From Page to Practice

Books to Reframe Your Work

Six *EyeNet* editorial board members review books that have shaped the way they practice.

One search on the Internet will yield hundreds of books offering to help improve your practice. But identifying those few that offer truly valuable insights can be particularly challenging. To help you sift through the search results, six *EyeNet* editorial board members have each recommended one book that has made an impact on their careers. Read these summaries and analyses to learn how you could apply them to improve your practice.

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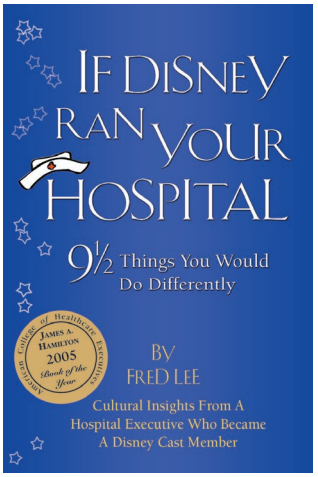
If Disney Ran Your Hospital, 9½ Things You Would Do Differently

By Fred Lee

"If Disney ran your hospital, your nurses would begin to believe that they are judged not so much against the standard of other nurses in similar settings, but against the standards set by the nicest people giving services anywhere. And the same would be true of your housekeepers, telephone operators, managers, and physicians."

As ophthalmic physicians and surgeons, we provide skilled, evidence-based care for our patients. And cutting-edge medical and surgical therapies allow us to achieve monumental outcomes that positively impact the daily lives of our patients. Why, then, do we sometimes struggle to consistently achieve corresponding degrees of satisfaction and loyalty among our patients and employees?

In *If Disney Ran Your Hospital, 9½ Things You Would Do Differently,* Fred Lee provides valuable insights to answer this question and proposes actionable steps for improvement. Mr. Lee served as both a hospital executive and a Disney employee, or "cast member," before passing away in 2017. His experiences in two seemingly different environments are carefully melded in this book, which should be required reading for those on the front lines of health care.



He starts by urging us to redefine our competition. As clinicians, we typically define our competition as being in the field of ophthalmology, or even in our subspecialty. But in reality, patients are comparing our practices with all the service industries—hotels, airlines, and even Disney! Our customer care practices are therefore held to a much higher standard than we realize, and this concept needs to be embedded in the mind-set of every employee in your practice.

Further, Mr. Lee notes that we assume patient satisfaction is directly tied to clinical and safety outcomes, but survey data suggest otherwise. Indeed patients expect competent and safe care as the baseline. Beyond that, satisfaction with our care and loyalty to our practices are dependent on patient perception and overall experience—which cannot be easily measured or verified.

To improve patient experience, Mr. Lee asserts that we should move away from standardized surveys with scores tied to physician and employee compensation or an intention to advertise. This model will always lead to "measuring to impress" rather than to improve. Ideal survey instruments formulate queries to assess patient loyalty, not mere satisfaction, which Mr. Lee refers to as "fool's gold." Since patient loyalty is tied to physician and staff compassion, survey tools should include questions with words such as "care," "compassion," and "concern." Responses to these questions should be used to measure success and track performance with the goal of genuine improvement.

But won't a focus on these vague considerations threaten our ability to provide smooth, efficient clinical care? Mr. Lee argues that the answer is no. In fact, he says, prioritizing courtesy toward patients over efficiency results in bottom-line growth. He explains that this growth is achieved through sharing of resources among various divisions in a given center or department. An example may be cross-training staff for scheduling and clinical work or work across multiple subspecialties.

An important lesson from Disney is that authority can be decentralized to empower frontline employees to solve problems and make independent decisions when addressing a patient complaint. This goes hand-in-hand with cross-training employees to execute various patient care responsibilities. With proper training, this approach leads to a team mind-set with unified goals. Ultimately, then, the external focus on patient courtesy leads to system-wide efficiencies that simply cannot be attained otherwise. —*Ahmad A. Aref, MD, MBA*

Make Your Clinics Flow With Synchrony

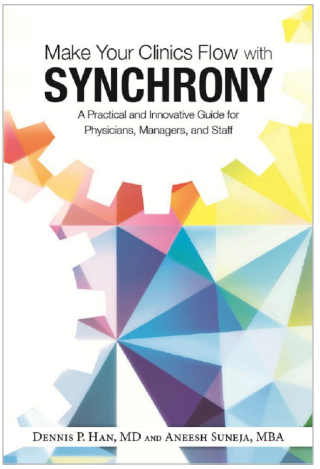
By Dennis Han, MD, and Aneesh Suneja, MBA

"Synchrony means valuing the patient's time and the physician's time equally, bringing them together when each is ready for the other, without waste or delay."

Imagine a half-day clinic like this: You arrive at 7:50 a.m. for an 8:00 a.m. subspecialty clinic with 30 patients. Following a brief team huddle to anticipate any potential problems, the techs, residents, fellows, and attending physician start their day in good spirits and with a plan in mind. Your first patient, a one-week post-op, is ready for you at 8:05 a.m. The morning proceeds smoothly, with the team working together like a well-oiled machine. New and established patients, as well as a few emergency add-ons, are seen in expeditious fashion. Seven surgeries and three lasers are scheduled during the clinic, which ends at 11:45 a.m., allowing time for a wrap-up huddle at the end of clinic and a focused case review to enhance trainee

and technician education. You enjoy lunch with the team before heading to your research lab for a productive afternoon. Everyone—physicians and staff alike—has had a busy but enjoyable morning. Patients are happy with their excellent care and eager to refer their family and friends (and to give high marks in their patient satisfaction surveys).

Does this sound like an impossible dream? If so, I encourage you to read *Make Your Clinics Flow With Synchrony.* This brief book (66 pages) offers a road map for achieving this vision. Using the principles of "lean" methodology (an approach promulgated by Toyota as early as the 1950s that strives to minimize waste without sacrificing productivity), this book describes the transformation in Dr. Han's practice that increased clinical productivity and satisfaction for Dr. Han, his staff, and, most important, his patients. This book is full of insights, including the idea that for maximum effectiveness, one must consider "both the physician and the patient as simultaneous and equal constraints whose time must be valued." Who among us has not been in the situation where we are ready to see a patient but none are ready for us because of inefficiencies in imaging, tech workup, and the like? Conversely, the scenario in which a patient is ready for us, but we are not ready for them, also reduces clinic flow, increasing patient wait time and decreasing patient satisfaction.



The authors also cite other factors, such as the location of various tasks (e.g., testing and surgical scheduling), as important contributors to optimizing the flow and, subsequently, the overall functioning of the clinic. Simple changes, such as having a tech multitask to scribe, educate patients, or simply escort them to the checkout area, can have profound effects on clinic flow to enhance patient and physician satisfaction.

In this era of declining reimbursements, we are all asked to do more with fewer resources. Physician burnout is an ever-increasing threat to medicine. This valuable book provides strategies to help us all be more efficient while having more fun and optimizing the satisfaction that is at the root of our careers as physicians.

—Kathryn Colby, MD, PhD

MORE ONLINE. Find the AAOE's lean management resources at aao.org/lean.

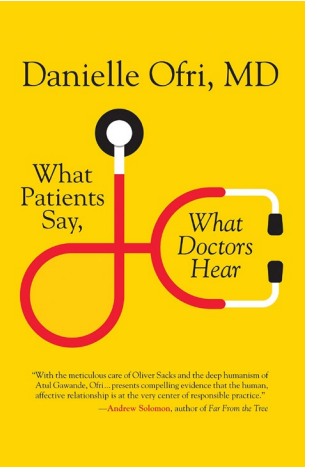
What Patients Say, What Doctors Hear

By Danielle Ofri, MD

"What's tantalizing is that it doesn't require much additional effort on the part of the physician to have a meaningful effect. Nearly every good-quality study that gave physicians concrete steps resulted in better communication and improved patient satisfaction. Whether it was getting doctors to ask more open-ended questions, or to elicit the patient's concerns, or to set a clear agenda, or to inquire about the patient's life beyond the illness, or to involve the patient in choosing a treatment plan, or just express more empathy—nearly any attention paid to these skills easily improved communication."

In the past, certainly when I was growing up and even in medical school, the communication between physicians and their patients was as follows: Doctor queries the patient on medical history, performs an exam, makes the diagnosis, orders the treatment, and then leaves the room. From what I witnessed, understood, and accepted, patients were expected to adhere to a "just the facts, ma'am" rule as an unspoken law of patienthood.

In *What Patients Say, What Doctors Hear,* the author outlines how this communication style, and many others, have far-reaching negative consequences. Supported by patient/physician stories and research studies, Dr. Ofri shows how certain common communication styles and behaviors have historically promoted patient dissatisfaction—and not dissatisfaction as it is defined by the pervasive hotel hospitality-type surveys but rather emotional dissatisfaction that commonly manifests as anxiety, stress, and hopelessness. She also convincingly explains how poor physician-patient communication leads to untoward health consequences from patients' nonadherence to their treatment plan.



Throughout the book, the author offers engaging insights supported by study results, such as:

- Physicians typically interrupt patients' explanations about the reason for their visit after 11 seconds. (Guilty as charged…)
- A physician who stands while communicating with a seated patient is putting the patient in a psychologic position of inferiority, which makes the patient less likely to ask questions. Standing

is also a nonverbal indicator that the physician is finished with the appointment, whether or not the patient is done asking questions. (Two strikes…)

- Nonadherence to a treatment regimen or to scheduled appointments is often not due to ignorance or indifference on the patient's part. Rather, it is often secondary to the realities of life, such as expensive medication not covered by insurance, onerous dosing schedule, lack of transportation to appointments, lack of childcare, and limited time off work. (When was the last time I asked a patient's mother if my patching regimen could realistically be accomplished? And if it could not, did I discuss feasible alternatives?)

It is self-evident that a physician's diagnostic acumen and surgical skills make a major impact on a patient's health. This book has convinced me that the communication skills, which reveal a physician's compassion, empathy, and respect, will also have a significant effect on the health outcomes of patients. *—Jane C. Edmond, MD*

Tribal Leadership

By Dave Logan, PhD, John King, and Halee-Fischer-Wright, MD

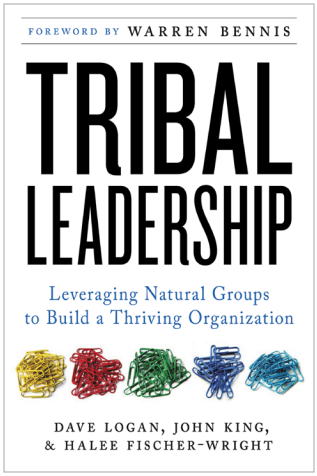
"If people change their words…they change their reality and their behavior changes automatically…"

You can tell the "feel" of a practice. You know whether it's a thriving place of productivity or whether it's dysfunctional. What causes the difference? What is the secret to success?

According to *Tribal Leadership,* the difference between terrible, so-so, good, and amazing companies is their culture, which is shaped by tribes, groups of 20 to 150 people to which humans naturally conform. Tribes, of which there could be many in a large organization or just one in a small organization, influence everything from who will lead to the quality of work produced.

This book provides recommendations on how leaders can improve the workplace culture by leveraging and upgrading the tribes. Leaders must listen to an individual's language and identify the "tribal stage" they are in. With this information, the leader can work to elevate the person's stage, thereby elevating the workplace culture. All individuals are in one of five stages:

- **Stage 1:** Despairing hostility. Language used is "Life sucks." The person is alienated.
- **Stage 2:** Apathetic victim. Language used is "My life sucks." The person constantly complains, and nothing makes them happy.
- **Stage 3:** The Wild, Wild West. Language used is "I'm great (and you're not)." The person is productive but competitive. Information is hoarded, since it is the path to power. Their motto is "the ends justify the means."
- **Stage 4:** Tribal pride. Language used is "We're great (and they're not)." The person's actions reflect core values and beliefs shared by the tribe. Productivity, employee satisfaction, and engagement are high. True teamwork takes place when information is shared for the greater good.
- **Stage 5:** Innocent wonderment. Language used is "Life is great." The person forms connections to anyone with shared values. Generally, a high-functioning Stage 4 tribe jumps to Stage 5 when it is producing amazing, historic work.



Eventually, if a tribe's culture is strong enough, members who really don't fit will leave, allowing a group with a very positive culture to continue to grow, excel, and attract new members.

This book would be valuable to any ophthalmologist because it provides fundamentals on how to be a successful leader. Several other books teach techniques for building a better team—for example, encouraging trust or engaging employees—but *Tribal Leadership* provides the foundation. The other management techniques work best in a Stage 4 tribal culture—and that culture definitely flows from the top.

One way to successfully apply the principles discussed in this book is to look long and hard in the mirror. I had to make sure that I was personally exhibiting the qualities and culture of a person in Stage 4 before I could expect to move others to that stage. I changed the language I used (e.g., "we" instead of "me"), and those shifts changed my approach to work for the better. While this journey hasn't always been easy, I am proud to say that today my team and I reap the immense benefits of a great culture. Together we have achieved more than I ever thought possible, and I have confidence that we can continue in this upward trajectory, regardless of the circumstances.

No matter what type of ophthalmology practice you are in, a productive, happy work environment is sure to positively impact patients and elevate the quality of care provided by your office. The ophthalmologist is the tribal leader: Go establish the culture that you want wherever you are! *—April Maa, MD*

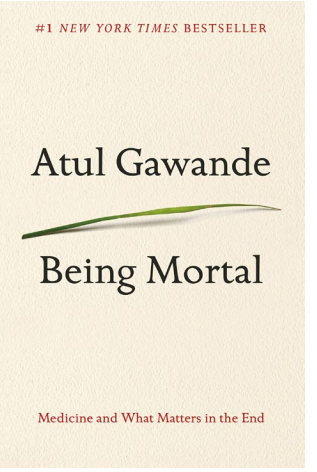
Being Mortal
By Atul Gawande, MD

"The trouble is that we've built our medical system and culture around the long tail. We've created a multitrillion-dollar edifice for dispensing the medical equivalent of lottery tickets—and have only the rudiments of a system to prepare patients for the near certainty that those tickets will not win. Hope is not a plan, but hope is our plan."

We all must die. In *Being Mortal,* Dr. Gawande explores how the "modern" approach to elder care and end-of-life medical decision-making has led to a system that many people, including physicians, find to be incompatible with personal desires and perceived quality of life. Dr. Gawande approaches the subject from social and medical directions, and the book covers two main topics.

The first is how society treats people as they grow older. Dr. Gawande contrasts the multigenerational care system of the past with the challenges presented by the nuclear family of the present. Conflicts between generations arise when the older generation, used to living independently, can no longer do so without assistance. Using examples from his family as well as interviews with experts in the fields of geriatrics, family medicine, and psychology, Dr. Gawande contrasts the needs of the elderly, who desire autonomy and control, with the concerns of their children and other parties, who see safety and security as paramount. He suggests, through a series of vignettes involving his family and acquaintances, that we should prioritize independence above security; doing so will maximize our elders' happiness and quality of life. As ophthalmologists, we frequently care for older patients who face these problems, especially when failing vision threatens to take away their independence. Starting these difficult conversations and helping family members understand that a balance of concerns must be achieved is something we can and should do.

Dr. Gawande then tackles the second subject: end-of-life decision-making. I was surprised by his initial lack of familiarity with the art of end-of-life conversations and his hesitancy to have such discussions with his patients. I had expected him, as an experienced general surgeon and accomplished author, to have greater facility with the topic. Yet he showed his vulnerability in describing his struggles to speak frankly with his patients who had complications of incurable cancer for which he was asked to intervene. He discusses how doctors might better understand patients' perceptions of their disease and desires for the future, as quality of life has a very different meaning for each individual. Furthermore, patients may overestimate their chances of response to treatment, hearing only the best outcome possible. For this reason, all physicians must endeavor to communicate clearly, frankly, and empathically. It may be helpful to follow a simple approach of having patients repeat back what they have heard to make sure that they understand it.



He brings his points home poignantly through experiences with his patients, as well as his own father, reminding us that none of us can avoid consideration of aging and end-of-life issues. Furthermore, we, as ophthalmologists, treat chronic illnesses—such as age-related macular degeneration and glaucoma—that cannot be cured but only slowed. Thus, it is our duty to ensure that our patients clearly understand the goals and possible outcomes of therapy.

Overall, *Being Mortal* reminds us that we cannot and should not shy away from tackling these tough issues: Addressing them openly will help our patients have better and more fulfilling lives in their later years. —*Prem S. Subramanian, MD, PhD*

The Gene: An Intimate History
By Siddhartha Mukherjee, MD, DPhil

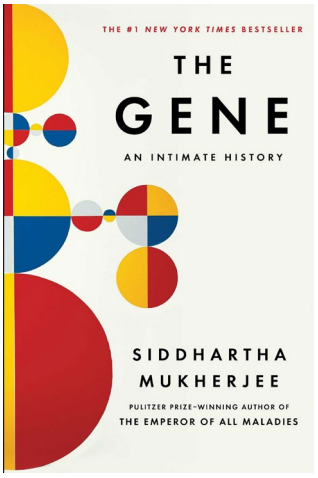
"'Monet is but an eye,' Cézanne once said of his friend, 'but, God, what an eye.' DNA, by that same logic, is but a chemical—but, God, what a chemical."

This entertaining book catalogues the history of humankind's attempts to understand genetic inheritance. Rather than relying on bland facts and figures, however, Dr. Mukherjee spins a fascinating story of genetic knowledge through the centuries while weaving in his own family history of mental illness, explaining what sparked his own interest in genetics and inheritance.

He starts his history by discussing Pythagoras' theory of semenism, whereby the father provides the "image" or likeness of the child, while the mother only nourishes the fetus—a theory disputed by Aristotle, who had a differing view of the parents' contributions, observing astutely that children resembled both parents. From the ancient scholars, Dr. Mukherjee jumps 2,000 years to the 1850s to recount the nearly simultaneous discoveries of the two giants on whose shoulders all of genetics stands: Charles Darwin, who found

that dispersion and natural selection explain how organisms change and differentiate over time; and Gregor Mendel, who proposed that discrete pieces of genetic information transferred from parents to offspring are responsible for familial likeness. What Mendel called "units of heredity" came to be known as genes 50 years later.

Finally, Dr. Mukherjee travels to the 20th century and beyond, discussing the landmark events that have created contemporary genetic studies and have allowed humans to manipulate genes. He describes the race to unravel the structure of DNA, culminating in Watson and Crick's depiction of the now-familiar double helix. After the discovery that a fixed set of genes can respond actively to its environment, scientists raced to map the entire genome so that scientists could identify and attempt to modify the actions of the genes. This goal of sequencing the human genome was pursued cautiously and diplomatically by some scientists (e.g., Francis Collins, Director of the NIH) and belligerently by others (e.g., geneticist Craig Venter).



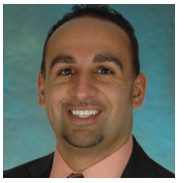
Although the information Dr. Mukherjee presents is fascinating, the book is particularly interesting to me because it delves repeatedly into the ethical dilemmas that have dogged the study of genes throughout history. The term eugenics was coined by Francis Galton, Darwin's cousin, who was also responsible for another memorable phrase: "nature versus nurture." Negative eugenics, or the attempt to cull out negative genes, brings to mind the horrors of Nazi Germany. But eugenics had been practiced long before that in the United States, as evidenced by the forced sterilizations of the "feebleminded" throughout the 19th and early 20th centuries as well as by "Better Babies" contests that touted the benefits of positive eugenics in the early 20th century.

Backlash over such historic abuses has led to an unspoken law, or "moral boundary," forbidding genetic manipulation except in certain cases: when the genes have high penetrance, when the patient is experiencing extraordinary suffering, and when the intervention is not coerced. Unfortunately, this triad of criteria is hardly well defined. Who decides what is extraordinary suffering? Who decides for the individual unable to give consent—for example, does the parent choose for the child? Dr. Mukherjee closes by discussing the science and ethics of genetic testing and genetic modification.

All of this leads to ophthalmology today. With the recent advent of a gene therapy for Leber congenital amaurosis type 2 and therapies for several other inherited retinal diseases on the horizon, it is more important than ever for ophthalmologists to understand genes and genetic diseases. This book is an easy-to-read primer that educates while telling a story. I recommend it highly.

—Sonal S. Tuli, MD

Meet the Reviewers



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