Tips for the New Retina Attending

BY DARRELL E. BASKIN, MD; CHIRAG P. SHAH, MD, MPH; AND JEREMY D. WOLFE, MD

It has been a long road, one marked by transitions from completed education to anticipated training. This summer, the next class of vitreoretinal surgeons will make another transition into their first job. Of course, training continues for most of these new attendings but without the security inherent in residencies and fellowships. The real, unsheltered world requires a command of practical skills, such as marketing, coding, and management—skills refined during the early years of practice. We thank Torsten Wiegand, MD, PhD, and John Denny, MD, two successful attendings who recently completed their training, for sharing their insights into the early years of practice.

—Darrell E. Baskin, MD; Chirag P. Shah, MD, MPH; and Jeremy D. Wolfe, MD

Q: What were some of the challenges of being a new attending and how did you overcome them?

Torsten Wiegand, MD, PhD: As you are entering this new phase in your career you should be looking forward with anticipation rather than trepidation. Fortunately for vitreoretinal surgeons, the transition from fellowship to attending is relatively seamless. You have developed the skills, knowledge, and stamina required for your new job, but it will take some time to grow comfortable with your new position. Initially, every patient will be new to you, and as you quickly develop a mental picture of their ophthalmic history, problems, and possible required treatments, do not forget that your patient is also a person. Try to spend the extra 5 minutes to get to know each patient on a personal level. If possible, limit your schedule initially to no more than four patients per hour, and tighten appointment slots as you become more comfortable in your new position. Patients appreciate this care and attention to detail, and they will speak of this to their friends. Word of mouth is a powerful practice builder.

For the first time in your medical career, the ultimate responsibility for the patients' well being will rest on you. Although it is gratifying to help patients, encountering complications or progressive deterioration of vision despite your best efforts can be a crushing experience. Empathy is important for a young vitreoretinal surgeon, but remember that everyone will encounter patients with recurrent retinal detachments requiring multiple surgeries or diabetic patients with progressing diabetic retinopathy despite aggressive treatment. Try to achieve consistency in your approach, always do what you think is best for the patient, and don't let the occasional bad outcome destroy you. Do not shy away from offering patients a second opinion in difficult cases or those with poor outcomes. Express that although you are comfortable caring for the complexity of their situation, you would be happy to help arrange this. Pick a few senior practitioners in your area whom you trust and respect to use as second opinions as necessary. It is always better to guide this practice than to have patients select perhaps less than respectable or skilled second opinions.

John Denny, MD: As a fellow, I was used to taking my cues from my attendings. It can be stressful to transition into taking sole responsibility for the care of your patients. You will have to develop your own style of care. It is helpful to consider how you have managed common conditions with different attendings. Decide which method seems to work best for you, and use that as a starting point. Do not be afraid to ask the advice of senior physicians in your practice as well as the attendings from your fellowship.

Q: Are there any practical skills, such as coding or managing office flow, that you recommend fellows develop during fellowship?

Dr. Wiegand: Proper coding and billing are crucial for junior attendings. You should be reimbursed properly for your work; however, you should protect yourself from the risk of over-coding or under-documentation during a potential audit. Coding training during fellowship is often limited, and fellows usually do not review billing sheets completed by the attending after the patient's visit. During fellowship, try to get in the practice of coding the patients you examine, or at least writing down how you would have coded them, and comparing this to your mentors. Ask questions regarding differences. It is helpful to attend coding classes offered during local ophthalmology meetings or at national meetings such as the American Academy of Ophthalmology (AAO). Because a limited number of billing scenarios account for the bulk of patient encounters collected, at the end of your fellowship, collect a list of the top 20 most common encounters with proper billing. These should include scenarios such as a patient with age-related macular degeneration (AMD) receiving an intravitreal injection, a diabetic patient undergoing a focal laser treatment for clinically significant macula edema, or a consultation for a retinal detachment.

For management of office flow and the numerous clerical tasks surfacing during a busy practice day, it may be best to rely on well-trained ancillary staff. It is important to ensure that your staff is well familiar with your approach, attitude, and clinical recommendations, as they will represent you in the eyes of your patients.

If you find yourself in a practice where you perform your own injections for fluorescein angiography, make sure that your phlebotomy skills are up to speed; nothing would destroy the trust of a new patient in you faster than turning them into a pincushion during a diagnostic test. It is best to refresh these skills in fellowship if possible.

Dr. Denny: It is imperative to learn the basics of coding during your fellowship. You should know what constitutes adequate documentation for each level of service and have a working knowledge of modifiers. Most large institutions have teaching resources to help you learn coding, and I would highly recommend that you take advantage of them. Practice coding in clinic and ask your attending to check for accuracy.

Q: What are some tips to allow one's practice to grow?

Dr. Wiegand: The old standard for practice growth of availability, affability, and ability still holds true. With the completion of your vitreoretinal fellowship, ability will be a given. Make yourself available for any patient at any time. Friday afternoons will magically turn into a prime period for urgent referrals. Accept them with enthusiasm rather than resentment and your practice will grow quickly. Of the three A's, affability can be the hardest to maintain. Even in stressful and difficult times, try to derive joy from your work. Patients and referring providers will notice if you truly enjoy what you are doing, and word will spread. This may not be the fastest way to grow a practice, but it will be the most sustainable.

Dr. Denny: In my opinion, it is important to always be available. This will be a distinct contrast from a busy training environment where self-preservation requires you to keep a reasonable workload. Make it easy for the patients; make it easy for the referring doctors. Additionally, humility goes a long way when dealing with colleagues and patients. Remember that there are many different ways to approach a situation and be open to learning new things.

Q: What are good ways to become known in a new community?

Dr. Wiegand: If you have moved to a new geographic location from your fellowship to your attending position, it is important to become established in the community. You should make efforts to reach out, both to patients and referring providers. Large retirement communities would be delighted to have you as a speaker, for example, talking about the basics of AMD in a patient-appropriate framework. Advertisement in local papers is useful to inform the community of the arrival of a new specialist. If you have joined a larger academic or private practice, suggest underwriting at your local National Public Radio station to increase exposure. If your practice has a Web page, it should include a summary of your training and accomplishments, diseases you treat, special interests, and a high-quality recent headshot. Attending meetings of the local chapters of ophthalmologic societies, particularly to give presentations, will be helpful to establish you in the community.

Dr. Denny: Hosting educational dinners is a reasonable way to start, but in my experience there is no substitute for personal contact. Travel to the referring doctors and introduce yourself.

Q: How do you recommend reaching out to potential referring doctors? Should they all have your cell phone number?

Dr. Wiegand: Optometrists, general ophthalmologists, internists, and endocrinologists who treat patients with diabetes will provide the bulk of your referrals from outside providers. Accessibility and ease of transfer of the patient from the referring doctor to your care is of the utmost importance. One way to accomplish this is to provide referring doctors with your cell phone or pager number. However, if you choose this route, be prepared for disruptions of your clinic flow. Most patients will understand if you briefly break to accept an urgent or emergent patient. Personally, I prefer to route most referrals through my administrative assistant who collects the information and alerts me of a potential need for a call back to the referring doctor. Remember to provide all referring physicians with a prompt and detailed consultation letter and send updates as necessary on subsequent patient visits. With the increase in use of electronic medical record systems it may be tempting to simply send a copy of the exam, but the nuances and personal touch will usually be lost.

Stress to the patient the continued need for routine follow-up visits to the referring optometrist or general ophthalmologist. Although it is generally accepted practice to refer the patient to another subspecialist, such as a neuro-ophthalmologist in the case of an ischemic optic neuropathy, the patient should see the referring physician in case interventions, such as cataract surgery or nd:YAG laser capsulotomy, are needed.

A personal introduction at the office of local optometrists or general ophthalmologists may be helpful to establish relationships. Often, however, it is more efficient to invite a group of referring providers to talks about common retinal pathology such as AMD or diabetic retinopathy.

Dr. Denny: We use preprinted sheets that have our contact information with maps to our offices that make the referral process as easy as possible. I do give my cell phone number out to referring doctors, as it is a convenient way to make myself available.

Q: Should new attendings take as much call as possible?

Dr. Wiegand: Taking call is one of the quickest ways to ensure the growth of a budding practice and to establish a relationship with new referral sources. If the call is retina-specific and fellows are providing first call with attending back-up, maximizing call is useful in building surgical and clinical volume. Try to avoid taking primary call, however, for general ophthalmology coverage at community hospitals. This type of call will be low-yield for practice building. Additionally, it can expose you to potential medicolegal liability if you are unable to attend to urgent or emergent cases in a timely manner during a busy clinic day. In general, you should try to balance work and call with family or extracurricular activities. It is important to pace yourself. Remember that you are at the beginning of your career as an attending, and you want to be able to sustain your work for the next 30 years.

Dr. Denny: It probably depends on the individual practice. If it will increase exposure to new patients and referring doctors, then yes. If it is mostly calls from existing patients and hospitals, it is probably less important. In some practices, tradition dictates that the new doctors take more call as a way of building "sweat equity." If you find that is the case in your new practice, it will still be better than being a fellow!

Q: Should new attendings go to national and regional meetings, or should they stay behind and work, building their practice while their partners are away?

Dr. Wiegand: Once you have joined a private practice, it is easy to become isolated from the retinal community. Although you can stay abreast of emerging technologies and developments by following the scientific literature, attending national retina-specific meetings will help to keep you in touch with your colleagues. Attempt to attend at least one large national meeting such as the American Society of Retina Specialists, or the AAO Retina Subspecialty day, where cutting edge work is presented and condensed into a few days. Attending regional or local meetings may be beneficial if it can be done with minimal clinic disruption to establish or continue contact with local ophthalmologists. If you have joined a group practice, don't begrudge the fact that the senior partners typically will have priority in attending meetings. Try to work around their schedules and look forward to the time when your seniority increases.

Dr. Denny: It's a balancing act. There is usually ample opportunity for everyone to attend one or two meetings a year. It is important to be available and keep the practice running. Being the only doctor in town is a great way to gain exposure to new referring doctors. Yet continuing education remains important, so plan ahead with the other physicians in your practice to ensure that everyone stays up to date.

Q: If one is not at a university-based practice, how do research and other academic endeavors fit into a new practice? Should new attendings focus their time on building patient volume or on their academic interests?

Dr. Wiegand: If you have developed academic interests during your medical training, there is no need to give them up for your transition to the attending position. Often the clinical schedule of a junior attending will be light, allowing you to continue academic endeavors in which you have been engaged. In fact, it is often easier to continue academic activities rather than to put them on hold while building a practice and then restart them at a later date. Although basic research will be beyond the scope of most attendings in a private practice setting, you can participate in company-sponsored clinical trials. You might feel tempted to participate in a large number of studies, but it is more prudent to limit yourself to a select few trials from which you feel your patients will benefit the most. It takes time and effort to enroll patients into clinical trials, and you will be more motivated to do so if the benefit to your patients is tangible. Outside of company-sponsored clinical trials, you can continue to publish interesting case reports or small case series, but remember that the approval of an internal review board is required for most publications. The benefits of academic activities are less tangible initially but over time will become more obvious. Cutting-edge research can be a powerful advertising tool, as you may be given the opportunity to present your work at prestigious meetings. Research needs not be mutually exclusive with building a busy practice.

Dr. Denny: In my opinion, it is not an either/or situation. It is fairly easy to incorporate clinical trials into a private practice. Involvement in these trials is a good way to set your practice apart from competitors, and patients appreciate exposure to cutting-edge developments. Basic science research would be more difficult to implement in a private practice. If that type of research is important to you, it should be a major criterion for a new position, as many private practices simply do not have adequate resources.

Q: At what point should new attendings feel busy in their clinics and ORs?

Dr. Wiegand: Following a busy fellowship, a new attending position with initially limited clinical volume may feel like a vacation. Enjoy this honeymoon period because it will not last long. As the population ages and the prevalence of diabetes increases, retina specialists are in high demand; this is a good time to enter the subspecialty. Growth, however, may be incremental. Consider making yourself available when many are not, such as on holidays and during large meetings. Find ways to allow referring physicians to get to know you and to appreciate and trust your care of their patients. Treat their patients well, and they will return to the referring physician singing your praises. Follow these steps and you may find yourself busy sooner than expected.

Your OR volume will build with the clinical volume. Although it is important to be available for emergent procedures such as retinal detachment repairs after hours and on weekends, don't be an aggressive surgeon initially for elective procedures such as epiretinal membrane peels. It will often be better to follow patients for a while and ensure that they are sufficiently symptomatic before consenting them for surgery. Spend time with all of your surgical patients prior to procedures to cover risks and potential complications. Aim to underpromise and overdeliver.

Dr. Denny: It will vary tremendously from one practice to another. It depends on the size of the practice and the number of new patients referred per month. Additionally, you should know whether you are taking over existing patients from a retiring physician or whether you are expected to build your panel from scratch. If the latter, expect to have some free time, probably unwanted, in your first few months. Don't be frustrated. It takes time to establish yourself in a new area.

Q: In the OR, if a new attending trains fellows or residents, when should he or she start passing surgical cases? Initially, should new attendings do all the surgery to establish themselves in their community and become comfortable operating outside of fellowship?

Dr. Wiegand: As a surgeon, your primary responsibility is to ensure the best outcome for your patient. As you received your surgical training from your mentors, you want to pass your knowledge to your fellows, but the combination of a junior attending and a junior fellow can quickly lead to a precarious situation in the operating room. Initially you should have a low threshold for taking over cases and transfer more of the surgical responsibilities to your fellows as their surgical skills and your supervising skills develop. Also, remember that your surgical volume will significantly drop from your senior fellowship year–during which most of you will have operated almost every day–to your first attending year. You should perform a sufficient number of cases as the primary surgeon to allow continued honing of your surgical skills. When scheduling complex surgical cases, do not hesitate to seek the advice of your senior partners or attendings from your current fellowship program to establish the best approach and appropriate instrumentation and to allow for anticipation of potential complications.

Dr. Denny: I think it depends on the individual situation. The comfort levels of the attending and fellow should be the deciding factors. In my opinion, patient safety is the primary concern, so you should be confident in your ability to maintain control of the case before handing over the reins.

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Efficiency in the ASC: A Team Effort

At Spectra Eye Institute, we strive toward the common goal of excellent patient care.

BY JAN AMATOR, MBA

I have owned and operated in an ambulatory surgery center (ASC) for the past 17 years. During that time, I have learned that the message, management, and mission (the "3 M's") of the ASC will determine its success or failure. I am proud to be a founding member of the Spectra Eye Institute, one of the busiest retina ASCs in the world. At Spectra, as in all other ASCs, the 3 M's are critical to our success. This comes from the top. Jan Amator is our CEO and her job is to be a keeper and advocate of the 3 M's. Jan's leadership of and commitment to Spectra are well documented in this two-part series. The success of Spectra has indeed been largely due to Jan's pledge to administer the 3 M's. I am convinced that her insights will be valuable to all ASCs coveting increased efficiency and profitability.

-Pravin U. Dugel, MD

Many visitors have come through the doors of Spectra Eye Institute, located in Sun City, AZ, seeking insight into the facility's processes and procedures. We welcome surgeons to observe surgery and learn new techniques and administrative and clinical staff members to learn about our operations.

Spectra Eye Institute is a freestanding ophthalmic-based outpatient surgery center comprising three operating rooms and one minor procedure room. All procedures are performed under monitored anesthesia care. On average, 7,200 patients per year are treated at Spectra. Of course, patients come first in every procedure and process at our surgery center, and our resources are allocated as such. Achieving the best possible patient care is what drives our human resource management and our recruiting efforts, and it has a profound effect on how we assign staff members. In my role as the administrator of Spectra Eye Institute, I have found that efficiency is critical to success. Further, an efficient staff is one that integrates, accepts, and understands the common goal of exceptional patient care.

A DRIVE TO SUCCEED

As any administrator will tell you, the vast majority of overhead for an ambulatory surgery center (ASC) is spent on staffing and supplies. To remain profitable in these difficult economic times, all staff, from the administrator to the scheduling secretary, must take an active role in the process of managing these resources. At Spectra Eye Institute, we call it the "taking ownership interest in the business" approach. This does not mean that the administrative staff must be knowledgeable about the profit-and-loss and balance sheets. Nor does it mean that the clinical staff has a say in salary and benefits information. What is does mean is that all members of the staff take a personal interest in the business and are encouraged and empowered to take steps for the greater good of the facility and its patients. One example is the scheduling secretary who is empowered to manipulate the surgical schedule to make better use of the day. Another is the clinical staff member who reviews the staffing needs for a

Figure 1. Spectra Eye Institute in Sun City, AZ.

Figure 2. The staff at Spectra.

Figure 3. The surgical suite.

particular surgical day and helps facilitate scheduling of all staff members. Although many ASCs require a superior to tackle these types of tasks, we do not. Our operations are based on the theory that if everyone is to benefit from the efficiency and productivity of the team, staff members should be actively involved in the process.

MATCH THE STAFF MEMBER WITH THE TASK

A key aspect to profitability and sustainability of an ASC is the efficient and effective use of the staff. This is not to be confused with speed. Efficiency and effectiveness have more to do with the way in which processes and procedures are carried out to give superior patient care. Many strategies can be utilized, starting when a physician's office schedules a case and culminating when the patient receives a postoperative phone call. To follow are some processes that have worked to increase efficiency.

Prior to the day of surgery. All patients receive a preoperative phone call a few days prior to surgery to review and verify information such as demographics, health history, and financial responsibility. This allows the patient to address any questions or concerns in a confidential manner. Issues such as advance directives and financial interest disclosures can be addressed at this time. Concerns regarding payment of coinsurance or deductibles can be discussed and settled in a confidential manner. Questions relating to anesthesia can be addressed by nursing staff or anesthesiologists.

Day of surgery. Upon registration, the administrative assistant greets the patient and requests copies of the insurance cards. All necessary paperwork, including the informed consent, is signed, and the patient is ready for the clinical staff. This whole process takes about 5 minutes from greeting to completion. Many patients remark at how efficient the check-in process is; all tasks are performed in such a way as to alleviate the unnecessary stress on the patient, maintain confidentiality, and prevent bottlenecks in the admissions process.

Once admitted into the surgical suite, a nurse and a patient care technician (PCT) are assigned to the patient and assist him or her to a surgical stretcher where the patient will remain for the duration of the stay. Although appropriate nursing staff is available, the PCT plays a vital role at Spectra Eye Institute. In house, they are often referred to as "patient movers," and their role is critical to the success of the efficiency model. PCTs are able to handle all aspects of patient care that do not require nursing intervention. This, in turn, allows the nursing staff to better focus on nursing-related needs of the patients. The PCT acts as the patient advocate, spending time assisting in preoperative care, anesthesia administration, and postoperative care.

An important part of efficiency in an ASC is good utilization of OR time. Room turnover must be efficient and it is in this role that the PCT is a critical player. The PCT enters the OR at case completion and assists with everything from disconnecting the patient from the monitor removing the trash from the case to assisting in the transport of the patient to the recovery area. Another PCT prepares the next patient for surgery, transports him into the OR and hooks him up to the monitor. Turnover times for our ASC run 3 minutes for a cataract case and 7 minutes for a retina case. Once in recovery, the PCT hooks the patient to the monitor, offers them a snack, retrieves family members waiting in the lobby, and reviews the postoperative instructions with the patient, all while a nurse is assessing the patient for recovery. After assessment by a member of the nursing staff and the anesthesiologist, the patient is cleared for discharge. The PCT then escorts the patient, and family members to their vehicle.

Evening after surgery. The evening after the surgery day is when the nursing staff attempts to contact patients to check on their progress and condition. A nurse discusses with patients any concerns, comments, or questions they might have prior to their appointment with their surgeon the following day. It is at this time that the nurse will complete the patient record and, if necessary, instruct the patient to contact the surgeon for further evaluation should an untoward situation arise.

EFFICIENCY VS STAFFING COSTS

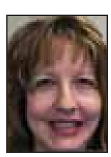
It is no secret that salary costs, particularly for nurses, can have a profound effect on an ASC's budget. Although care must be exercised to manage and control these costs, it must be done in such a way as not to jeopardize excellence in patient care. One of the ways that Spectra Eye Institute has managed these costs is to assign the right staff members to the right tasks as discussed previously. Additional processes are noted below.

Flex time. The challenge is to better utilize staff during peak hours and decrease staff during nonpeak hours. Many staff members at Spectra, full time and part time, maintain varied hours according to the surgical schedule. For example, a staff member might work a 10-hour-shift on a busy surgery day, and a 6-hour-shift on a lighter day. "Flexing" allows better staff alignment by maintaining adequate head counts, all while reducing nonproductive hours and overtime.

Low census. Low census allows employees to take time off without pay at their discretion in the case of a decrease in staffing requirements. The nursing staff appreciates the increased flexibility.

EFFICIENCY REQUIRES TEAMWORK

To remain profitable, one must always be on the lookout for effective ways to increase revenue and decrease costs. Spectra Eye Institute has become a success story not because of the volume of patients but because of the entire staff's firm commitment to delivering outstanding patient care in an environment of stellar teamwork via an efficient and effective process. ■



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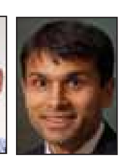
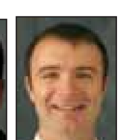
Q: How do you recommend handling ethical dilemmas in the workplace, such as issues with staff or colleagues, as the young attending at the bottom of the totem pole?

Dr. Wiegand: Most ethical dilemmas can, at least in theory, be solved by asking yourself "What is in the best interest of my patient?" The implementation of such a solution in a diplomatic fashion, however, can be difficult for a junior attending. Initially you will find yourself in a vulnerable position, depending on the help and collaboration of staff and colleagues. If problems are encountered, it is usually best to elicit help from a senior partner or senior practice manager whose judgment you can trust. Pick your battles carefully, but if you encounter a serious situation, you should stand your ground.

Dr. Denny: This issue gets to the heart of job selection. The most harmonious arrangement is for the younger physicians to follow the lead of the more experienced physicians. For this reason, it is paramount that you trust and respect the doctors you join. If your moral compass points in a different direction from that of your group, serious conflict is inevitable.

Drs. Baskin, Wolfe, and Shah: We leave you with the advice of Dr. Wiegand, "You are about to enter one of the most exciting and rewarding transitions in your life. Work hard, be careful, be compassionate, but, most of all, enjoy yourself!" ■





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