for comment around the table, but don't allow this to go on indefinitely or for the discussion points to get off-track from the core issue.
- d) Make a motion, table the item for the next meeting, or send to committee. One of the more important arts of chairmanship is that you firmly move your board members from discussion to resolution. This shifting of gears can come from you as a directive, or as a question, such as: "Does anyone else here think we should send this difficult issue out to a committee of staff members so they can come back with a possible solution?"
- e) Second: If a motion has been made ("I move that we direct Carla to get bids to change the décor of the Waterville office.") ask for a second. This saves time and inhibits renegade board members who might otherwise float items in which others are really not interested.
- f) Secondary Discussion: Once a motion has been made and seconded, allow a few minutes for subsequent discussion. For instance: "I agree that the Evanstown office needs to be freshened up, but I don't think we need an expensive makeover . . . I think all we have to do is lay down new carpet and paint the waiting room."

- g) Motion Refinement: This secondary discussion will often lead to improvements in the original proposal. Make sure you are creating an “accountable motion,” that is, designating an action item where completion can be measured. “We will try to reduce no-show rates” is not an accountable motion. “We will put Barbara in charge of a program to reduce our current 10% no-show rates to industry standards of 5% or less” is accountable.
 - h) Vote: Most votes in a practice setting are held openly. With some especially difficult decisions, it can be useful to have a secret ballot. Know and follow your practice’s established rules for balloting, quorums, proxies, majority voting, and super-majority requirements. It can be helpful sometimes, if you’re stuck on an issue, or only halfway through an elaborate matter, to hold a straw poll, such as: “As an indication of interest only, who here by a show of hands would like to omit the last three items from today’s agenda so we can devote more time to the matter at hand?”
 - i) Assign: Once a binding vote has been made, make sure the minutes reflect WHO is responsible for the action item and WHEN the item is due.
20. If you must run over, do so with the open acceptance of the group. Thirty minutes before the scheduled end of the session, say: “It’s clear that this important topic could take us into overtime this morning. Is everyone okay with staying an extra 15 minutes so we can get closure on adding the new doctor?”
 21. Invite feedback on your performance as board chairman. This can be sought formally through questionnaires or informally in the lounge. “Mike, what do you think I should do to keep the meetings flowing better?” Some effective chairmen will close each meeting with a rapid-fire roundtable question: “What could we have done to make this an even better meeting?”

#

APPENDIX 20

TWENTY RULES FOR GROUP PRACTICE HARMONY

I'm often called in to restore doctor-to-doctor relationships in practices where the providers are no longer harmonious. Here's a checklist to improve harmony in your own setting.

1. Have a Written Business Plan

Until the owners of a practice are clear about their goals, it's easier to have partner relationships go adrift. Your goals can be abstracted into a terse punch list or elaborated into a major document. Either way, you'll have a reference for prioritizing near-term actions and acquiring the resources you need to get ahead.

2. Employ a Strong Administrator

Although no lay manager can—or should—act as a referee between arguing practice owners, the best management executives can help you keep your practice humming along well enough that there are fewer reasons for discord.

3. Select the Right Physician Leader

The best practices are led by one strong lay manager and one strong physician. Too frequently, the latter is an unpaid, figurehead position only. Your group practice's managing partner should be elected for two or more years, and receive a stipend that is equal to about 5% to 10% of their total professional compensation.

4. Always Have a New Physician Leader in the Wings

Unless your term of office exceeds three years, nominate the next managing partner in the "batter's box"

who will be stepping up in a few years. It takes at least a year or two to get ready to lead. Selecting the next leader is easier in a large practice with a deeper bench of prospects.

5. Run Formal, Fact-Based Board Meetings

It's common as practices grow to maintain the old informalities of their mom-and-pop stage. Re-read "Robert's Rules" and follow them. Your meetings will be faster, fairer, and more effective. And, you will make decisions based on facts more than feelings.

6. Support the Board's Decisions. Always.

Does this happen in your practice? You make a decision by majority vote. Then one or more of the dissenters go out the next day and say to staff, "I know we voted for 'X,' but I'm going to do 'Y' instead—the board is wrong." Nothing will undermine overall practice morale faster than an owner who can't respect majority decisions.

7. Pick the Right Doctors to Join Your Practice

No matter how much you interview, how much you check references, or how closely you observe their surgery tapes, only about 50% of the time will you hire the right doctor to join your practice. The other half of the time "Dr. Wonderful" will end up being the wrong fit. Work hard and you'll be 55% correct.

8. Remove the Wrong Doctors Quickly

When you pick the wrong doctor to join your practice, identify and correct your mistake as quickly as possible, and find a new home for your mismatched associate. In hindsight, most hires that don't work out are visibly wrong within the first 120 days.

9. Oblige Every Owner to Understand the Business

There was once a time when all you needed to know as a practice owner was the location of the key to the back office door. Not any longer, especially if you're in a complex group practice. Small errors in judgment or a lack of proper financial oversight can now balloon into a significant business killer. Rather than having just one or two doctors in a group understand the business, it's helpful to teach every owner—and every partner-track associate—the basics of business.

10. Ensure Every Owner Has a Personal Financial Plan

In the typical five-doctor client practice it's almost certain that one of the partners is mismanaging his or her personal financial life. This is usually due to either a lack of spending or savings discipline, which is usually linked to the absence of a personal financial planner or involved accountant. If one of your partners is making poor personal money moves, this will adversely impact his or her judgment in the boardroom.

11. If You Need a Second Subspecialist, Protect the First One

Imagine you have one overworked retinal specialist in your group. You know you need a second subspecialist. But if you add doctor #2, you're going to hurt #1's income for a year or more. What should you do? The easy and fair solution is to build a floor under doctor #1's income, so that for a period of 12 to 36 months post-hire, #1's income is preserved at (let's say) 80% of their historic levels. Since *everyone* gains over time with the addition of a new doctor, it's only fair that *everyone* should take the same financial hit transiently.

12. Control Your Practice's Access to Patients and Share Them Fairly

It's easy to control capacity—just hire a new worker or equip a new exam room. It's a lot more difficult to control the VOLUME of the practice. Marketing, contracting, and customer service must work just right to bring you the correct mix and number of new patients. Meanwhile, make sure that the patients you do serve are shared fairly among all practice providers to preserve harmony.

13. Let Doctors Do Their Own Thing . . . to a Point

It's best to not unduly limit a provider's scope. For example, every appropriately trained surgeon should be able to perform cataract surgery or provide LASIK, rather than only allowing the senior doctors to get the "good" work. But don't be shy about requiring lower-quality surgeons, despite their abundant other attributes, to give up operating.

14. Coach Individual Providers Actively

If you're the administrator or managing partner of a group practice, it's easy to focus so hard on the big

picture that you forget that your practice is really composed of a lot of individual careers. These careers should each be coaxed along, at the same time that you're managing and coaching the entire team.

15. Be Clear About Provider Productivity Expectations

Most practice overhead is fixed. If partners or associates drop off in their productivity, practice overhead goes to waste, and profitability can plummet. As part of their individual contracts with the practice, providers should have specific volume and revenue production expectations.

16. Make the Practice as Profitable as Possible

As a wise old man once said, "If you think it's not about the money, then it's probably about the money." Money, as crass as it may sound, is a wonderful solvent for partner-to-partner squabbles. I've noted that partner discord is rising sharply just as profitability is declining in recent years. Do all that you reasonably can to optimize profit.

17. Share Practice Profits Fairly

There is no perfect compensation methodology in a group practice. That said, you need to continuously adjust and fine tune the compensation model over time to at least ensure that every partner is equally *unhappy* with the math.

18. Treat Partner-Track Associates Well

Many practices are set up to treat pre-partner associates as second class citizens. Instead, provide your partners-to-be with abundant access to performance data, a voice (if not yet a vote) in management, and a robust education in the intricacies of practice ownership.

**19. Hold Plentiful Group Meetings
Between Management and Owners**

At least once a quarter—monthly is better—there should be a time when all of a practice's owners and all management staff gather to jointly identify and solve problems. Don't leave your administrator obliged to act as postman, passing messages back and forth between the board and the managers.

20. Play Together Outside of the Office

The happiest group practices are owned by those who not only respect their partners as surgeons and

clinicians, but who truly enjoy each other's company. If your practice is less "kumbaya" than you would like, try to engineer better relationships with an annual board retreat, quarterly partner social dinners, or sporting tickets shared around the group.

* * *

The Greek philosopher Plutarch wrote two millennia ago that to understand and treat in medicine one has to first examine disease. In the same manner, to understand and nourish harmony in your group practice, it's important—even if occasionally unpleasant—to face up to areas where you and your colleagues are discordant.

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APPENDIX 21

RECOGNIZING, REVISING COMMON ADVERSE OPHTHALMOLOGIST BEHAVIORS

Most ophthalmologists behave in a way that pleases their staff and patients, and honors their teachers and their profession. They work extremely hard, set high personal standards, and do the right thing regardless of the economic consequences. They relish team building and will readily admit when they need to improve. They are widely admired.

I'm sure this applies to most of you reading this book.

But even the most virtuous eye surgeon is often plagued by a cluster of human frailties that seem to be particularly common in the profession. The most self-aware ophthalmologist will readily confess to a number of attributes and behaviors he or she is not so happy about but working to improve.

Abstracting from tens of thousands of staff and provider interviews, here's a short list of common, adverse behaviors along with a few pearls to reverse these, whether you're one of the surgeons in question . . . or working with them.

* * *

Only Trusting Yourself

This is a perfectly understandable way to behave if you've been trained as a surgeon. In most work settings, you're the smartest and best-trained person in the room. The patient is bonded to you and trusts your experience. And most of all, you're going to take all the heat if there's a misadventure. But there's a lot more going on in your business and clinical world than *your* brain and *your* hands treating *your* patient. To be simultaneously effective as a practice owner and at ease as a provider, you have to learn to select, inspire—and ultimately trust—others to do their part.

Making Mostly Solo Decisions

This is a behavior related to only trusting yourself, of course. Sometimes, you *should* be the only one making a critical decision. But you'll better endear yourself to others if you let them get involved. This involves both staff and patients. Even if you've made a final, binding practice policy decision, write it up and circulate it among your team as a "draft for comment." And even if you *know* your patient needs a procedure, ask, "What do you think?"

Being Malcontented:

"Nothing Is Ever Good Enough"

You're probably a great physician in part because you obsess over the smallest details. People want this trait in their microsurgeons. But the same malcontent applied to far less critical parts of the practice will drive your staff and partners nuts. Does it really matter which chairs your office manager picks out for the waiting room, the color of a form, or what's ordered for lunch? Try to be more contented and appreciative.

Indecisive

Because the standard of care in medicine is "slow and perfect," it can be extremely frustrating for surgeons to operate in the business world where the standard is closer to "brisk and good enough for now." You may freeze up trying to make perfect decisions in an imperfect environment. As a practice owner, you have to flip back and forth several times a week, stepping out of "doctor mode," and plunging into the much crisper, lower-stakes world of business.

Defensiveness

It may sound odd, but even among the most talented surgeons in America insecurity is common. How can that be? If you think about it, this is the way our society picks its professionals: Start with a really smart kid who wants to please his or her parents and is always on edge about whether he or she is living up to everyone's expectations. Perfect becomes the only acceptable standard. But even if you're very smart, it's a lot of work and worry to nail "perfect" in every class. Fast forward about 20 years and out the far end of the educational tube pops an ophthalmologist. So, at least a little durable insecurity is to be expected. In turn, defensiveness is just one coping behavior if you're feeling a little insecure. The best cure for this is awareness, combined with one simple phrase you can probably use every day. When an unhappy patient or staff member is getting after you with a complaint about something you've done (or failed to do), simply say, "You know, you may be right!" Not only will you disarm your assailant, but you'll be open to learning something helpful from whatever they have to say next.

Disproportionate Response to Stimulus

This trait, along with defensiveness, also comes with being a surgeon. By the nature of your work you are conditioned to be very cautious. A small negative stimulus in the O.R. or clinic (such as a case that's not going especially well) leads to a sometimes massive response. Beads of sweat. A curse. Thrown instruments. You don't come across many surgeons who are laid back, proportionate responders to stimulus. Or professional chefs or professional money managers. In fact, a disproportional response to stimulus may be the key to success in any profession. But taken too far, and applied to nonclinical areas of your practice, will actually reduce your standing as a leader and your effectiveness as a provider.

Narcissism: "What Are You Feeling?"

I'm not referring here to the common lay use of the word, which connotes vanity, but to its professional context: a diminished ability to have empathy for the feelings of others. This is obviously a tremendous disability for someone

who has to relate to thousands of patients and numerous staff members. As you can imagine, people—in their role as your customers or employees—are going to be most attracted to you if they know that you genuinely care about them and their perspectives. Simply being aware of this tendency, and witnessing it in yourself, is often enough to reverse others' perception that you are self-absorbed.

A Lack of Proportionality: “In My Book, You’re a Hero or a Zero.”

Eye surgeons of my acquaintance will often be thrilled with a new staff member. They'll imbue the worker with unrealistically high skills, saying “Molly is a 10-plus.” Not uncommonly, these same surgeons will report a few months later, “Molly is worthless . . . she’s a 2.” Obviously, it’s unlikely that “Molly” is either a 10 or a 2 . . . but rather a nuanced, ever-changing 7 or 8 or 9 like the rest of us.

Lay Staff Are “Servants,” Here to Serve Us Doctors

This is a delicate point, one sometimes lost on younger or less sensitive providers. Yes, there’s clearly a chain of command. “You” are the leader and “they” are the followers. But at a very practical level, your lay support staff members are vital partners in your joint success. If you treat your staff as lowly servants they'll commonly perform down to your expectations. Treat them like fellow teammates and they may just exceed your wildest dreams.

“Put This Great Idea of Mine in Place . . . NOW!”

This impatient, noncollaborative behavioral style gets a lot fewer results than saying, “I have an idea . . . maybe it’s a good one, maybe not . . . what do you think?” Collaboration with others (even when you know your idea is perfect) will ultimately speed up implementation and increase acceptance for unpopular policies.

An Aggressive, Confrontational Style

Safe, appropriate, respectful confrontation is a good thing. It’s the stuff of effective organizations and leaders. But perhaps that’s not your style. In the words of one doctor, “I don’t know why, but there’s just something I kind of like about stirring up trouble . . . I think people listen and

perform better when they're uncomfortable." The truth is that they don't. Instead, they freeze up. In the worst cases, they'll simply leave you for an employer who helps them feel comfortable, competent, and willing to make a few mistakes on the way to improving their skills.

"Flame-Mail" and Angry Voice Mail

Technology has made communication much more efficient, but at the same time, potentially far coarser. Some surgeons, in a zeal for efficiency (or a desire to avoid interpersonal conflicts) replace nuanced two-way phone calls and live meetings with asynchronous communication. They often do so unconsciously and end up saying things in e-mails or voice messages they would never say in person. In the worst cases, they'll call and leave a voice mail message when they know the recipient won't be picking up the phone. The most difficult topics should always be handled face-to-face.

Saying, "We Lost, and It's Your Fault."

Would you like to be admired—even adored—by your staff and colleagues? It's simple, really. As a leader in your practice, when things go wrong accept 100% of the responsibility. And when things go right? Tell everyone the team did it. And give away 100% of the credit. They'll still be talking about you years after you retire as, "The best doctor I ever worked for."

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APPENDIX 22

IS EYE CARE SLOWLY INDUSTRIALIZING?

What do you think of when you hear the word, “industrialize”? Smokestacks? Sweatshops? Grit? Nothing to do with the profession and the business of eye care, right? Think again.

In the career span of this book’s youngest readers, we will witness a profound shift in the way eye care is delivered. We’ll have to.

Health care now consumes about 18% of every GDP dollar in America, and the cost of care is rising at nearly three times the growth rate of the general economy. While the total U.S. population is growing at about 1% per year, and the net number of practicing eye surgeons is growing at the same rate, the demand for ophthalmic services is growing at an estimated 3% to 5% per year, because of the rapid rise in the number of seniors. We’ll have to industrialize the delivery of care just to keep up with the demand for services, much less to sustain surgeon incomes in the face of falling fees.

This “industrialization” is nothing new in eye care. It has been playing out slowly over the past two generations or longer. For instance:

- Even the most vanguard eye surgeons could once only perform a few cataract cases per week. New techniques and technology now allow America’s busiest surgeons to treat dozens of eyes a week—four to six cases per hour in the fastest hands.

- It was once common to see no more than 20 or 30 patients in a clinic day. The doctor took all measurements, and did all special testing . . . and worked out of one or two rooms. Economically viable practices now transit 45 or more patients per day, and 60+ patient days are now fairly common. To accomplish this, the typical ophthalmologist is now supported by one technician for every 6 to 15 daily patient visits.
- Technologic sophistication—and cost—are exploding. Forty years ago, in inflation-adjusted terms, the typical eye surgeon (with no computers, OCTs, or personal lasers to buy) made total capital investments of \$100,000 or less to equip a fairly modern office. Today it's easy for a soloist to spend \$300,000 on a basic, starter suite of capital goods.

Of course, this ramp-up in cost and productivity has been accompanied by a persistent reduction in the value paid per unit of service. In just one dimension, the price paid for cataract surgery, the professional fee has fallen by 99% in the last 40 years. (Do the math. Remember when gold was \$35 per ounce and surgical fees were \$2500? Today's surgical fees are lower than the price of a good brake job and gold has now crested the \$1000 per ounce mark.)

Count on the industrialization of eye care to continue apace. As much as you may bridle at this evolution in the medical arts, this shift isn't all bad.

Before food production was industrialized—initially with the invention of farming, and over and over again with draft animals, mechanized farming, and synthetic fertilizers—feeding yourself was an uncertain, time-consuming enterprise.

Before the industrial revolution, most goods were precious, rare, costly, and reserved for the wealthy alone, because they were made by hand.

Until papermaking, printing, and binding were industrialized in the 15th century, reading was a privilege reserved solely for the wealthy and the clergy.

The common man of 16th-century Europe owned one or two changes of clothes, not the closet-full eventually allowed by industrialized weaving and sewing.

Until recording and playback technology allowed music to be industrialized, you either had to play your own music or be among the elite who could afford to hire an orchestra for Saturday's party at the family estate.

Carpentry is being industrialized (with pre-fab housing). Teaching is being industrialized (with larger classes and online education). Cobblers have nearly been industrialized out of existence. But the intimate, delicate, one-on-one professional delivery of eye care services is one of the last human pursuits that have not yet been materially industrialized.

Eye surgeons now stand alongside a diminishing pool of professionals—trial lawyers, gardeners, fly fishing guides, and a few others—way at the back of the long human line marching toward industrialization. But as a surgeon you are indeed marching, along with everyone else on your practice team.

I know that the idea of industrializing this august, elegant profession is distasteful to many. But perhaps there are compensations, both to society and to the individual provider. Before the earliest steps in industrialized health care, the medical arts were primitive, home-based, and largely ineffective. Would you de-industrialize immunization? Peri-natal care? The billions of antibiotic doses manufactured each year? Computer-designed and milled IOLs?

Not that everything mass-produced is all that great compared to custom made. Most of us would prefer to drive a hand-built Rolls Royce instead of the family Toyota. Or wear a bespoke suit from a London tailor over ready-to-wear threads. Or grace our living room with a \$100,000 custom-engineered sound system instead of our plug-and-play outfit from Best Buy.

But the point is that almost everyone in the industrialized world gets to enjoy pretty-good cars, clothes, and stereos. At the same time, the workers in these industries tend to make more than old-time craftsmen ever did.

By continuing to industrialize health care and eye care, in the most appropriate ways, we'll hopefully be able to enjoy the good aspects of industrial scale and avoid the aspects that are less wholesome.

How will this all play out, specifically in eye care? How will your professional life change? How well will your talents be valued and rewarded in the future? Here are some predictions for the next generation of eye surgeons, changes that will wash over the profession (and it will remain a valued, well-compensated *profession*) at an accelerating pace over the next 35 years or so.

"Hyper" practices will proliferate. At first this will not be driven by technology. Until technology can catch up, the only way for you to generate industrial volumes of patients as an eye doctor is to become a kind of machine yourself. Working harder, longer hours allows a 30-patient-per-day ophthalmologist to see 45 patients. Working harder, longer, more intensely, and *smarter* hours can double this figure. Given the high fixed costs of running a private practice, these incremental patient volumes can keep up with and exceed the best efforts of third-party payers to give you a pay cut. Some surgeons—the quick-thinking, athletic, and perky ones—are especially talented at this kind of ramping up. If you can combine this tempo with redoubled efforts at affability (mastering the 30-second social exchange with patients who once loved chatting with you for three minutes), you can elevate not only revenue, but patient satisfaction.

Incomes will be redistributed. The historic, wide bell-curve distribution of incomes in ophthalmology will continue to change, with a reduction in average, inflation-adjusted income for the majority of providers, BUT along with it comes an opportunity for significant incremental income for doctors who are willing to be at least a little

bit industrial (and capitalist) in their practice management strategy, employing nonsurgical providers, technical staff, and emerging technology to augment their personal productivity.

Depending on the future pace of health payment reform, bulk contracting may ensue. In the 1990s, there was a limited Medicare experiment to bid out blocks of cataracts to surgeons willing to lock in several thousand cases for a low, fixed global fee including facility charges, professional fees, and lens implant costs. Although this experiment was ultimately abandoned, bulk contracting for cataract care is still occasionally seen in the VA medical system. A return to block contracts would obviously help those few providers in a position to win the contracts, but harm everyone else. Moves in this direction could shift American ophthalmology to the environment seen in some European countries, where a far higher percentage of ophthalmologists maintain a nonsurgical practice.

There will be far higher capital investments per provider. The typical eye clinic invests about \$250,000 to \$500,000 to support a single ophthalmologist. The vanguard clinic of the future may be investing \$1 million or more per provider to automate the more mundane aspects of diagnosis and treatment and ramp up productivity. Opportunities will abound for equipment companies that are able to help beleaguered doctors increase their efficiency. This is analogous to, but obviously will stop well short of, what has happened in manufacturing around the world, where multi-million dollar robotic systems, tended by a small number of technicians, are able to perform work faster, better, and cheaper than human hands alone.

Mid-level providers will proliferate. The average ophthalmologist in private practice today is supported by perhaps a quarter of an optometrist and two or three technical staff. This still leaves the typical surgeon spending up to half of each clinic day doing work that could be done by support staff. The most effective way to boost a surgeon's economic productivity is to have him or her doing largely surgical and higher-level medical work. In the future, an individual

surgeon will work with two or more optometrists and far more technicians than is the case today.

Eventually, we'll have Smart Health Cards. These cards, pulled out of a wallet or embedded in a subcutaneous chip, will contain the patient's medical record as well as their health coverage benefits. Such cards will be scanned at a kiosk at check-in (just as we do today to check in at the airport for a flight). Just like at the airport, the patient (read "eye care passenger") will then walk to each of the proper testing "gates," be worked up by specialist-technicians, provisionally diagnosed by a super-tech or computer, given a draft treatment plan, and (at the end of the assembly line) receive a final, brief over-read by the attending ophthalmologist. Portal to portal in 30 minutes or less, leaving plenty of time to pick out a new pair of glasses (if these still exist in the future).

What about global competition? Are you at risk? I don't expect your job as an eye surgeon is going to be outsourced to India or Mexico anytime soon. Although it makes some economic sense for expensive inpatient care to be offshored and to take a hip joint replacement "vacation" in Singapore, most forms of eye surgery are comparatively inexpensively delivered locally.

* * *

The continued industrialization of health care and eye care will not eliminate the core art of medicine or the ability of especially talented, hands-on professionals to establish custom, niche practices. A few "concierge ophthalmologists" are already setting up shop in America today. Fine artists still paint. The best of them are in high demand. And the happiest would rather retire than become commercial artists. The same dynamics will play out in the next few generations of eye surgeons.

#

APPENDIX 23

RECOGNIZING AND ADDRESSING PROFESSIONAL BURNOUT

*"I have a theory that burnout is about resentment.
And you beat it by knowing what it is you're
giving up that makes you resentful."*

Marissa Mayer

*"It is impossible to control outcomes or results,
although most of us have been programmed from a
very young age to believe otherwise. The idea that we
can perform actual 'magic' causes tremendous
dysfunction, unnecessary suffering and prevents
the development of emotional resilience."*

Christopher Dines

Radiation film badges were first developed in the early 1940s during the Manhattan Project, which ushered in the atomic age, led to the first nuclear weapon (and parenthetically employed my first boss when he was just a graduate student.)

Today, specialists who work around radioactive material—whether they are dental assistants, X-ray techs or nuclear scientists—wear a radiation badge to assure that they have not received a dangerous level of exposure to ionizing radiation.

I'd like to invent a similar "dangerous exposure" badge for ophthalmologists. But instead of measuring radiation, this new badge would measure the approach of burnout which comes from undue stress, impossible tradeoffs and excess workloads. After nearly 40 years as an "ophthalmologist-ologist" I can report the following examples from extensive field observation:

- The surgeon who arrives at work later and later, avoiding the start of the clinic day
- The doctor with a once-cheerful and socially generous disposition, who others report now as being, "Not herself . . . withdrawn . . . rarely complimentary of others"
- The ophthalmologist who asks staff to open clinic and surgery slots, and then bites their heads off a month later for "overbooking"
- The practice partner who once made brisk, intelligent business decisions, but who is now frozen even with smaller matters before the board
- And especially, the doctor whose lifestyle costs are growing faster than practice profits, squeezing him into an impossible and unsustainable position

This happens at different workloads (and with differing levels of superimposed general life stressors) for different ophthalmologists.

It's hard to become an eye surgeon without a degree of obsession and workaholism, of course. But shifting from 40 patients a day to 60 (to cover rising costs) while simultaneously undergoing partner stresses or a personal health crisis, can put even the most resilient surgeon over the top.

My colleague Dr. Craig Piso presents in the sidebar accompanying this column a recap of 10 burnout cures. Each of these, individually or in combination, with or without outside professional support, can help an overly crispy eye surgeon walk back from the edge of burnout. But none of these are likely to be undertaken without recognizing that you are flying a bit too close to the sun.

Like too many x-rays, exposure to too much work can sneak up on a surgeon. Years of slow accommodation to more and more work and stress can pass without being recognized until a breaking point is reached. Let's make this simple. If you notice *any* of the following six ophthalmically-centered markers in yourself, you may be at or beyond the point of burnout:

- You don't start most days (both clinical and surgical) with a sense of positive anticipation regarding the people you'll help and work with, and the livelihood you'll be making.
- You have no financial wiggle room. Your personal expenses consume 100% of your paycheck, savings are scant, and you can't conceive of a way that you could increase income or decrease expenses.
- You literally (or at least figuratively) flinch every time a staffer enters your office, thinking to yourself, "Oh no . . . what now?"
- When new, common problems are thrown at you (everything from Federal regulations to a surgical complication or an unexpected repair bill) your shoulders slump as if under a blow.
- When new opportunities arise (a new procedure to learn, a new service to provide) your first instinct is to say, "Impossible . . . not one more thing."
- You don't end most days with a pleasant fatigue, a sense of accomplishment and gratitude for having found your way to ophthalmology.

Whether you have a case of full-blown burnout or are just crispy around the edges with a subclinical case of "brown-out," think about the issues raised briefly in this column, recognize what's at risk both personally and organizationally, and intervene with vigor, just as you would for any patient that you serve.

* * *

THE CURE FOR BURNOUT: SELF-EMPOWERMENT

BY CRAIG N. PISO, PH.D.

Common indications of burnout include physical or emotional exhaustion, becoming cynical and overly critical towards oneself or others, and struggling to find enthusiasm, motivation, and a positive focus. Recognizing any of these symptoms in yourself should ideally prompt you to stop any self-defeating behaviors, escape the workaholic treadmill, and reinvigorate yourself.

The cure for burnout is a combination of healthy self-care and personal empowerment. Here are some possible “trail-heads” for you to consider on the path back from burnout.

1. ***Understand and accept reality*** since information is power and acceptance of reality, no matter how unpleasant or unfair, liberates energy being wasted in denying or avoiding the truth. Accept and move on!
2. ***Become non-defensive*** by developing personal responsibility, genuineness and humility. Be accountable for your choices with confidence and transparency. Be real!
3. ***Become mindfully present*** by focusing upon and engaging every moment. A past or future focus detracts from such engagement and limits your being present to others. Be here now!
4. ***Dare to dream*** with a sense of adventure and excitement about embracing appropriate risks. Faith in your dreams generates hope, and hope provides you and those sharing your dreams with energy for living and striving. Look beyond!
5. ***Walk to the beat of your own drum*** by thinking, feeling, and acting as the driver of your life. Honor yourself as the author and creator of your life by doing what is right for you, even if that means assuredly paying the toll when some might disapprove. Be yourself!

6. **Look internally for joy** since it originates deep within, while pleasures come from outside, and even healthy pleasures when overdone, eventually steal our power. Finding appropriate ways to express love and joy will pay a return in fulfillment and freedom. Liberate yourself!
7. **Strengthen your social connections** by developing meaningful relationships with others because healthy interdependence creates a sense of wholeness, safety, and fulfillment. Get connected!
8. **Become optimistic** by adopting positive attitudes, perspective, and expectations. When you fail, bounce back with self-forgiveness and renewed faith that you will succeed eventually through perseverance. Take heart!
9. **Count your blessings** with gratitude, comparing yourself and your life situation with no one else. Failure to appreciate your blessings is the root of discontentment, a sense of want, and painful envy. Be contented!
10. **Find a purpose greater than yourself** and a mission for serving that purpose in order to avoid becoming self-absorbed or preoccupied with personal issues. Happiness flows from such unselfish, outwardly directed service. Create a legacy!

#

APPENDIX 24

PRACTICE DECLINE SYNDROME . . . FIGHTING THE DWINDES

*"There is at least one point in the history of
any company when you have to change
dramatically to rise to the next level of performance.
Miss that moment—and you start to decline."*

Andy Grove

*"Success comprises in itself the seeds
of its own decline"*

Pierre de Coubertin

Based on what I'm seeing in my client travels around the country, an increasing number of once-great practices are undergoing PDS: "Practice Decline Syndrome."

The syndrome can go something like this composite from several practices over the years:

Stage Zero: It's 2001, and a large practice (let's say with seven MD partners, two associate ODs, two locations and \$11 million in annual revenue with 42% profits) is healthy and in the pink. All partners are still in their peak earning years. Strategic planning is little more than a list of priority actions for the administrator in the next 12 months. And one of the doctors says, "Why worry about the future? I've got 23 cases on for this Thursday."

Stage One: It's 2008. The Great Recession is taking hold. Refractive surgery is abandoned, replaced only in part by more senior care. The practice's first, awkward EMR conversion, because of insufficient planning and a poor vendor choice, has led to an 8% drop in production and a 15% drop in profits. And the doctors say, "What the heck . . . a 36% profit margin is still pretty good, right?"

Stage Two: It's 2012, and practice profits are now 30%. Of the five remaining partners, two are edging toward retirement, and one has a sick spouse curtailing his clinic time. To maximize partner profits (for this year only, of course!) they pass up hiring a young, partner-track surgeon, which means that within a couple of years there will only be three owners. There is still no succession plan. And the doctors say, "Hey, why bring on another surgeon when any two of us can handle all the cases by ourselves?"

Stage Three: It's 2016, and practice profits have now fallen to 26% for the two remaining partners. Board squabbles over resources and policy are increasingly common, and harder to resolve with just two votes in the board room. Frustrated by conflicting demands from the owners, and increasingly *impossible* demands from Medicare, the administrator resigns. He is replaced by a pleasant but inadequate naïf. And the doctors say, "This isn't what I was hoping for in a practice or a partner, but I only have to hang in here another 9 years and my retirement plan will be fully funded."

Stage Four: It's 2018. The practice fails, splits up or sells to a better-organized competitor . . . or starts a turnaround process bringing it back from the brink.

* * *

PDS is driven by a number of underlying national conditions and local failings. Most of these can be prevented or cured. Like some diseases, a few have to be endured. Let's run through the four primary factors:

The first is a lack of advance business planning, which has been chronically present in ophthalmology. In the good old days, running a practice was like gardening in

Hawaii . . . just about anything you tried, worked. We are now in an era in which perfectly sensible investments can fail, and thinner profit margins make failure more painful to the owners. Even the smallest practice should have a written 5-plus year plan outlining the desired service area, service mix, provider mix and growth rate. Larger practices, and especially those where the average owner age is 50 or older, need a formal succession plan showing a realistic timeline for when new need providers will have to be onboarded (even if this leads to transient profit reductions for owner-physicians.)

Second is the logarithmic growth in complexity and leadership demands as a practice expands. A practice growing from four doctors to eight needs four times as much management oversight, not twice as much. Curing this problem rests equally on four pillars:

- The board of directors, which in modern times can no longer meet just a couple of times a year and rubber-stamp the practice manager's work . . . or worse, meet weekly, usurping the administrator's and managing partner's roles and power.
- The managing partner, who has to move beyond being a figurehead-leader to be (and stay) more engaged . . . in practical terms, this can mean 8+ hours per week in a larger practice with a strong executive director, and even more time in a modest practice where administrators are typically more junior.
- The administrator, who needs to put more raw time and more care than ever before into the job . . . few can accomplish this without working 45+ hours per week, attending a week or more of continuing education classes every year, and having the support of numerous outside professional experts (as well as everyone else on the management team).
- The mid-level managers, department heads and supervisors, who must grow to the level of responsibility once held by office managers a generation ago . . . they need to know the key performance indicators for their departments and be accountable for hitting their numbers, not just making sure their people arrived at work this morning.

The third decline factor is the baby-boomer bulge of late-career surgeons . . . and the lack of replacement ophthalmologists. It's not unusual to find practices where the average age is over 60 and the practice has been searching for years to find successor doctors. Succession planning must occur earlier, owners have to think outside of the box, and expectations have to be tempered by contemporary realities. A few considerations:

- Labor substitution is a practical cure for a lack of MD candidates. One third or more of the typical ophthalmologist's daily clinic load can be handled by an appropriately trained and selected optometrist. And the country is drowning in optometrists at present.
- If your practice is located in the fly-over states, you either have to be very patient, very lucky, or pull out the big guns (professional recruiters, very high starting salaries, signing bonuses, discounted buy-ins, etc.)
- If you own a small practice in a less desirable community, your personal financial planning should anticipate the likelihood that you will close your practice one day without a successor, extracting nothing more from your practice at the end than its residual accounts receivable and the salvage value of your medical equipment.

And fourth (and most vexing), regulatory burdens that are stealing time from bread and butter business management. Depending on the year, each new pronouncement from CMS represents the business equivalent of herpes or multiple sclerosis . . . something to be lived with but never cured. This is particularly true for smaller practices, which, frankly, if they remain small, will not have the resources needed to respond to each new obligation coming over the horizon. Some of these practices are fighting fire with fire: staying more informed, hiring experts and getting providers more engaged with the new obligations of regulatory reform. Others are conceding, and trying to find ways to mitigate the expected penalties of non-compliance with greater top-line revenue, lower practice costs or new models of practicing.

APPENDIX 25

DEVELOPING A DOCTOR'S CODE OF CONDUCT

*"On my honor, I will do my best to do my duty to God
and my country and to obey the Scout Law; to help other
people at all times; to keep myself physically strong,
mentally awake and morally straight."*

The Boy Scout Oath

In some countries littering brings a \$1000 fine or even a "Community Work Order" in the case of Singapore . . . you wear an orange jumpsuit in public while you pick up other people's trash for a day. In other countries, littering is overlooked, along with graffiti scribbling, spitting and general mayhem.

It is the same in ophthalmology, where each practice is like a tiny country, with laws and customs all their own. Some are tight, some loose.

Small practices, and administratively neglected larger ones, are typically informal about boorish doctor behavior. They overlook tardiness, grumpiness and rudeness. They ignore poor grooming, sloppy patient care and late paperwork. Or they write rules and wag fingers, but don't really establish a consequential environment.

But largish practices, and those more formally (and effectively) led, have developed an evolving code of conduct and a fair set of consequences to help providers keep their darker tendencies at bay.

This small vs. large practice difference is understandable. A practice with two doctors has lower odds of loutish behavior in a month than a practice with 20 doctors.

Some physicians, especially practice owners, consider such codes of conduct to be another intrusion on their autonomy . . . and they are correct. While a majority of eye practices are still mom-and-pop scaled, the average practice size is growing. In more settings, autonomy and anything-goes atmospheres have to yield to what is best for the group (which, conveniently enough, is often what's best for patients and staff, too.)

If your practice is on the verge of (or beyond!) needing a behavioral statute book, here's a starter kit of 10 general guidelines. Even if you only adopt some of these, they will provide your managing partner and administrator with a starting point for reigning in behaviors that may be harming your company today.

Beyond these common-sense sample items, you can also look to your local hospital's bylaws, the AMA's comprehensive and widely adopted ethical canons, and within your own four walls, where adverse behavior unique to one of your very own doctors might suggest a customized approach.

* * *

1. **Show Up (and Stay) On Time** An efficient ophthalmological practice is a study in industrial engineering, with all work stations humming together. When you arrive late, or get lost reading your e-mail between patients, the factory floor grinds to a halt at great expense. Timeliness also applies to inside and outside business meetings and promised phone calls. As the old man used to say, "Early is on time and on time is late."
2. **Respect Your Practice's Governance Model** Boards, managing partners and administrators have the unpleasant task of saying "No" more often than they say "Yes." This is difficult for iconoclastic surgeons

to accept. As each issue arises in the boardroom, say your peace, contribute your thinking, then vote in your practice's best interests. And then publicly support every vote, even the ones that don't go your way.

3. **Work to Establish and Preserve Trust** This is fundamental to all healthy relationships—with patients, staff and partners alike. The best-cared-for patients trust their doctor. The most effective staffs trust their boss. And the highest functioning doctors trust their partners. Scan often and work hard to bridge any trust gaps.
4. **Be Equally Effective as a Leader and as a Follower** For most eye surgeons, leading comes more naturally than following. But both are important in a group practice. The key to success with either role is to put the interests of others first.
5. **Accept and Follow Through on Your Agreements** Volunteer for projects. Take your fair share of call responsively. Accept work-ins without protest. Strive to do more for others than they do for you.
6. **Practice Only Within Your Sphere of Competence** Accept that even with continuing education it can be hard to be all things to all patients in a professional world trending to ever-greater subspecialty focus. If you are uncertain about your appropriate scope of care or care pathway, talk to your partners or respected colleagues outside of the practice.
7. **Do Everything in Your Power to Grow the Entire Practice, Not Just Your Part of It** When speaking with referral sources, mention your partners and their respective subspecialty interests. Ask them to support the entire practice, not just your surgical volumes. Take internal referral seriously and strive to provide better care by letting your patients know how your colleagues might be able to help them.
8. **The Patient Is Always Right, Even When Wrong** Convey clearly to all patients through your actions and tone that you have their best interests at heart. With a belligerent or unreasonable patient, this can be much harder to do than to rescue a surgical complication, but it is as core to your life as a professional as any other skill. Learn to let go of hurt feelings.

9. **Be Open and Non-Defensive** When challenged by a patient, staffer or peer, say, "You know, you may be right. Tell me more." Then hang in there and listen patiently and actively, without rolling your eyes, while the other person lets you have it.
10. **Be Physically and Financially Productive** Ophthalmology doesn't require the brute strength of orthopedics or an OBG's tolerance for sleep deprivation, but it is a physically and mentally taxing profession. You owe it to your partners and staff to be work-hardened and capable of taking on the peak patient loads that are increasingly obliged to be financial effective in private practice.

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APPENDIX 26

REPLACING, TRANSITIONING YOUR PRACTICE ADMINISTRATOR

"When I meet successful people I ask 100 questions as to what they attribute their success to. It is usually the same: persistence, hard work and hiring good people."

Kiana Tom

"When I'm hiring someone I look for magic and a spark. Little things that intuitively give me a gut feeling that this person will go to the ends of the earth to accomplish the task at hand."

Tommy Mottola

Much has been written about adding, subtracting and shifting care providers in an ophthalmology practice, because it happens so much today. Labor substitution between MDs/DOs and ODs requires advance planning, especially with upside-down physician labor markets and practices bidding up the price of professional labor.

Not enough has been written about the parallel labor volatility taking place in the upper levels of practice administration. The complexities of modern practice, combined with trends toward practice mergers, are demanding stronger practice CEOs and Executive Directors, when once Office Managers and Administrators would do.

Here are few common questions.

Why do practice executives leave?

Administrative departures are about 50% practice-driven and 50% driven by the manager who retires or leaves for a better career. When managers are terminated, it's very rarely for a singular error or omission. Ophthalmologists are famously non-confrontational, and slow to pull the plug. Most fired administrators have to rack up numerous career missteps over time. When I ask the typical physician client, "Why do you think it's time for Frank to go?" the typical response is, "It just feels like he's over-stayed . . . it's no single thing . . . something has simply gone out of our relationship. It's time to move on." When managers leave, the answer is a bit more focused: "I'm ready for a bigger challenge" or "The handwriting is on the wall. I'm no longer getting the respect here I once enjoyed, and I'd rather leave voluntarily than be terminated."

Is it time to replace or simply augment our administrator?

No manager can be all things to all practices. Your administrator may be a numbers whiz but lack interpersonal skills . . . or vice versa. No amount of interviewing and background investigation can guarantee that the final administrator candidate you hire will be an intellectual and temperamental fit this year—much less in the years ahead, when practice scale and complexities may outrun their competency. In many cases I find a perfectly acceptable, hands-on operations manager who (through no fault of their own) lacks the strategic chops, critical thinking or financial acumen the board desires. Certainly, in many such settings replacing the manager (or hiring a CEO-level executive above them) is the right step. But in other cases—smaller practices, or those which are economically pinched—boosting the engagement of the managing partner or backfilling missing skills with outside accounting support, can be the best and thriftiest path forward.

What skills should the contemporary practice executive possess?

The cheeky answer is, “All of them.” And it’s not too far from the truth. It helps to be a polymath. In a single week, the manager of even a modest two-surgeon practice can be involved with federal regulatory issues that could shut the practice down . . . architectural decisions that will influence efficiency for the next decade . . . and human resource choices that will make or break your clinic flow. But few practices of any size can afford an all-knowing, all-doing Swiss Army Executive. So, you have to focus on those talents that are the most pressing and frequently needed. If your practice is economically on the ropes, financial skills head the list. If you have a co-managing cataract practice, sales and outreach talents may be the most important. Hire for the chief problems—and opportunities—while realizing that any less-critical skills missing in your new manager can generally be outsourced or handled by someone else on staff or in the board room.

Should we hire from within or go outside to find our next business manager?

Two generations ago, any smart, energetic technician or billing clerk could reasonably aspire to practice leadership. No so today, except for the smallest boutique settings. But neither does a largely theoretical MBA or accounting degree, alone, guarantee success. More typically, we see that the best practice lay leaders today have a solid formal grounding in accounting or finance, combined with many years of progressively greater responsibility in ever-larger organizations. Given the staff composition in most practices, this means that you almost certainly need to recruit outside of your practice. What’s the most predictive success factor? Selecting someone who has been successful in a medical practice that is the closest to yours in terms of service mix, structure, scale, growth pace, work intensity and boardroom environment.

What planning steps should we pursue in replacing our current manager?

In the ideal situation, where a replacement has been anticipated months or even many quarters in advance, you can undertake the following, serene steps:

- Update the practice's long-term business plan, so you have a context for deciding what level of administrator will be required.
- Form a search committee, inclusive of the outgoing administrator, board members and mid-level managers.
- Cast a wide net and be patient in selecting a just-right fit.
- In the best circumstances, arrange to have your outgoing administrator available as an ongoing consultant to aid the transition, and to also hedge against the typical 50% odds that the next administrator you hire will not work out, and you'll have to start all over again.

When your administrator's departure is abrupt, or worse, acrimonious, you may be obliged to skip some of the above steps, and add others:

- Making an appropriate, upbeat announcement to practice staff and associates
- Notifying vendors and others in the community about the change in status
- Naming an interim administrator (commonly the managing partner)
- Requesting that mid-level managers prepare to work more autonomously for awhile
- Calling on your accounting and other consulting services to bridge the unplanned gap
- Cutting a few corners in securing the next administrator in the practical interest of time

How long will it take us to find a new administrator?

The answer to this is proportionate to the size of your practice, your expectations and the resources you apply. Small practices, with luck and modest needs, may secure an acceptable candidate in a matter of weeks, often raiding a nearby, like-sized practice. Large practices have greater

needs and more at stake. Such practices, which hire one or more executive search firms, and muster a formal search committee, may be able to onboard a replacement in as little as 3–4 months from launching a search, but 6+ months is a more realistic expectation.

What are administrator compensation trends?

In a word, “Up.” Let’s break this down into zones, for the starting base salary ranges typically seen at four practice scales in the average market for the average qualified candidate:

- Small, 1–2 doctor, \$1–3 million practice: \$60,000 to \$80,000
- Medium, 3–5 doctor, \$2–6 million practice: \$80,000 to \$110,000
- Large, 6+ doctor, \$7+ million practice: \$110,000 to \$200,000
- Very large, 15+ doctor, \$20+ million practice: \$200,000 to \$300,000 and up

In most cases, typical benefits include:

- A potential performance bonus equal to 10–20% of base salary
- A relocation allowance of up to \$10,000
- 3–5 weeks combined vacation, CE and sick leave from the outset
- A \$2000 to \$5000 annual CE stipend
- Personal and family health coverage

These figures are much higher than a decade ago. Is it fair that administrator wages have been rising at a faster pace than ophthalmologist wages? Of course not. But supply and demand, combined with sharply greater career burdens at every scale of practice, drive the market.

What can our practice—and especially our doctors—do to make our next administrator more successful?

This is a potentially very long list, but the three most prominent success factors are:

- Strategic intimacy . . . getting the new manager and the doctor-owners on the same page regarding the five- to ten-year plan for the company
- Numeracy . . . assuring that the new administrator, managing partner and middle managers are communicating fluently on the key performance indicators (profit margins, growth rates, surgical density, payer mix, optical remake rates, etc.)
- Accountability . . . providing the board with not less than a monthly written recap of the status of all open projects, and alerts regarding any looming performance lags

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APPENDIX 27

WHAT BURNING MAN TAUGHT ME ABOUT OPHTHALMIC PRACTICE MANAGEMENT

*"Burning Man is a cross between a Vatican ceremony,
the Cirque du Soleil, and a necro-erotic
cannibal mantis mating ritual."*

www.wikiquote.org

"Human beings are flawed and complicated and messy."

Brit Marling

"I like messy. What fun is tidy?"

Dasha Zhukova

Burning Man, an annual, temporary, flash city of 70,000 splendidly artistic, variously intoxicated citizens, comes to a fiery climax on a dry lake bed east of Reno, Nevada every Labor Day.

Burning Man has grown up. There were only 25,000 of us in 2003, the first and only time I attended with a couple of ophthalmologist pals, John Corboy and David Schneider, now both happily retired. It was a fun field trip to explore alternate realities, with just enough practice business discussion on the side to make our tax advisors happy. We were the three squarest attendees, except maybe Corboy, who was never quite able to find his pants.

After three days of desert camping, somehow managing my contact-lens-over-RK-incision hygiene with talcum-fine sand swirling, they lit off an articulating 80-foot wooden man standing atop a pyramid filled with 1,000 gallons of propane and \$150,000 of fireworks. And then we all went home.

The most important concept I learned at this (ahem) CE meeting was “MOOP,” short for Matter Out of Place.

Because of restrictions put on this annual bacchanalia by the Bureau of Land Management, the organizers of Burning Man are obliged after the festival to remove every trace of MOOP. So, for weeks, staff and volunteers stick around to pick up cinders and gum wrappers and abandoned bicycles and haul it all away.

While physics has a more elegant name for it—“entropy”—MOOP lends a more evocative, yeasty grip on the concept of practice messiness. “MOOP” is also a lot more fun to say out loud during your next staff meeting.

MOOP is not just a messy hallway or cigarette butts in the parking lot. MOOP takes many forms:

- Misplaced staff . . . this can be excess staff, or departments that are not equally balanced with enough labor to handle patient loads, or staff whose core skills are not aligned with their job duties (e.g. a gruff but excellent biller, who has been assigned to fill in at the front desk).
- Unproductive satellite offices . . . which can rob profits. A practice with two offices is four times as complex as one with a single location. By measuring the net profit per doctor-hour in each of your locations, you’ll quickly identify any targets for closure.
- Tests and procedures that are no longer effective or profitable . . . every surgeon loses time and money over the course of a long career learning unfruitful techniques and buying equipment you’ll never use; some of this is inevitable, especially in the early years of your career, but use your experience to be more critical in the future.

- Money located in the bank accounts of patients, the Federal government, insurance companies, instead of your practice's account, because staff are behind in billing.
- Misplaced thrift, which can rebound into costly practice failure when marketing is cut back, continuing education meetings are skipped, or staff training is neglected.

Here's a **Ten-Point MOOP Test** to score your practice. Apply the following points for each item:

2 Points: "This describes our practice"

1 Point: "We try but fall short on this"

0 Points: "This really *does not* describe us"

1. ___ Our board, lead doctor and administrator are aligned on our standards of appearance and operations; most of these standards are in writing.
2. ___ Our facilities look a little fresher and better kept each year; we stay ahead of routine maintenance, make repairs as soon as possible, and make frequent upgrades.
3. ___ We use benchmarks to make sure we employ the right number of support staff (e.g. in general ophthalmology, we generally employ 2.5 staff hours per patient visit).
4. ___ Staff don't freelance how they do their job; they follow written protocols, which, in turn, are reviewed and updated frequently to improve efficiency.
5. ___ We collect, on time, from patients and payers, all the money that is reasonably owed to us; we don't tolerate excessive open accounts.
6. ___ We only buy medical equipment when it is needed to keep up with community standards, enhance patient care or improve financial performance; we don't make purchases on a whim.
7. ___ When a patient lodges a reasonable complaint, it isn't ignored . . . it is used to improve the level of service for all of our patients.
8. ___ Our providers are kept appropriately busy; we don't waste their time with empty appointment slots, nor do we overwhelm them with excess patients.

9. ____ We formally review all external vendors at least annually; we praise great ones, encourage good ones to improve and replace weak ones.
10. ____ We continuously review our “internal vendors”—our support staff—and replace weak links without hesitation.

How did you score? Very few practices will get a perfect score. Our average client who is trying hard to improve comes in at around 14 points. Gather the leaders of your practice, take this quick test, discover your consensus score and agree as a group on where you would like the score to be in three months.

Let's close with the Four Rules of MOOP:

1. Practice growth (and especially anything above an 8% per year growth in patient visits, about twice national averages) leads to extra MOOP . . . you have to apply greater anti-MOOP vigilance if your practice is thriving than if it is just growing slowly.
2. MOOP thrives on the tolerance and leniency of doctors and staff who overlook things out of place . . . use the above concepts to immunize yourself against MOOP passivity. Make it a game to find one thing out of place in your practice every day, and then *fix that thing*.
3. Your administrator and mid-level managers are your practice's Anti-MOOP Squad . . . make sure they are just as sensitized to MOOP as the practice owners.
4. MOOP is not just harmless office clutter . . . it is anything that is out of place which harms efficiency, profitability and customer service.

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APPENDIX 28

WRITING A TWO-PAGE, TWO-HOUR STRATEGIC BUSINESS PLAN

*"Planning is bringing the future into the present
so that you can do something about it now."*

Alan Lakein

*"Let our advance worrying become
advance thinking and planning."*

Winston Churchill

Not even one ophthalmic practice out of fifty has a written, updated business development plan. There are understandable reasons for this.

Ophthalmologists are smart, exacting and professional, but they think and live in the "now." This is not surprising. Most surgical and clinical work units are highly repetitive and last just 10 minutes. So, their timeframe for long-term strategic planning involves clocks more than calendars.

On top of that, most ophthalmologists have experienced 30 years of parents, teachers and professors telling them exactly what they are to do next. So, it is an unnatural act, with a third of your life already done, to start thinking for yourself about the future.

Throw in time poverty, a lack of business training and the uncertainty of forecasts in an uncertain world, and the lack of strategic business planning is understandable. But it is still inexcusable.

I'm going to make it relatively painless for you to write your practice's long-term plan. Simply read along and change the facts to fit your practice.

I've drafted this plan imagining the busy solo practice of "Dr. Jones," a 55-year-old general ophthalmologist. But you can change the facts to match your setting. Whether yours is a part-time solo practice or a \$50 million regional supergroup, the same chief strategic dimensions still apply.

1. Our practice was started in 1997 by Dr. Frank Jones, the current sole owner. Dr. Jones plans to work as a surgeon another 10 years, and then start tapering his practice, transitioning to medical care only and fully retiring at age 70.
2. The practice collected \$1.5 million in 2017, and Dr. Jones enjoyed pre-tax profits of \$450,000. The practice has always been slightly over-staffed, and spends 35% of cash flow on wages, taxes and benefits for lay staff, a figure which is commonly closer to 30% or a bit less. We realize that in the present environment, especially with unemployment down and labor costs rising, we will have to right-size staffing more carefully than we have in the past.
3. Average collections per patient visit now stand at \$179. This is lower than many of our colleagues. Part of the problem is our low refraction collections, which in turn has three drivers. Doctors only charge for a refraction at about 10% of encounters when the typical figure would be 20%. Our refraction fee is \$35, much less than the current \$45+ average around the country. And the front desk is weak at collecting at the time of service.
4. Dr. Jones has worked with his accountant and determined that he will need to earn an extra \$100,000 per year—from \$450,000 to \$550,000—in order to be safely over his retirement finish line at age 65. A priority in our practice plan will be to generate these incremental earnings without undue risk, time commitment or fatigue for Dr. Jones, who at 55 is enjoying taking his Friday afternoons off.

5. The practice occupies a 3800 square-foot rented office suite, and we have 8 years left on our lease. We have just four exam lanes and a small optical dispensary—which is really more of a patient convenience than a profit center. With 700 patient visits monthly, our exam rooms are approaching full capacity, and on busy days, techs must wait for a room to open up before they can call back the next patient.
6. Historically, the practice has been growing 3% annually, which is a little under the organic pace of demand growth for eye care services. So, we are slowly losing market share. We would like to boost our growth rate to 6% to slowly increase our position in the community, to boost earnings to aid Dr. Jones' retirement funding, and to help cover rising labor costs.
7. The practice employs one part-time optometrist, working two days per week, who will be retiring in a year. We believe replacing this doctor with a full-time optometrist will free Dr. Jones so he can accept more new patients, which will in turn increase surgical and special testing volumes and the average revenue per patient visit.
8. If we grow at 6%, by 2023 we will be seeing a bit over 900 patients per month. This means that we will need more than one MD and one OD. We will decide at that time whether we are ready to hire a second OD or recruit an ophthalmologist.
9. A zip code study shows that most patients come from a 10-mile radius of our office, a service area with about 125,000 people. The senior population is in line with national stats, but our community is served by only three ophthalmologists, instead of the five or six that a community our size would normally support. So, if we are successful in ramping up growth, we should be in a position in five years or so to start recruiting the next MD, which will provide a successor for Dr. Jones when he slows down at 65.
10. Ours is a one-hospital town. Based on conversations with the hospital CEO, they have no plans to buy up specialty practices except for cardiology and orthopedics. We believe that private/independent practice and patient access will remain feasible for the rest of Dr. Jones' career.

11. New patients are currently sourced to 60% word of mouth, 10% MD referral and 5% OD referral. To achieve our growth goals, we will boost our marketing activities with a new website, optometrist outreach and senior vision screenings in the community. We currently see 90 new patients per month. By the end of 2018, we would like to see that number grow to 120+. While bringing in more new patients, we also want to do a better job of holding onto established patients. Our established patient pool is only growing by 3% per year, when 5% or higher would be normal. We will review recall and appointment reminder protocols to try to correct this.
12. The office is getting a bit dated. We are currently working on plans for modest interior design improvements . . . nothing lavish, just catching up on neglected routine upgrades.

In consideration of the above, our priority tactics in the next year will be:

- Condense our two separate doctor's private offices into a single "bull pen" office, freeing up one room to become our fifth exam room. This will increase our capacity to 850+ exams per month without going to evening or Saturday hours.
- Renegotiate our facility lease so that rather than eight remaining years we can renew for at least 15 more years.
- Conduct a labor productivity study and find a way to limit labor costs to not more than 30% of cash flow, which will bring about \$75,000 to the bottom line.
- Raise average collections per visit from \$179 to \$190, through a combination of slightly more assertive testing and treatment, elevating refraction fees to \$47, and charging this out about 20% of the time rather than the current 10%. This will boost practice profits by about \$90,000 annually.
- Make a decision about our optical, either expanding and freshening it up to be more profitable or closing it down to refocus on developing optometrist referral support.
- Toward the end of 2018, we will recruit a full-time optometrist to replace our part-time optometrist. If we

decide to close down our optical, our new optometrist will have time available to do outreach work with ODs in the community.

- Complete the interior facility upgrades; hold a patient open house in the summer.
- Improve recall and establish tighter care pathways; audit to assure that all patients leave with either a firm appointment, a recall or a formal discharge. If we are able to increase our established patient growth rate from 3% to 5%, we should grow profits by about \$30,000.
- Launch the new marketing plan, with an early emphasis on OD outreach. If we can increase new patient visits by just 10% in the coming year, that would add \$25,000 or more to practice profitability.

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APPENDIX 29

PRIORITIZING YOUR MUST-DO ACTION LIST

BY CORINNE WOHL, MHSA, COE
AND JOHN B. PINTO

*"The key is not to prioritize what's on your schedule,
but to schedule your priorities"*

Stephen Covey

Surgeons learn early in their training to triage—addressing big medical problems first, and small ones later. And yet, somehow, too little of this lesson is applied when doctors and managers are running their practice businesses. *Everything* can be flagged as a priority, which is a little like a doctor treating his patient's shattered orbit and toe blister at the same time.

Learning how to quickly and effectively prioritize business tasks is at the heart of great practice management.

We all pay lip service to prioritization. The surgeon-owner asks his administrator, "What are you working on now, Susan?" "Plans for the new satellite office," Susan replies. And yet, when she continues down the hall to her office, Susan faces a whiteboard with a list of 26 urgent tasks, none of which is really number one.

Practices, managing partners and administrators who thrive, develop a system to nominate the most important tasks, and communicate these priorities up and down the organization.

* * *

Applying Covey's advice, it's best to tend to the non-urgent/important items before turning to urgent (and the only seemingly important) ones.

But the contemporary demands on practice leaders encourage all of us to either address the "on-fire" issues (which could have been prevented with earlier attention), or worse, to put first efforts every day into those things which are either easy to check off your list, or fun to do, but not necessarily a priority. By the end of the day, the truly important tasks can be left untouched. Again.

Good and bad prioritization habits are part of each practice's culture. We see practices where everyone diligently pursues the most important priorities first . . . and practices where the opposite is true.

What's the culture of your practice? Do you apply major attention to major items? Is procrastination called out or overlooked? Are blown deadlines blown off, or is there an appropriate, adverse consequence for not getting your agreed tasks done on time?

Prioritization is so important and fundamental to success that it's something best periodically relaunched formally at the board level and then refreshed once again down the ranks. Doing this creates a culture of shared urgencies.

Business prioritization is perhaps more art than science, something that the most fortunate of us stumble upon for ourselves rather than by learning an effective system. But every effective executive eventually finds what works best for them. If you want to speed up the process of learning how to better prioritize, what follows is a systematic approach, abstracted from the best habits we see in our travels around the country:

1. First, let's address *structure*. Examine your current to-do list, no matter how ugly. Ask:
 - a. What's the format of your list? Consistency here is as important as what physical tool you use. Some perfectly excellent managers manage their to-do list on 3 x 5 cards . . . others on a yellow tablet or like most today, on a Word file or Outlook task list. All of these can work, but they work best if used consistently.
 - b. Do you have a system which flags true priorities? This can be "A, B, C" or 1 through 5, or even a simple asterisk next to vital items.
 - c. Do you review and update your task list at appropriate intervals? Obsessively editing your list several times a day is not an effective use of your time—but neither is checking your list weekly. Some of the most effective ophthalmic executives we know make it a habit to examine their to-do list closely twice a day . . . once at the start of the work day as a reminder of the priorities . . . and once at the end of the day, when the next day's priorities are flagged.
 - d. Are the right timeframes covered . . . your current to-do list should probably not be bogged down with tasks you won't get to until next quarter.
 - e. Are all of the tasks on your list, really YOURS? Or do you clog up your to-do list with the actions that others are responsible for, simply to assure you haven't forgotten what you delegated?
2. After considering the structure and content of your action list, let's turn to *function*. The whole reason for having an action list is to stay on task with the *priorities* of your company. Do you know what these are? Surprisingly, very few practices have a formal, written strategic plan. But even in the absence of a plan, your practice's leadership team should at least have a punch list of longer-term strategic priorities, each of which should match up with one or more actions on your to-do list. Here's an example:

Sample Strategic Priority	Sample Tactical Actions
Grow practice revenue 7% annually	• Hire an advertising agency to help boost new patient volumes • Audit recall systems in the practice
Improve cataract surgical outcomes	• Secure surgeon buy-in to measure individual outcomes • Agree on a methodology to measure these outcomes
Complete a succession plan to replace a retiring senior partner	• Draw up employment and partnership contract terms • Engage a recruiting firm

3. And last, comes *discipline*. Make sure you apply sufficient energy and focus. The best list-making in the world is for naught unless you act on your action list. Here are a few pearls from the most diligent administrators we know:

- As a mechanic pal once said, “When you lift up the hood do something easy first—it gets your confidence up.” You, too, may feel more is being accomplished if you complete one or two easy things first thing. This may give you confidence and boost momentum.
- Alternately, if you are the procrastinating type, you may find it most effective each day to tackle the most gruesome of your projects first.
- Don’t forget to cross each completed item off your list (or change the color of that line item on your electronic list). Celebrate each completed task as a small reward to get you through the day.
- The fastest way to plow through a to-do list is to not do some of the things at all. Is there anything on the list that can be eliminated altogether?
- Review your task list for potential delegation. Does everything on the list require your personal attention . . . or can some of it be distributed inside the practice or outsourced?
- Don’t be too harsh on yourself. An ophthalmic executive’s task list is never completely checked off. In most settings you have to live with practical limits on how many big-picture tasks you can be

pursuing at one time. Most of each day will probably be taken up with basic operations, obliging that some tasks on your daily to-do list will be carried forward to the next day, no matter their priority.

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APPENDIX 30

HOW TO EVALUATE & REDUCE YOUR PATIENT NO-SHOW RATE

BY CORINNE WOHL, MHSA, COE
AND JOHN B. PINTO

"Lost time is never found again."

Benjamin Franklin

Filling 100% of your desired appointment slots daily is a top priority found in the best-run practices. No-show patients must be kept to a minimum for the sake of both your patients and your bottom line. Under-booked appointment templates and excessive no-show rates cost the practice significant revenue and keep patients from needed care.

Listed below are the challenges of this multifaceted problem and success factors to control the no-show rate. First, some facts:

- Normal no-show rates for anterior segment practices are 5% in most settings, edging up to 6–8% in coastal/urban settings where folks are simply less courteous about keeping appointments.
- In rural America and in retinal practices norms are generally 2–4%.
- Pediatric practices average 10–15%.
- ODs average around 8–12%.

To calculate your no-show rate, divide the number of daily no-show appointments by the number of scheduled appointments you had when the day began. Be sure your

reports are showing only true no-shows and not appointments where the patient calls before their appointed time and reschedules. A patient who was expected in the office this morning, but who calls (even at the last minute) to reschedule, is not a no-show, by way of convention.

Track all no-shows in both your IT system and be sure to follow-up with a phone call the same day to reschedule the appointment. Note this action in the patient chart.

Once the data is collected, analyzing it by doctor, location, day of the week (and even time of day if you are tracking a severe problem) will provide the patterns you need to deduce the cause and reduce the rate. You may also find that the average is different from doctor to doctor. For example, surgically oriented and senior docs typically have lower no-show rates.

There are many common drivers for excessive no-show rates:

1. Higher no-show rates can be due to doctor-mediated gaps: a failure to impress on the patient the importance of keeping their next appointment (because of family history, etc.).
2. Sometimes excess no-shows can be caused by lower levels of patient satisfaction. Patient: *"Sure I'll make an appointment . . . (because you are insisting, but I'm not actually going to come in because I don't like it here)."*
3. Some of the problem may be due to clerical gaps. It is common to see staff insist that they faithfully make reminder calls, but when you audit formally, you find that some or all of the calls are missing. You can't just take staff at their word that they are making the calls . . . you need to audit directly.
4. If you are booking appointments out for one year, which is recommended, build a system that reminds the patient earlier than the typical two days in advance. We commonly advise a reminder via phone call, text or e-mail set 1–2 weeks in advance and then another reminder two days ahead of the appointment. The more last-minute the reminder is, the higher the chance of a forgotten appointment.

5. Pediatric and higher-volume Medicaid practices tend to have much higher no-show rates. A common work-around for this is to multiply the number of appointment reminders . . . for example, automated calls five days out, live calls three days out to non-responders to the auto-calls, then a final automated call one day out to everyone. This obviously irritates diligent patients but can accomplish the desired result of a lower no-show rate.

Here are a few common approaches to alleviate an excessively high rate:

1. Keep a call list ready of patients available on short notice to fill empty appointment slots.
2. Schedule repeat offenders at times when it will affect the overall schedule the least.
3. Write a policy to discharge patients who are persistent no-shows. Provide appropriate notice for them to find an alternate doctor.
4. Don't book more than two family member visits at a time, unless you purposely make an exception for a family with which you are familiar. This avoids a larger gap in the schedule if they do not show.
5. If your systems allow, find the best reminder method for each patient, e.g. automated text, e-mail, phone call or postcard reminders. In purely geriatric practices, no-show rates may come down if you experiment with live calls rather than automated calls.
6. Consider charging a no-show fee of \$25 to \$50 and waive the fee liberally to avoid ill will. This was first tested in pediatrics, and is now seen in perhaps 5% of general practices overall. Some practices now keep a credit card on file to facilitate such charges, just as we now commonly experience when booking a hotel or restaurant reservation.
7. Establish enough appointment slots so that based on your average no-show rates you will usually have a full clinic (and live with the fact that sometimes the no-show rate will be much lower, creating a stressful day.)
8. Patient satisfaction is a key driver for improving no-show rates. Strong, bonded relationships between

doctors (and staff) and patients help to reduce the number of no-shows.

9. No-show rates can accelerate quickly when not being monitored regularly. Generate a report at least monthly to keep close tabs on any internal changes that may happen subtly.
10. Make a reduction in no-show rates a priority for your staff and managers. Remind managers that avoiding just one missed appointment a day can cover the annual salary for a receptionist or technician.

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APPENDIX 31

STRENGTHENING MID-LEVEL MANAGERS FOR A STRONGER PRACTICE

BY CORINNE WOHL, MHSA, COE
AND JOHN B. PINTO

*"The way management treats associates is exactly how
the associates will treat the customers."*

Sam Walton

In every practice, large and small, middle managers will make or break you. They will either handle the bulk of daily operations, freeing up time for the administrator to focus on higher-level responsibilities like strategic planning. Or your middle managers will require constant oversight and be a barrier to harnessing the administrator's true value.

Middle managers commonly play an important dual role. They act both as front-line workers and as working supervisors. Being the lead receptionist may optimally require 10 hours a week of supervisory time, but with the demands of a busy office, this manager may only be allowed an hour here and there to mold and improve their team.

Being a middle manager is exhausting, and the smaller the office, the more tiresome it gets. "Middle managers" are appropriately called that because they are inserted into the *middle* of complicated relationships with the administrator, owners, employee doctors and staff. One minute they are following the leader and a minute later they are expected to be the leader.

Here is a list of 14 skills that the best mid-level managers possess.

1. **An understanding of business concepts.** Engage your managers in areas outside their own departments by discussing how your practice works. What drives revenue production? Cost containment? Motivate and inspire by asking for their input and sharing your strategic thinking and overall practice goals. Pass down the business concepts and management tools that you have learned throughout your own career.
2. **Human resources management.** HR management is a large part of every manager's responsibility. At a minimum, mid-levels need to know how to legally interview, hire, orient staff, apply a fair disciplinary process, and how to help prepare to terminate employees. They also need to know how to motivate staff with a professional, kindly manner, while also expecting high performance achievement from each employee.
3. **Conflict resolution.** This is a key skill for managers. Knowing how to stay calm, gather all the facts before leaping to conclusions, apply policies consistently, and follow up in a timely manner, especially with uncomfortable situations, is critical. Educating managers using case histories from errors the practice has made is effective . . . and reinforces the hardest lessons you have learned as a senior manager or practice owner.
4. **Numeracy: Mastering the underlying drivers of economic performance.** Lots of managers brought up through the ranks fear numbers. It's common to hear, "I hate math; I'm not a numbers person." There is no magic to it as few business math calculations rise above the sixth grade. Teach your people how we measure practice progress through financial performance in the same way that doctors use basic lab data to treat patients. Middle managers can gain this experience by having budget and key performance indicator responsibility for their own departments. An example: For a technical director this might be expressed in terms of tech payroll hours per patient visit.
5. **Communication skills.** Written and oral communication skills are necessary for mid-level managers to be

able to pass your message forward with clarity to their people. If your managers are not already proficient at this, you may need to employ remedial training: how to write a memo . . . how to present to a staff group.

6. **Effective delegation.** Less experienced managers often believe they are better off doing a task themselves than taking the time to train others. This is a short-sighted viewpoint, but something that even some experienced managers have difficulty grasping. Encourage your managers to invest in staff growth; the time taken to do so now will free up supervisory time in the future.
7. **Organizational skills.** If you were not born an organizational wizard, you can be taught. Mid-level managers, especially working supervisors, must develop this skill to survive. Test this with questions like, “How are you preparing for the new doctor to join our practice?” If the clinic manager pulls out a two-page list she prepared, you have a great starting point. If she starts rattling off a scattered bunch of to-do items, she needs help.
8. **Spend major time on major things, as prioritized by practice goals.** This is another challenging skill for new managers. Over a career, we learn how to prioritize and not let the smaller, easier projects jump in front. We also learn to balance competing tasks . . . this is especially hard to do when others are pressuring you. Spend time with your mid-level manager reviewing prioritization and how to determine how long each project will likely take.
9. **Written operational guidelines for each department.** Every department needs an operations manual memorializing the “one, agreed, best” way to do everything. It forces service consistency, reduces errors and costs, formalizes employee training, and advances quality improvement. Make this a priority for each department manager.
10. **Be action-oriented; follow through and be accountable.** There is a difference between “being busy” and taking effective, appropriate action. Be sure your middle managers know the difference and hold them accountable for taking action that advances the interests of your practice. Express this expectation and follow up consistently . . . and your managers will grow.

11. **Customer service focus.** Medical practices, like other kinds of businesses, are being held to higher standards. Your customer service reputation is derived mainly from your front-line staff. Be sure the managers are setting high standards and leading by example.
12. **Understand the need for forgiveness.** Don't hold grudges. Staff will make errors. Correct these and move forward. Managers must help staff move beyond their inevitable errors. Encourage learning from mistakes made, rather than badgering or bullying staff based on their past blunders.
13. **Make the shift from peer to supervisor.** Most mid-level managers move up through the ranks. Changing from peer to boss is not easy. Newer managers need support in the area. Provide this assistance when a new mid-level manager is first elevated, not months later when role conflicts are starting to break down a department's function.
14. **Turn management skills into leadership skills.** Prepare each manager's career development plan. This should include specific goals and time lines. Update it annually. Make an ongoing effort to boost the management skills that are of most value to your practice. Build alignment here with the practice goals. Individualize the plan to each manager's career stage.

* * *

It takes tremendous self-discipline to coach yourself, let alone others. We all accomplish more and do better under the influence of someone else pushing us to the next level. By helping your management team improve as individuals, your practice will be on the path to achieving more, too.

#

APPENDIX 32

ARE TURF WARS IMPACTING DECISION MAKING IN YOUR PRACTICE?

BY CORINNE WOHL, MHSA, COE
AND JOHN B. PINTO

“Good management is the art of making problems so interesting and their solutions so constructive that everyone wants to get to work and deal with them”

Paul Hawken

Decision making that consistently prioritizes the practice and its patients—rather than doctors and workers—leads to organizational success and ultimately to the benefit of owners and staff, alike.

In contrast, poor decisions flow from paying too much attention to the various “sides” in your practice, and the turf wars that quietly (or loudly!) bubble up in any large, complex organization where the stakes are high and the people are smart. Too-hasty decisions that benefit only individual providers, managers or specific departments more than the overall practice, may feel the most expedient in the moment, but can often backfire over time, to the detriment of patient care and overall financial performance.

Are underlying turf wars adversely impacting your practice’s problem-solving ability? The care you provide patients? The practice’s ultimate destiny?

Turf wars can take different forms:

- Classically, they may emanate out of frictions between the billing department and the front office staff. Because each of these two departments depends on the other's work being correct, and they don't appreciate the pressures and constraints each side experiences, each side tries to convince upper management and the board (the ultimate decision makers in the practice) that the "other" side is incompetent.
- Or turf wars can surface between technician/doctor pods in your clinic area, with each side feeling competitive or protective of their own subspecialty area and its needs. This can result in the loudest—and not necessarily most worthy—pod getting attention and resources from management.
- Another common conflict that can impair management and boardroom decision making is the common struggle between reception and tech staff cohorts. Appointment schedulers just trying to follow the booking rules conflict with techs trying to lighten the load for *their* doctor.

Practices run at their best when doctors and staff understand that functioning collectively as one cohesive team ultimately benefits all. But this is often not an easy lesson to teach or learn. Such alignment takes energy and commitment from the top to supersede personal preferences and long-standing internal conflicts.

Why is it tempting for individuals to make decisions without thinking of the entire practice?

- Employees are generally evaluated and rewarded as individuals, not as teams.
- Doctors are also often economically rewarded based on individual performance.
- Self-motivation is common for super-achievers often found in health care settings.
- Favoritism by doctors or management can stoke this fire.
- Perhaps most important is a lack of communication about overall practice goals.

Here are five ways to help prevent and cool down turf wars:

1. Promote formal, written, regularly scheduled communication about common practice goals . . . not just long-term company goals, but day-by-day imperatives to increase patient satisfaction and care excellence, such as
 - managers telling staff daily, reminding workers in the course of the clinic about our values and priorities;
 - administrators reinforcing the importance of collaboration at all general staff meetings, and
 - managing partners emphasizing “team-first” ahead of individual or departmental goals and reinforcing management’s efforts to serve the overall practice’s interests.
2. Train managers to consistently emphasize the importance of broad teamwork over individual efforts. Provide your managers with examples to share with their department. In Corinne’s early days as a hospital administrator, there were constant battles between the nursing and the housekeeping departments. Nursing felt superior and sometimes created barriers for housekeeping to get their work done. Yet for patient satisfaction, it didn’t matter how excellent the nursing care was if the patients were disappointed and reported that the floors looked dirty. This is one example of how patient care teams must work together, sometimes in unexpected ways.
3. Use managers meetings (which should be biweekly) as formal problem-solving sessions. These meetings provide an excellent opportunity for team building. A bit of management magic occurs when you ask managers to offer opinions on things outside of their own area. If encouraged, they tend to offer objective, creative observations and solutions. If the administrator running the meeting helps guide this process, the immediate problems get solved faster and it demonstrates at each meeting the benefits of teamwork.

4. Be collaborative in your decision making at all levels, with everyone involved in the issue. When you have a multi-disciplinary problem to solve, assemble representatives from each department the issue touches. This way there is no suspicion raised by those not invited, and you avoid expanding any existing turf war.
5. Effective listening is essential for clear communication. Listen to feedback and solve the long-term problems that are creating the barriers and boundaries that lead to turf wars.

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APPENDIX 33

SEIZING LIFE IN PARIS, SEIZING LIFE IN YOUR PRACTICE

[The following was written in Paris on Thursday, April 11, 2002, at the Cafe Rue du Bac, 7 months after 9/11.]

I am sitting close to the north entrance of the Louvre Museum, in a small outdoor café, counting down the last few hours of a 10-day, bittersweet trip. A dear friend from my youth, a mid-level French bureaucrat named Jean-Philippe Atger, had died on October 31 of the previous year, from some indeterminable collaboration between his poorly managed diabetes and hepatic cancer. So it goes.

Jean-Philippe and I were supposed to see each other about a month before he died, but September 11 intruded, international travel was thrown into question, and that visit was replaced by this one, to attend a series of small gatherings in his honor.

Along with many old friends, I have just spent several days with Marie-Claude, Jean-Philippe's mother. She and I first met some 25 years ago. I had reminded her back then of the young American soldiers who had liberated Paris when she was just 14 years old. It was, back then as now, love at first sight for both of us.

Here was a woman who had spent her tender, formative years under the leering eyes of the German Gestapo. She had lost a husband and now, not one but both her sons. Yet, like her vibrant children, she is squeezing the juice

from life even now. A semiretired librarian, 72, and bearing a cane, she had just returned from a research visit to Italy the day I arrived in Paris. On the phone, she sounded like a school girl. She still attends the opera weekly. She entertains lavishly. Her cooking one-ups Wolfgang Puck's. And at one of our parties, when I poured her a whiskey, she insisted, with a frown, then a smile, that I tipple a bit more into the glass. That's Marie-Claude.

It's nearly impossible to be somber in Paris. But, sitting here in the shadow of what remains of the world's greatest artists, perhaps the world's greatest thinkers, it is abundantly easy to be philosophical. Perversely, here at my sidewalk seat, my thoughts return back to the work that's waiting for me back home as a consultant . . . and the growing misery of the average ophthalmologist in America.

Are we again at the fringes of a gathering storm in the American health care system? As one academic surgeon recently wrote to me, ". . . we are like pilots, with the nose of our plane pointed down, approaching terminal velocity, while we are screaming, 'May Day! May Day!'" And no one is listening. I should know. In the weeks before I left for Paris, I had separate calls from a couple of clients—active, nominally successful, young-for-their-age physicians—who each said they were ready to hang it up.

The Washington Post and *The New York Times* op-ed pages now regularly print columns on topics that haven't been tackled since a decade ago, in the early 1990s. "It is virtually certain that health care will be as big an issue in the 2004 presidential election as it was in 1992 . . . conventional wisdom in politics has held that only incremental change (the muddling through we've all experienced in ophthalmology) makes sense. But a growing number of major players are now challenging that view," writes David Broder. He quotes a leader of the emerging National Coalition on Health Care (with august members such as AT&T and the retirement system for all of New York state), saying that the problem is far more serious than anyone in politics is acknowledging. Incrementalism must yield to a top-down national policy fix, they are now saying.

Once again, medical spending is growing much faster than the rest of the economy. Simultaneously, the number of uninsured and underinsured is growing. Employers are shifting a larger portion of health care premium costs to workers, who, quite naturally, will acquiesce to watered down coverage to maintain the largest possible share of their shrinking real incomes. "Surely, this is intolerable, and change will follow," said Leon Eisenberg, MD, of Harvard Medical School, in a 1999 speech. "What is not self-evident is what will be left in its wake."

Whatever is left, I promise you, will translate to less net income per unit of service you provide to your patients as an ophthalmologist. Consider it already a fact. And given that fact, you have three possible responses:

1. *You can leave the profession.* This is suitable for those who are financially and otherwise prepared for retirement. Unfortunately, for the majority who are short of retirement—by age or net worth—there is relatively little to go on to with their highly customized skills that, without significant additional training and luck, will yield more income (and I dare say more satisfaction) than will be enjoyed by the average eye surgeon, even 15 years from now. The average ophthalmologist this year will make about \$230,000 before taxes. Cut in half, that income is still easily in the top 10% or so of American wages. The green grass on the other side of that fence may be Astroturf.
2. *You can kick and fuss and make yourself miserable.* But consider this: Very few fellow physicians, much less the general population, will have much sympathy for your cause. And everyone around you will be miserable, too. Your patients. Your staff. Your family. Many surgeons I know are still trying on this option for size.
3. *You can commit to making the aspects of your practice that are under your control as successful, pleasant, and joyful as possible . . . and somehow live with the parts you can't really control.* Still want to make as much income as possible? Simply learn how you can transit 90 patient visits a day. (It can be done in a way that keeps patients happy.) Be more productive. As long as we're in a largely

fee-for-service environment, expand the scope of care you provide, within the envelope of your personal competency, and refer a little less out to subspecialists.

Yes, your work must be clinically correct. And it must also be commercially practical. But there limits to perfection in both cases. Your medical and surgical judgment will never hit 100%, not even on a single day. The next era of reimbursement constraints will likely drop both the clinical and profit altitude of your practice. In France, they have a saying that uses the analogy of a hunted bird, that while surviving, nonetheless takes a few lead pellets in its wings, and thus flies a little lower to the ground. That's where we're headed, I'm afraid.

Try being a little more European in your outlook. If in the future you can't have the thrill and cash flow of what medical entrepreneurship used to provide, you can at least reintroduce a little alternative control and *joi de vivre*:

- *Surround yourself with staff who please you.* Don't hire anonymous cogs in your machine (old thinking). Rather, surround yourself with fascinating, extraordinary individuals you truly love working with (and who love working with you and your patients, so their wage demands will be tempered). Ask yourself, "How many of the staff I employ today would I love to take out for a long lunch to talk about the world?"
- *Decorate your office in a manner that pleases you.* I don't care if that means several pieces of fine art or Uncle Louie's stuffed moose. You're in the vision enhancement business, so start by first enhancing what *you* get to stare at eight hours a day.
- *The same goes for sound.* Pick out 100 CDs of your favorite music and play them in the background all day long. You're the boss, so why not? And when your favorite piece comes on, instruct your staff to crank up the volume. Your office, your rules.
- *Tell your office manager he or she is now really a "happiness manager."* Charge your manager with making you smile, not just fiscally, but in many other ways . . . and with fewer hassles and great, independent decision making. Be sure to return the favor.

- *Tell your management consultants, accountants, and attorneys to change from focusing solely on maximizing profit each year.* Ask them also to focus on helping you be as productive and as happy as possible, given the times ahead.
- *Dismiss patients you really don't like.* Are you still in free enterprise, or are you a slave? Even the most modest retail establishments still post a sign that reads, "We reserve the right to refuse service to anyone." Skip the sign, but cop the attitude. It will be good for your head, while everything else is slipping a bit further out of your control in the coming years.
- *Stop being so damned deliberate.* You are working in one of the most precise fields of medicine. Don't simultaneously put your life in the vise grip of orthodoxy. If you wake up and feel like wearing a wild tie and high tops, go for it. Revolt. As Thomas Jefferson said, "A little rebellion is a good thing."

While you're at it, drive small, fast cars at breakneck speed down crowded streets. Eat delicious, moldy cheese, even if once out of ten-thousand times it will send you to the hospital. Have wine with dinner and afterward, the cognac and the espresso, even if it keeps you up at night. And for God's sake enjoy an occasional cigar. Stop being safe, sane, conventional, and sanitary.

From time to time, be a little less Protestant in your work ethic, and goof off for the day. Putter. Don't be entirely practical. Your life—and by extension your practice—should be a work of art. How's the canvas progressing so far? Have you just been using paints called "surgical volume" and "net after tax income," or is there more to your palette?

If your practice and where it's going are not making you happy, find additional passions to replace those you used to get from earnings and case volumes and competing with Joe down the street. If you're alone, join others. At least 20% of the clinical facilities, equipment, and support staff in this country are wasted. Sit down with a few local colleagues to see how you could use the excess a little more efficiently . . . sharing a visiting subspecialist, perhaps.

A few days ago, here in this great city, I had dinner with another old pal, Michel Arowns, and his friend Anne. She's a clinical psychiatrist and probably one of the more successful physicians in Paris, yet she drives around a 12-year-old beater so she can spill resources with abandon into the things that seem to be more important in her life—a beautiful art-filled office, a "little place in Corsica," and some of the best wine I have ever tasted.

Hers is the path followed by medical professionals throughout Europe. Soon, perhaps, it may be the path followed by her colleagues in the United States. Here, we spend more than 15 cents out of every dollar on health care. In Europe that figure is 5 to 10 cents, depending on the country. There's simply not as much to go around. European physicians have been resource starved for decades, but their world hasn't come to a halt. They have compensated with smaller homes and office spaces that are still immaculately appointed. They have compensated with shorter work weeks and by taking the time to not only smell the roses, but to grow them as well.

Don't let the distress of your practice rob you of the pleasures that are all around you. Certainly not now, and not even later, as the inevitable reform pressures are reapplied to all of us in the years ahead.

Slack off a little. You'll live longer. But don't slack off entirely. Set aside enough extra income for your own foreign fact-finding visit this year. I promise you the things you'll learn in a few days on the streets of Paris will serve you better than any management course I could ever hope to give.

* * *

*Faites que le rêve devore votre vie a fin que
la vie ne devore pas votre rêve.*

[May your dream devour your life before life devours your dream.]

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