IF I KNEW THEN …

Surgeons describe how they approach investing in technology.

BY LUCIO BURATTO, MD; P. DEE G. STEPHENSON, MD, FACS; JOHN P. BERDAHL, MD; AND ELIZABETH YEU, MD

"If I knew then what I know now. …"
The line, or some variation of it, has been used in many popular songs by artists from Kenny Rogers to the Backstreet Boys to Katy Perry. The idea is that the experienced individual wishes that he or she could impart to his or her younger self some of the lessons encountered in the course of a life. *CRST Europe* asked several experienced surgeons to share wisdom with our readers about investments in technology for a modern ophthalmic practice.

Concentrate on What the Patient Sees

Lucio Buratto, MD

In considering investment in new technologies, first of all we should determine whether the purpose of the new device will be to improve the quality of our consultations in the clinic, to improve our results in the operating room, or to increase the number of patients visiting our clinic. These three areas involve three different strategies.

It is of fundamental importance that a clinic possess a comprehensive range of diagnostic instruments. In my opinion, these must take preference over other possible investments because these are what the patient sees, and their presence can greatly affect patients' impressions of and confidences in the clinic. Again in my opinion, it is better that a clinic possess a wide range of diagnostic tools, each with a specific job to do, rather than invest in a single piece of equipment that carries out many tests. Patients must perceive that the doctor's staff members are performing all of the tests necessary for their conditions, and this perception will best be reinforced by the number of tests performed and the range of technological tools available.

For the purposes of the clinic, the two most useful and valuable pieces of equipment are the OCT and topography devices.

By contrast, the patient will not see the instruments in the operating room, even though these are truly more important than the diagnostic equipment given the role they play in the final clinical result. Therefore, the clinic should make good investments in technology for the operating room but without going overboard.

The phacoemulsifier, the operating microscope, and a good operating table are the three most important items required in this area. The least cost-effective machines in the operating room are undoubtedly the femtosecond lasers now being used by many who perform cataract surgery. They greatly increase the cost of procedures, but, unless their presence in the clinic is supported by adequate marketing, they do not necessarily increase the number of patients operated on.

No technology can be purchased to increase patient volume; however, there are technologies that can be used for advertising purposes to bring patients in. The most helpful of these are the Internet, television broadcasting, and promotional campaigns.

Choose Technology to Best Benefit Patients

P. Dee G. Stephenson, MD, FACS

I am a solo practitioner, and I have always been an early adopter of new technologies. With all of the cutting-edge technology available today, deciding what to choose is a never-ending task. Residency programs today are progressive and allow their residents to be exposed to many new technologies. For years,

I have given the same advice to residents as I do my colleagues: Learn and perfect what you do best, then add the technology. Find out whether and how it affects your outcomes, then perfect that technology before adding something else.

I practice in a competitive part of Florida, and I wanted to do something that would set me apart from the surrounding large group practices. Eight years ago, I was fortunate to become involved with WaveTec Vision. I became a key opinion leader for the company and learned its Optiwave Refractive Analysis (ORA) technology like the back of my hand, as they say. The ORA System, subsequently acquired by Alcon, has evolved into a state-of-the-art intraoperative guidance system and has changed the way I perform surgery. It has allowed me to improve my outcomes to the point that many of my patients have become great sources of referrals due to their high level of satisfaction with their surgeries. I more recently added the Lensar Laser System (Lensar) to my surgical armamentarium and have enjoyed using the technology and precision offered by the laser with its Streamline custom cataract software and Cassini (i-Optics) integration.

My success using these innovations has improved my bottom line, as I am able to implant more premium IOLs and to correct astigmatism using toric lenses and astigmatic incisions. But, more important, I can also provide better care for my patients.

My opinion is that the best bang for your buck comes from investing in the best technology that you can afford. I have never regretted purchasing the ORA System. I would go as far to say that, if it came to choosing between the femtosecond laser or ORA, I would choose the ORA. It has allowed me to add other technologies that complement the system and has made cataract surgery on post–refractive surgery patients very successful.

In my 28 years of practice, I have made mistakes. The old saying that "it looked good on paper" but was less so in reality really can be true. Any investment has got to work for your practice. How much time is it going to take to perform a given diagnostic test versus your return on investment? Will it make you a better doctor? Is it something that will make your life easier, such as a new electronic health records system? Do you have the staff to make it work? Success is always easier to reflect upon in retrospect than to achieve.

AT A GLANCE

WORDS OF WISDOM FROM YOUR PEERS

- Patients must perceive that the doctor's staff members are performing all of the tests necessary for their conditions, and this perception will best be reinforced by the number of tests performed and the range of technological tools available.
- Learn and perfect what you do best, then add the technology. Find out whether and how it affects your outcomes, then perfect that technology before adding something else.
- When faced with a decision on a new technology, the first thing one should do is ask the question, "Do I believe this is going to help us deliver on the trust that patients put in us?"
- Acquisition and incorporation of new technologies can help to advance one's practice in the areas of excellence in patient outcomes and continual improvement in clinical efficiencies, but this is not always the case.

Let Philosophy Guide Investments

John P. Berdahl, MD

Our practice is not a bottom line–driven practice. We are more driven by doing the best that we can do and being the best that we can be. Everything filters down to the bottom line, and we know that, whatever comes to pass, we will be able to put food on our tables. I did not take an oath to our bottom line, to the ophthalmic industry, or to insurance companies. I took an oath to do the right thing for the patient. In his TED Talk,[1] Simon Sinek talks about why we do what we do, and he says clearly that what we must do is deliver on the trust that patients put in us.

When we face a decision on a new technology, the first thing that we do is not a spreadsheet calculation to determine whether it will make us money or not. The first thing we do is ask the question, "Do we believe this is going to help us deliver on the trust that patients put in us?" If the answer is yes, we do what is necessary to acquire that technology and deliver on that trust.

> "I like to believe that we are going to be able to take better care of patients 3 years from now than we can today. I want to be part of shaping that story, so our practice has a tendency to be friendly toward new technologies when we see the potential that they have.
> — John P. Berdahl, MD

If the answer is no, then we pass. Focusing on that question really helps bring clarity for us on technology decisions. We do not want the tail to wag the dog, as the saying goes, and make the decision based on financial factors.

That being said, with many new technologies it is hard to answer that question because new technologies are, by definition, new. It is often not clear whether a technology will benefit our patients. In that scenario, the first question I ask myself is still, "Would this allow us to deliver on the trust patients put in us?"

How do we arrive at that conclusion with a brand-new technology? There are a number of factors. First, do the claims of the manufacturer seem to make sense? Second, what do the data say (assuming data are available)? Third, what effect will this technology have on our outcomes? Doctors are, in general, not good at assessing this. And finally, with this technology, will we be providing fair value to patients, fair value to our practices, and fair value to payers? The technology will be sustainable only if it provides value to all three of these parties.

Another element in decision-making has to do with one's outlook. Are you a believer? Are you a skeptic? Are you a cynic? (Do not be a cynic.) If you are a skeptic, you may say, "I do not think this technology seems right, and I am going to look for the data before I make a decision." That approach makes sense.

I tend to be a believer. I like to believe that we are going to be able to take better care of patients 3 years from now than we can today. I want to be part of shaping that story, so our practice has a tendency to be friendly toward new technologies when we see the potential that they have.

Most of the time, we have been right in making these decisions. Occasionally, however, we have signed on for technologies that did not have a meaningful impact and were not sustainable. What do you do in a case like that, when you have made a poor investment and the technology is not working? How do you recover?

The first thing that we do, obviously, is stop using the technology. The next thing we do is call the vendor and say, "We were expecting X result, but we got Y instead. How can we come to a place where everybody feels OK going forward?" For the most part, vendors are receptive to this conversation and have treated us fairly. They may even work with us to try different things to see if we can achieve better results.

The unfortunate exception is when the company says no. Usually that is the case of a company that does not have the means to address the problem. If something did not work for us, it probably did not work for a lot of other people, and, if that is so, the company is probably just trying to keep its head above water.

1. Sinek S. How great leaders inspire action. TED Talks. https://www.ted.com/talks/simon_sinek_how_great_leaders_inspire_action?language=en. Accessed August 3, 2016.

Focus on Excellence

Elizabeth Yeu, MD

I think the field of ophthalmology is unique among other areas of medicine because we are so heavily technology-driven, and there is not necessarily one right way of doing things to achieve a decent outcome. Several factors should be considered when reviewing technology, including a balance between the financial burden or added costs to overhead, the learning curve and disruption to an established workflow, and the potential risks undertaken. As a result, the *how* and *when* to add technologies into clinical practice can be daunting. For our practice, we embrace innovation, but we wisely have a strong administrative side, led by a chief executive officer who balances the wants and needs of our practice in order to maintain fiscal viability.

Our clinical practice has two main focuses: (1) excellence in patient outcomes and (2) continual improvement in clinical efficiencies. Acquisition and incorporation of new technologies can help to advance us in these areas, but this is not always the case. In the past 5 years, there have been a few technologies that have made truly positive impacts within our practice, but accompanying the fruits of our labor were the growing pains of early adoption. We were among the first practices in the United States to acquire a LenSx femtosecond laser system (Alcon). Acquisition of this expensive capital equipment made sense for us because of the existing cataract volume and the

refractive nature of the practice. This has been a game-changer for marketing and expanding our refractive cataract surgery practice, and we have continually advanced our patient outcomes with the use of laser-assisted cataract surgery (LACS). Our in-house results have demonstrated a clinically significant improvement, with 92% of LACS patients within ±0.50 D of refractive target versus 78% of those undergoing manual cataract surgery. This has also allowed us to more effectively diversify our revenue stream, and this benefit cannot be overlooked.

At times, the addition of technology is an enhancement to a practice, and, at other times, necessity drives the process. The needs of a growing or declining practice can dictate what should be added, and the marketplace can also be a strong influencing factor. Regardless, improvement does not always require an expensive acquisition; rather, small additions and prudent investments have been some of the most successful ones for us recently. The Cassini LED topographer, with its insight into total corneal astigmatism, has proven to be a tremendous asset for our cataract surgery patients, and it has enhanced our ability to achieve better postoperative outcomes with a significant reduction of refractive surprises. Similarly, upon querying my colleagues about the various technologies in our practice, our optometrist Chris Kuc, OD, stated that the OPD-Scan III topographer (Nidek) has been one of the most impactful for him in the evaluation of cataract surgery patients.

In the end, some investments work out and others do not, and such a risk will always exist. It is often a tough decision to make, and many factors will play into this. A good assessment of the practice's needs and goals are an absolute must, and I have never regretted seeking advice from those I trust. ■

Lucio Buratto, MD
- Director, Centro Ambrosiano Oftalmico, Milan, Italy
- office@buratto.com
- Financial interest: None acknowledged

P. Dee G. Stephenson, MD, FACS
- Founder, Stephenson Eye Associates, Venice Florida
- eyedrdee@aol.com
- Financial disclosure: Consultant (Lensar, previously WaveTec)

John P. Berdahl, MD
- Vance Thompson Vision, Sioux Falls, South Dakota
- jberdahl@vancethompsonvision.com
- Financial interest: None acknowledged

Elizabeth Yeu, MD
- Private practice, Virginia Eye Consultants
- Assistant Professor of Ophthalmology, Eastern Virginia Medical School, Norfolk, Virginia
- eyeu@vec2020.com
- Financial interest: None acknowledged