The Cycle of Ophthalmic Practice

Technological advances drive changes in practice patterns.

BY LEE T. NORDAN, MD

My observations of the patterns of ophthalmic practice in the US during the past 30 years have always revealed interesting dynamics. Most often, advances in technology fuel changes in practice patterns. Historically, eye surgeons learn conservative techniques during their training, because they are taught by professors who have the inclination and appropriate motivation to wait until new technology is proven effective. Then, the young ophthalmologists enter private practice and are confronted with the need to become comfortable with an increased level of surgical aggressiveness.

OVERVIEW

In the 1950s and 1960s, the mecca of ophthalmology was the university in the shadow of the "Old Germans" who brought the best in diagnostics and intellect to Boston, New York, and San Francisco. In the 1970s, Charles Kelman, MD, introduced phacoemulsification, and other private practitioners contributed to the development of IOLs. Over the next 20 years, the emphasis of general ophthalmic practice shifted dramatically from diagnostics to surgery. The private practitioner was offering a cataract procedure that was far superior to the surgery performed at the university. The academic institutions were playing catch-up, and professors began teaching phacoemulsification and IOL implantation to residents.

The field of refractive surgery blossomed with the advent and increasing popularity of RK and astigmatic keratotomy in the mid- to late 1980s. The offerings from private practitioners generally outstripped those at universities. More importantly, a significant minority of the private sector accepted that an eye with a refractive error was abnormal and that ametropia could be treated surgically. Again, academic training practices caught up by exposing residents to refractive surgery, especially PRK, LASIK, and astigmatic keratotomy.

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Some large-volume private practitioners dabbled in combining practices within a large corporation, becoming more efficient, and selling their shares of stock for oodles of money. They generally met with disaster. Similarly, some companies prospered by using an optometric practice model as a means of finding refractive surgery patients. Their success lasted until it was difficult to divide a $500 LASIK profit.

TODAY

Universities are great resources for treating difficult cases. Private practitioners are being forced into providing elective procedures. The reimbursement for cataract/IOL surgery remains approximately $500 (plus between $200 and $300 for visits, studies, and Nd:YAG capsulotomies). It is therefore likely that general ophthalmologists will soon need to offer cosmetic surgery and/or refractive surgery to patients. The question is, can most of the cataract/IOL surgeons and staff learn to handle the temperaments and demands of refractive surgery patients? I don't know. My bet is about 25% will. That will leave the correction of presbyopia in the hands of the current refractive surgeons and the adaptable cataract/IOL surgeons.

The private practitioners of the future, however, may not even have the opportunity to perform refractive surgery to the degree that they were able to in the past. The LASIK market has changed. The procedure has become a commodity, and the large corporate providers are now in a battle for market share. With the increased amount of technology required for cus-

tomized LASIK with the flap created by a femtosecond laser and the large marketing muscle of corporate providers, the profit margins for competitive LASIK have been compressed. In the same way that the family hardware store is in serious trouble when Home Depot (Atlanta, GA) and Lowe's (Mooresville, NJ) move into town, the private practitioner is facing a serious challenge from the corporate LASIK providers that have pressure from Wall Street to show growth. The LASIK market has become intensely competitive, and only the strong will survive.

After a late start, the university training programs have done a laudable job of admitting, understanding, and participating in the reality of refractive surgery. I predict that these institutions will soon confront the challenges of phakic multifocal IOLs. The teaching programs will have an opportunity to become more aggressive with respect to the treatment of presbyopia than most general ophthalmologists. I estimate that this cycle will take approximately 5 years once the new technology is introduced.

CONCLUSION

The cycle of ophthalmology continues. Each ophthalmologist will have to decide for himself how to handle new technologies for presbyopic correction, which I believe will have an impact equal to the introduction of phacoemulsification and LASIK. In the near future, however, the timing and degree of academic institutions' and general ophthalmologists' involvement in these momentous changes may differ significantly from the past. ■

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