

Opinion

Recession in Your Practice II: The Calm Before the Storm?

I hope you haven't experienced a drop-off in practice volume because of the effect of copays in a declining economy. If you haven't, I doubt that you have logged a dramatic increase in revenue, either. Most ophthalmologists, like other business owners, are being extra cautious with buying and staffing decisions. In this environment, slowing down on wet pavement is sensible business strategy. But it also delays the inevitable because, as we have heard so often recently, the Boomers are coming.

The statistics are compelling, if not alarming. According to Etzioni et al.,¹ by 2010, the workload of ophthalmology will increase 15 percent over 2001 levels, while the U.S. population grows only 7 percent. In 2020, ophthalmic services will need to be 47 percent above 2001 levels, at a time when the population is up only 17 percent. Why the discrepancy? Because the bulk of ophthalmic services are delivered to those over 65, and that's the growth segment of the population. In fact, among the medical and surgical specialties, only cardiothoracic surgery and geriatrics are even close to ophthalmology in projected growth.

During his Keynote Address at the 2008 Academy Joint Meeting, Harvey V. Fineberg, MD, PhD, the president of the Institute of Medicine, emphasized the need for ophthalmology to get ready to care for this onslaught. But then he said something that his audience had not expected to hear. He said that ophthalmology would need to team with

optometry to get the job done because neither profession will be able to do it by themselves. He suggested that we should focus more on what optometry *can* do, rather than what it *cannot* do, as we move forward. I think he meant that we need a change in emphasis rather than a change in guiding principles. There is still a dividing line between "can do" and "can't do" that needs to be vigorously defended and the Academy will continue to do that with your important contributions to the Surgical Scope Fund and OphthPAC. But continuing to do that does not rule out a new emphasis on activism in forming eye care teams, in which all members are valued and respected for their contributions to quality patient care.

The Academy's Task Force on Eye Care Delivery that was headed by Paul P. Lee, MD, JD, concluded that there was not one practice model that would fit all situations; innovations in meeting this need would come from all of us collectively. Different practice circumstances and attitudes should dictate how eye care teams are constructed and deployed, hopefully respecting ethical principles and training differentials, with the goal to increase practice efficiency and throughput while increasing quality of care. Translated, this means that individual ophthalmologists will need to assess their own practice needs, call on the extensive information available through the Academy (visit www.aao.org/efficiency), and implement

changes in their practice accordingly. It's far too late to increase the number of ophthalmologists being trained to care for the demographic shift; the pipeline is too long for that. Efficiency tweaks are unlikely to increase our productivity by the requisite 50 percent. During this calm while the eye of the recession passes over us, it might be a good time to plan for changing the way we practice by increasing productivity, creating eye care teams, or both.

1 Etzioni et al. *Ann Surg* 2003;238:170–177.

The opinions expressed are solely those of the Chief Medical Editor. Rebuttals are welcome.



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