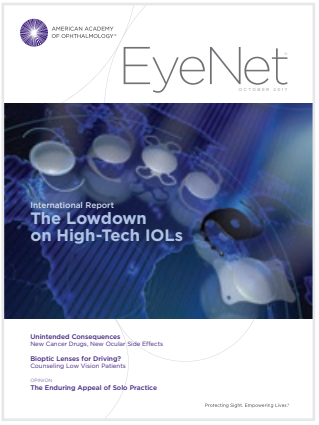
Letters



How to Shift Your Perspective

In light of Dr. Williams' column titled "Solo Practice in Ophthalmology: Resisting the Tides?" (Opinion, October), I want to encourage physicians to shape their futures despite the obstacles created by the following: Medicaid cost sharing with the federal government, uncertainty around the fate of individual insurance markets, looming MACRA and MIPS regulations, and more.

What happens when we take the reins. I invite you to imagine what is possible (and importantly, under our own control) when we shift our perception of health care reform and value-based care from externally imposed burdens to internally driven improvements. By focusing on your individual practice, you can solve your own unique challenges. There is plenty to do to improve your practice for intrinsic reasons, and fortunately many of these changes can also help you survive the transition from fee-for-service to value-based payments—for example, inefficiencies are a threat like never before.

The 3 elements of improvement. The foundation for physician-directed practice improvements rests upon 3 pillars: autonomy, mastery, and purpose. Much has been written lately about these and "physician engagement with work"—and, yes, it is possible to use these concepts to find joy in our work. For example, when you problem-solve to eliminate inefficiencies in your practice, you can find pleasure in this exercise of autonomy. As your practice improves due to the solutions you found, you experience the element of mastery. Finally, a higher-performing practice allows the individual and organization to more effectively fulfill its purpose of helping others. Conversely, actions that do not feature these 3 principles lead to frustration and increase the risk of burnout.

Choose the best path for you. Both solo and group practice have their pros and cons; the choice boils down to how strongly you value autonomy. For some ophthalmologists, achieving mastery is found by working alone; for others, mastery can be facilitated through the advantages of a group practice.

At a minimum, we must continually evolve our clinical and surgical skills as well as basic business skills. At some point, however, we realize the importance of community and advocacy to achieve a higher purpose (the pillar of fulfillment): service to others. The Academy, state and subspecialty societies, and their advocacy groups exist to defend our professional autonomy, support our individual and collective efforts to achieve professional mastery, create vital bonds with like-minded professionals, and ultimately fulfill our purpose as healers.

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More on Low Vision

I read with interest "Low Vision Drivers: The Ophthalmologist's Role and Responsibility" (Clinical Update, October), which quite thoroughly discusses the benefit that bioptic vision aids may offer to many individuals who would otherwise be unable to acquire a driver's license, with the independence that this certification offers.

This remarkable visual/driving aid was brought to my attention in 1996. At that time, I evaluated a then 8-year-old boy who was found to have Stargardt disease, with his acuity eventually dropping to 20/200 in both eyes. With subsequent evaluation by C.J. Reed, OD, COMS, at the Judith A. Read Low Vision Services in Akron, Ohio, and fit with the then-available Ocutech VES II/6 × magnification, he has been able to continue successfully through college and obtain ongoing driving privileges.

A debt of gratitude needs to be given to William Feinbloom, OD, PhD, the "father of low vision care" in the United States, who introduced the concept of bioptic driving[1] in this country. In 1932, at age 28, he used an astronomer's telescope as a model to design a small 3 × power telescope that was small enough to be mounted in a spectacle frame, restoring one individual's functional vision.[2]

Later, in 1958, he introduced the concept of a bioptic telescopic system, which combined a prescription eyewear lens with a small mounted Galilean telescopic system. His system allowed the patient to change view from the telescope to the general prescription.

The website referenced below, with information from Richard L. Windsor, OD, is a most valuable resource, describing a number of up-to-date options that ophthalmologists/optometrists/low vision specialists may find useful, adding to *EyeNet*'s informative article.

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1 www.biopticdrivingusa.com

2 Feinbloom W. The training and after care of the partially blind patient. *Journal of the American Optometric Association.* 1958:29:724.