

Secrets of a High-volume Retina Surgeon

Relationships and positive interactions with entities ancillary to your facility are key components of success.

BY DIDIER DUCOURNAU, MD



Didier Ducournau, MD, is an internationally recognized vitreoretinal surgeon who has been an early adopter of surgical efficiency in an ambulatory surgery center. In this article, he gives us valuable information regarding the construction of a reputable referral surgical retina practice. He describes how to care for the two most important elements: patients (first) and referring physicians (second). This column and his advice are germane to retina surgeons in all stages of their career.

— Pravin U. Dugel, MD

Every specialist in medicine is well aware that to have a robust practice, one must establish sources of referrals. Over many years I have worked to build a network of referral sources, and I believe I have been successful—I perform an estimated 1700 retina surgeries per year on patients who are referred to me from approximately 500 different ophthalmologists. In this article, I share some of the things that I have learned along the way in my efforts to accomplish this.

HONOR THY REFERRER

Fostering good relationships with other ophthalmologists is perhaps the most important point to accomplish in one's effort to build a referral network. To follow are some tips that I believe go along way to building a relationship.

- Accept phone calls as soon as you can and offer advice freely. This shows that you are interested in and willing to help other ophthalmologists. I suspect that following this advice will also help you to build strong personal relationships with your colleagues in ophthalmology.
- Accept emergency cases. It is not unusual for ophthalmologists to have difficulty finding facilities that will take emergency cases such as retinal detachments or macular holes. Answering these demands not only helps the referring doctor, but also helps you in that you will become known as flexible and more available. Efficiency helps with this point because, if you can work more quickly and efficiently, you will be able to make room in your schedule to take emergency cases. For example, if 2 retinal detachment surgeries and 2 macular hole surgeries take 6 hours to complete, it will be difficult to fit in unexpected cases. If, however, you can perform 4 procedures in 1 hour, this will not be an issue. This is the situation in my practice, and I usually plan 12 to 14 cases (eg, 10 epiretinal membranes, 2 cystoid

macular edema cases, and 2 pars plana vitrectomies [PPV]) in the morning so that, up to the day prior to my surgery day, I can add 8 emergencies (eg, 2 macular holes, 2 PPVs, and 4 retinal detachments).

- Protect a referring physician's reputation, and never speak ill of his or her capabilities. The referring ophthalmologist should always be considered the best doctor in the city when you are speaking to a patient. You, however, are merely a technician who is called upon to solve a given problem.
- Do not try to address any issues that can be managed by the referral source until a service is specifically requested. Even in this situation, the patient should be sent back to his or her physician for follow-up.
- Never compromise on quality. All of the above becomes obsolete if your results are not good.
- Do not compromise principles for convenience. I never operate without prior examination, even if this causes a delay in the OR. Additionally, I never allow the anesthesiologist to switch from general to local anesthesia for the last patient on the day's surgery schedule for speed's sake.
- Always choose the best technology, regardless of how it might affect your relationship with industry.

RELATIONSHIP WITH THE SURGERY CENTER

Although the rules are always changing with regard to economics, the constant goal for surgery centers is to increase profitability. As surgeons, this goal translates into increasing efficiency while maintaining safety and excellent surgical outcomes. To follow are some points on how we achieve high efficiency at the Clinique Sourdille (17 000 open globe surgeries annually in 4 ORs; an average of 20 surgeries per room per day).

- If the case warrants, consider local anesthesia. For surgeons who regularly use general anesthesia, a switch to local

might be considered—but only if success rates will not be decreased as a result. Our techniques and technology have improved to the point where we cannot jeopardize the result due to a non-perfect local anesthesia. For cases in which general anesthesia must be used, it helps to operate in 2 rooms, because it is unreasonable that patients be put to sleep and woken up in the OR, thus requiring more than 30 minutes in room turnover time. This solution may be unappealing to the surgery center, however, as more staff is needed in this situation.

- Organize the operating suite as an effective production unit. To avoid any circuit congestion, our operating suite offers 2 very large pre- and postoperative rooms. The first contains 8 anesthesia-equipped stations (2 patients in preparation for each OR); the second has 12 (3 patients per OR). With these 2 large rooms and 24 running operating tables (where the patient is placed upon arrival), we can then ask the anesthesiologists to carry out their pre- and postoperative duties outside of the OR. A video monitor connected to the 4 microscope cameras informs them when they must begin the local or general anesthesia. They perform it without rushing, controlling the patient's data on their monitors. When the room is cleaned, the patient is taken to the OR. (When general anesthesia is performed, the time during which the patient is disconnected is between 10 and 15 seconds.) The running table is placed and blocked according to marks made on the floor, which avoids the need to move the surgeon's foot pedals. When the operation is finished, the patient is taken to the postoperative room where he or she can wake up slowly under control, with an analgesic treatment if needed. The "lost time" between 2 operations is approximately 6 minutes.

- Decrease the duration of your surgery. Surgery is not a race, however, and there is no reason to operate faster if it causes poorer results. Minimally invasive surgery, for one, has allowed us to perform high-quality surgery with improved efficiency and reduced trauma to the eye, inducing less surgical trauma. Additionally, the use of a surgical slit lamp avoids the need to perform a third sclerotomy, increases the precision (and then the speed) of the manipulations (as the free left hand can stabilize the forceps), and cancels the risk of phototoxicity.

- Another improvement in my efficiency comes from the use of a vitrectomy machine equipped with an aspiration flow control system, which allows me to perform vitrectomy faster (using levels of vacuum that would be too dangerous with a vacuum control system) while decreasing the risks of catching the retina.

- Technique is also a consideration in reducing surgical times. For example, when the vitreous is relatively healthy, a core vitrectomy, within certain parameters, allows faster sur-

gery while also decreasing the risk of postoperative cataract formation. For macular hole, injection of a 3 cc bubble of 50% SF₆ (1.5 cc SF₆) with a 2-needle technique (20 seconds) is more efficient than a complete gas exchange (0.8 cc SF₆). For membrane removal, using forceps with a greater grasping effect allows the surgeon to remove larger areas of membrane while reducing the number of exits and entries.

- Decrease the cost of your surgery. The days when surgeons were considered "God" in the eyes of administration are over. If you want the surgery center administrator to continue his or her investment in you, you must consider the profit aspect of your surgery and keep an eye on reducing costs. Remember that when you perform a high number of procedures annually, the technology that you use pays for itself, so that the only cost left to consider is the price per procedure. I made several cost-saving choices at Clinique Sourdille that improved not only economy but also results. First, I found that the use of a surgical slit lamp not only results in decreased trauma, but it also saved money when I did not need to purchase intraocular fibers (saving €60 000 per year). Second, I decided to stop using expensive trocars and instead dedicate these funds to the purchase of Brilliant Peel (Fluoron GmbH, Ulm, Germany) dye, which I find invaluable for peeling internal limiting membranes. Third, I have found that the European-manufactured phaco-vitrectomy machines are not only more efficient (simultaneous control of aspiration flow and phaco/cutting frequency) but also result in a much lower cost per procedure. This technology choice has saved us more than €300 000 per year.

SUMMARY

The above information should not be viewed as advocacy for faster surgery. Vitreoretinal surgery is complex and cannot be mistaken for a simple procedure that carries no risk. As surgeons, however, we can make modifications that improve our practices and our overall efficiency in these difficult economic times. ■

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