

# Practice Under Pressure

Staffing, margins, AI, and capacity—how surgeons are adapting now.

BY CATHLEEN M. MCCABE, MD; MARGUERITE B. McDONALD, MD, FACS; MICHAEL PATTERSON, DO; GEORGE O. WARING IV, MD, FACS; ROBERT J. WEINSTOCK, MD; VANCE THOMPSON, MD; AND WILLIAM B. TRATTLER, MD



## CRST: What is the field's biggest unmet need and why?

**Cathleen M. McCabe, MD:** The greatest unmet need is the practical integration of AI across both clinical care and the business of medicine. The practices that learn how to use these tools to improve efficiency and outcomes will move ahead; those that do not risk being left behind. Potential applications span diagnostics and workflows; premium-lens targeting and patient education; scheduling; outcomes analysis (including surgical video review for efficiency and consistency); and business operations such as throughput analytics, bottleneck identification, and payer contracting. The opportunity is significant, but the pace of change is rapid. We need solutions that integrate cleanly into clinic flow as well as training and governance so that teams can adopt them confidently and responsibly.

**Marguerite B. McDonald, MD, FACS:** The field's biggest unmet need is a truly accommodating IOL that would allow a patient to see as they did at 30 years of age. Such a lens would eliminate trade-offs that require patients to accept glare, halos, or other visual phenomena in exchange for near vision. There are at least two laudable efforts worth noting: the OmniVu Lens System (Atia Vision) and the A-IOL (Adaptilens).

**Michael Patterson, DO:** I would say better practice models that preserve access and independence. We need high-throughput, team-based clinics that can meet demand without ceding care to other provider types, and we need succession pathways that keep physician-led practices viable. If senior surgeons sell exclusively at valuations younger surgeons

cannot match, entry points shrink and consolidation accelerates. More intentional transitions to early-career surgeons at sustainable terms would help maintain patient access, local competition, and the profession's long-term health.

**George O. Waring IV, MD, FACS:** Early and midstage presbyopia surgery is the field's biggest unmet need. Despite rapid growth in lens-based refractive care, the United States lacks presbyopia solutions explicitly labeled for lens replacement before visually significant cataract. Most tools and devices—from phaco platforms and femtosecond laser workflows to presbyopia-correcting IOLs—are optimized and labeled for cataract surgery (late-stage dysfunctional lens syndrome), not for earlier intervention (roughly ages 45–65 years).

Bridging this gap requires purpose-built instrumentation, study designs, and regulatory pathways for surgical presbyopia correction in the absence of cataract. Clear labeling would enable industry support, rigorous outcomes research, patient education, and responsible adoption. Conceptually, fixing the source—the aging crystalline lens—earlier is consistent with how medicine approaches many conditions. With appropriate evidence, training, and guardrails, earlier lens-based options could meet a large, growing clinical need while improving the patient experience and practice sustainability.

**Robert J. Weinstock, MD:** One of the greatest unmet needs in

ophthalmology today is a reliable surgical or pharmaceutical correction for presbyopia. Although LASIK, cataract surgery, and premium IOLs have dramatically advanced our ability to help patients live free of glasses, there remains a major gap: restoring youthful, physiologic, accommodative vision.

Multifocal optics have improved tremendously during the past decade to offer many patients impressive visual quality and significant independence from spectacles. The technology is not without limitations, however, and careful patient selection is essential to minimize issues such as glare, halos, and reduced contrast sensitivity.

The closest we have come to a true accommodating IOL was the

Crystalens, which showed promise but ultimately fell out of favor owing to inconsistent refractive outcomes and its inability to provide a full range of functional vision. Several companies are developing next-generation accommodating implants, including dual-optic designs; some programs have been in progress for more than a decade.

I remain hopeful that, in the near future, we will be able to offer patients a lens that re-creates the seamless, dynamic vision of an 18-year-old. Achieving this milestone would represent a transformative leap forward in our field and profoundly improve the quality of life of millions of patients worldwide.

## CRST: What is the biggest challenge in your practice right now, and how are you managing it?

**Dr. McDonald:** The biggest challenge facing our practice is keeping costs down while maintaining quality of care. This is the eternal problem: we are hit with reimbursement cutbacks while we must acquire the newest and best technology for our patients' benefit. Extremely careful time management of our staff is critical (avoid overtime if at all possible), as is placing new technologies strategically within our offices, where they will be used most frequently and by the greatest number of doctors.

**Dr. McCabe:** Staffing is my practice's greatest challenge. Salaries have increased across our market, and after the COVID-19 pandemic, there has been movement of nurses and experienced technicians between practices as everyone competes on pay and benefits. Staffing now represents a larger share of our operating expenses than ever, with no end in sight. We are doubling down

on intangibles that keep employees feeling valued—competitive benefits, a 401(k) match, solid health insurance, and team-building—while balancing the realities of the profit-and-loss statement.

Practice growth has also added expense (we recently acquired another practice), so we have made selective cuts elsewhere, even canceling our physician retreat this year. Operationally, we are piloting AI scribing to maintain clinic efficiency with fewer scribes per physician, which may allow us to support the rest of the team without continual headcount growth.

**Dr. Patterson:** Staffing costs amid declining reimbursement present the greatest challenge. We are an employee-heavy practice (multiple scribes and technicians per physician), and wages and health insurance premiums have risen sharply while CMS reimbursement has not

kept pace. The result is significant margin pressure.

To retain talent without eroding morale, we adjusted wages instead of cutting benefits and increased clinic access and surgical volume. We also diversified revenue—what I call *mutual fund ophthalmology*—across cataract/refractive, glaucoma, cornea, oculoplastics, and retina services so a cut in one area can be offset by others. Local labor markets can intensify the problem when large employers enter and raise prevailing wages; practices must respond to remain competitive.

**Vance Thompson, MD:** Our biggest challenge is managing the pace of our growth. We have been fortunate to attract world-class surgeons and team members, so providing outstanding patient care is not the issue. The real challenge lies in keeping our physical facilities aligned with the needs of our expanding team and patient population.

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**—ROBERT J. WEINSTOCK, MD**

At the moment, for example, we are busing staff from a nearby church parking lot to free up patient parking. Although our team has embraced this solution with grace, it does create inconveniences, especially when someone is ready to go home and must wait for transportation. In addition, we face increasing demands for diagnostic space to maintain efficient patient flow.

To address this, we are being deliberate and thoughtful—investing significant time in planning and meetings to make sure our infrastructure keeps up with demand. Building a new center is always a major decision, especially given the costs of health care construction, but it is a conversation we know we must have.

Throughout these challenges, what has not been difficult is growing our people. We have worked hard to build a culture where our team feels loved and cared for, which in turn creates an environment where patients feel the same. We have also prioritized strong financial support, ensuring that, when the practice thrives, our team thrives even more. Having

practiced for 35 years, I have already outgrown three buildings—each about every decade—and although I once thought our current facility would be my last, the remarkable growth we have experienced has made clear that we will continue expanding. Our goal is to do so in a way that celebrates both our team and our patients.

**William B. Trattler, MD:** Our biggest challenge is inventory management. In our previous system, multiple staff members ordered supplies, which led to overordering and, at times, expired items (eg, medications, punctal plugs). With declining reimbursement, an on-demand ordering process—placing orders only when needed—is critical to controlling overhead and supporting cash flow.

We designated a single point person, involved in practice management, to receive supply requests and order only what is needed. That person also evaluates whether certain items are unnecessary. This change has significantly reduced overhead.

**Dr. Waring:** Our current challenge is a downturn in laser vision correction volume. Cyclical factors—particularly consumer confidence and broader economic sentiment—track closely with demand, so we view this as part of a longer-term ebb and flow rather than a structural decline. The first rule is not to overreact.

Tactically, we lean in rather than out. During slow periods, we invest in staff training, refine standard operating procedures, and adopt new technology so we are fluent before the next upswing. We also maintain and, when necessary, adjust pricing to reflect the true cost of delivering care rather than cut quality. Marketing continues during lulls to ensure consistent awareness. The portfolio mix matters: growth in lens-based refractive procedures has offset the corneal laser vision correction dip, and overall, our surgical volumes remain at all-time highs. In short, we use downtimes to sharpen processes and position the practice for the next wave of demand.

**Dr. Weinstock:** The biggest challenge I face in my practice today is delivering a truly premium patient experience and consistently excellent visual outcomes in the midst of an increasingly difficult health care environment. Although my goal is always to provide patients with the very best—from cutting-edge technology to personalized care—the financial and regulatory pressures of running a private practice are becoming more and more daunting.

Reimbursement continues to decline year after year, while overhead costs climb relentlessly. Staffing, equipment, compliance requirements, and the ever-growing administrative red tape add tremendous strain. Even with the ability to offer patients advanced options such as astigmatism correction and presbyopia-correcting lenses during cataract surgery, the additional revenue streams are often offset by rising costs.

The broader economic climate only compounds the problem. Inflation, interest rates, tariffs, and political uncertainty influence patients' willingness to invest in services not covered by insurance. Even when they recognize the value of advanced technology and premium outcomes, economic forces can make them reluctant to move forward.

At the same time, I feel the responsibility to maintain the highest standards by offering the latest equipment, keeping staffing levels appropriate to provide warm, attentive care, and ensuring that every patient receives a personalized experience. The tension between wanting to elevate every patient's journey and the practical realities of a strained system is the greatest challenge I face today. ■

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#### **CATHLEEN M. MCCABE, MD**

- Cataract and refractive surgery specialist and Medical Director, The Eye Associates, Bradenton and Sarasota, Florida

- Chief Medical Editor, *CRST*
- cmccabe13@hotmail.com
- Financial disclosure: Alcon, Bausch + Lomb, Carl Zeiss Meditec

#### **MARGUERITE B. MCDONALD, MD, FACS**

- Clinical Professor of Ophthalmology, NYU Langone Medical Center, New York
- Clinical Professor of Ophthalmology, Tulane University Health Sciences Center, New Orleans
- Ophthalmic Consultants of Long Island, Oceanside, New York
- Member, *CRST* Editorial Advisory Board
- Financial disclosure: None acknowledged

#### **MICHAEL PATTERSON, DO**

- Private practice, Eye Centers of Tennessee
- Member, *CRST* Editorial Advisory Board
- michaelp@ecotn.com
- Financial disclosure: None

#### **VANCE THOMPSON, MD**

- Founder, Vance Thompson Vision, Colorado, Minnesota, Montana, Nebraska, North Dakota, and South Dakota
- Member, *CRST* Executive Advisory Board

- vance.thompson@vancethompsonvision.com
- Financial disclosure: None acknowledged

#### **WILLIAM B. TRATTLER, MD**

- Director of Cornea, Center of Excellence in Eye Care, Miami
- Vice Chair of Research, Department of Ophthalmology, Herbert Wertheim College of Medicine, Florida International University, Miami
- Member, *CRST* Executive Advisory Board
- wtrattler@gmail.com
- Financial disclosure: None acknowledged

#### **GEORGE O. WARING IV, MD, FACS**

- Founder and Medical Director, Waring Vision Institute, Mount Pleasant, South Carolina
- Member, *CRST* Executive Advisory Board
- waring@waringvision.com
- Financial disclosure: None acknowledged

#### **ROBERT J. WEINSTOCK, MD**

- Private practice, The Eye Institute of West Florida, Largo, Florida
- Chief Medical Editor, *CRST*
- rjweinstock@yahoo.com
- Financial disclosure: None acknowledged