FOCUS ON CARE

The AECOS Summer Symposium (American-European College of Ophthalmic Surgeons) in Deer Valley, Utah, included excellent sessions on new technologies, challenging cases, the changing landscape of ophthalmology, and practice challenges. As I listened, I could not help but wonder how we cataract and refractive surgeons balance all the responsibilities but put patient care at the top of the priority list. We all know this is our primary responsibility, but it does get tough as we are asked to wear different shoes. A few topics of discussion give insight into the increasing demands on us.

The first is growing a practice. Should we add a partner or a new specialty, build a surgery center, and/or open a satellite office? How about buy a laser? Hire more staff? Learn a new procedure? Answering these questions is not easy. The only advice I can give is to learn from trusted mentors, prioritize the care of patients, and—when in doubt—trust your instincts.

The second challenge relates to cataract surgery itself. Every year, conversations with patients become more involved, and their expectations rise. Keeping up with changes in refractive services and package pricing, educational tools, and marketing strategies is a full-time job. Add this to the growing list of tools for surgical planning we must learn to use. Corneal topographers, tomographers, biometry devices, preoperative registration and surgical planning software, posterior segment optical coherence tomography, formula after formula—where does it end? Sometimes, it takes me more than 20 minutes to digest all the data and develop a surgical plan for each and every case. Many ophthalmologists, including myself, have found it mandatory to delegate this complex process to trusted teammates. Then, we enter the OR, and the paradigm has shifted here as well. With femtosecond lasers, intraoperative aberrometers, and digital guidance devices, we have to make refractive decisions on the fly.

Meanwhile, our focus on patients is distracted by governmental changes in health care delivery. Electronic health records, mandates for meaningful use, the Physician Quality Reporting System, and the International Classification of Diseases 10 are probably just the start. Small practices are folding into larger ones. Residents completing their training are looking for 9-to-5 jobs with no administrative or ownership responsibilities. Ophthalmology practices are attempting to expand to cover large geographic areas, and private equity funds are starting to look at ophthalmic practices as a revenue stream and investment strategy.

As a whole, these changes can be overwhelming. For better or for worse, we have a responsibility to serve patients' best interest. If that ceases to be our focus, whose will it be? ■

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