GEMS my fathers[1] taught me (as well as others)

By Robert A. Kraskin, OD

Editor's Note: It should be noted this was my Robert A. Kraskin's personal notes for himself with direction for many of his lectures as to what to cover. It was written for the purpose of being published as is, but it is a good piece of historical writing that helps understand the person, the thought pattern, and the underlying concepts behind how he practiced.

1. Your practice is only as large as the one patient in your chair at that moment.
2. Always give more than patient expected, elaborate with examples e.g., alternatives, the annual even if no changes etc.
3. The importance of language in the exam, particularly the analytical; avoid any language that conveys the notion of patient answers being so critical to the correctness of the Rx
4. Program your patients throughout life for the benefit of the patient and the security of the practice.
5. For general practice regarding age distribution, do the following:
    a. with child patient, discuss adult vision care with parent
    b. with adult patient in chair, discuss children's vision care including prevention as well as protection and enhancement, as well as lenses and VT and different conditions etc.
6. The value of the conference — that which should always be discussed and shared with patient or parent
7. The alternatives and the total significance beyond that for the patient — e.g., letting all know all benefits they might have whether they need it or not; communication that may be significant for others in family or friends re: prevention, protection, and enhancement.
8. The multimillion-dollar statement: If all I knew today was what was known in my profession 3—4 generations ago, the only recommendation would have been. . . (conventional wisdom)
9. What does your reception room say about the practice?
10. What does your examination room say about the practice — e.g., re children, the coffee pot, etc.?[2]
11. What does your conference room say about you (i.e., the consultation office)? Books are sign of a learned man.
12. The OD must determine whom he wishes to serve:
    a. general practice, children only, VT only, etc.

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[1] Robert A. Kraskin, OD was the son of an optometrist, Lewis H. Kraskin, OD, but he considered many in the profession his "father".

[2] Editor's comment in email from Jeffrey Kraskin, OD: We had a top-of-oven percolator coffee pot that sat out. The point was the patient to question Why is it there? The pot was in-of-itself a great toy or child experience to put the pieces together, but more importantly was a strange item to have in the examination room thereby raising questions by a patient.

b. the socio—economic level desired:
method for developing level — who is programmed; anyone has friend for referral
both step above and step below; cultivate for referral

13. Every patient should be given the opportunity to become the trunk of a referral tree so long as the OD desires these referrals.
14. The OD must decide the percentage of referrals between professional and/or patient referrals.
15. There is no reason why every family member shouldn't be a patient for programmed vision care; this should be a goal.
16. The measurement of success with a patient is determined by how soon the patient makes a referral either in family or out of family.
17. The better measurement of success should be how soon patient refers both a family member and a non—family referral.
18. No practice should be permitted to be dominated by any one referral source — professional or patient for security and future success reasons.
19. The first GEM from my biological father: always use deodorant and don't eat onions for lunch.
20. Another from my biological father: always peen (using the peen end of a ball/peen hammer) the screws on the frames.
21. Don't try hard, TRY RIGHT!
22. The language of the analytical: do not use language that suggests that the patient is "selecting" their Rx; use worse in comparisons not better now or now; emphasize that are investigating "sensitivity and consistency", not right or wrong.
23. The language of the ophthalmoscope; don't just look or do on anything; be sure to talk, describe and assure.
24. The value of the conference for new patients; the write up of notes, the sharing of notes with patient and use of notes as report if patient desires; I do not write reports and why.
25. The monthly VT report from patient and possible additional use.
26. The progress case study (PCS) values in all ways; used to be called "PR' s" (progress reports) also meaning PR (public relations)
27. The use of telephone — elaborate this but describe personal reasons for talking with all new patients.
28. Determine how you want your practice relative to patient referrals; no more than 10% professional referrals.
29. Fees; no exam fee; have office visit fees "to walk through door". Have total program care fee related to benefits.
30. If the right question is raised, one will always get the right answer; this is more important than the answer (i.e. the question).
31. What does the office say: coffee pot, play table, small table in exam room, etc.?

32. Section on communication with letters: thank you letters (very important, always — no excuses); birthday cards, holiday cards are questionable; appointment cards in mail and PCS notifications; give examples of all of this in the text

33. For any child exam minimum 16 years old and under, a parent should be in the exam room primarily for two reasons:

    a. So that the parent can appreciate what child is doing and experiencing and behavior can be related to in the conference.
    b. So that OD can talk "adult vision' care (see #5 above)

34. Regarding discussion of adult vision care, particularly with parent but not restricted to this, an important point is that if we only had the opportunity of seeing them at least at the age of the child in the chair or some such age, we could have done so much to protect them, as we do today, from the heartaches and limitations imposed by visual dysfunctions

35. That which is always discussed in the conference no matter the person and/or needs: prevention, etiology, adaptations, and where one is now and benefits to be expected by and from various alternatives.

36. As your gift to the parents of a newborn and the gift to the child of patients, offer the first vision developmental examination as long as it is done during the first year of life; the most efficient and effective means of learning, understanding, and guiding vision development and infant vision function.[3]

37. Always make available as an alternative a level of care that could be provided by anyone — i.e. conventional wisdom; this should always be alternative #1 in the good, better, and best offerings.

38. Maintain minimum office visit fee above that of others in the area — i.e. maintain your minimum fee above that of the so—called "going rate" of exam fee (although we avoid exam fee in favor of office visit fees (new patient minimum, annual minimum, progress case study minimum, etc.

39. Reconfirm all examination and PCS appointments by telephone the day before appointment (on Friday for next Monday appointments. Avoid missed and forgotten appointments, particularly a problem if bookings are far in advance; regular scheduled VT are not necessary to reconfirm. This was learned from Airlines in the 1950's — all flights were reconfirmed the day before by the airlines

40. The appointment notice — give example sample; sent out on Thursday 10 days prior to appointment (rephrase to make this meaningful) This goes to all annual and PCS appointed patients; use appointment card for new patients in the mailing.

41. VT fees are always monthly in advance tuition fees — elaborate and also discuss the reason for tuition fees as opposed to "case" fees or time fees; also discuss the approach that works for total out—of—office VT program.

42. Re VT: everyone can learn to function better but not everyone needs to do so.

43. Re VT: anyone accepted for VT must identify goals and personal needs.

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[3] NOTE: This became a staple of the InfantSEE program.

44. Definition of a VISUAL PROBLEM: an unsatisfied vision—related personal need.

45. One is acceptable for VT if the needs cannot be satisfied by a simpler yet positive approach.

46. One should consider VT if the benefits to be derived (i.e., the satisfying of the identified needs) outweigh the efforts required on the part of the patient.

47. Always assure the amblyope — God Forbid, what if something happened to the "good eye".

48. Re: telephone / always answer a question with a question; give examples for example, an incoming call "with whom am I speaking?", Have you been here before? who referred you? etc.

49. Re: telephone — incoming call for the Dr.; answer "He's with a patient — please hold".

50. The concept of programming; elaborate re: annuals, PCS etc.

51. 50 This is possibly redundant to an earlier GEM: that which is ALWAYS discussed in the conference: Those items specific to the patient and those items related to anyone — e. g. etiology and prevention are general; healthy eyes, particular symptoms and needs are peculiar to the individual

52. (see #9) elaboration: magazines, pamphlets and articles—display and take home; the play table and chairs for children and selected harmless toys.

53. The importance of the Diagnostic Fact Sheet (DFS) paper, related to reports, and provides immediate opportunity for short form recording of all said to patient as well as predictions and other immediate info which will be significant to be seen and remembered in the future and on future visits.

54. Keep written notes on any and everything noted and/or reported by the patient, e.g. their children, happenings, weddings, trips, anniversaries, deaths, etc. makes it easy on following visits to comment and/or raise questions relative to families, happenings, etc. Creates an important family — type relationship between OD and patient, the notes support memory

55. "If it's in the person, it's in the analytical" • must always be concerned with the future, and prevention and/or protection; this is the basic reason for programming vision care throughout life— concern and predictability; can make predictions e.g., related to the presbyope — i.e., when next Rx change may be required as related to predicted "normal change" not adverse change

56. If conditions were ideal, from the Behavioral concept point of view, patients are seen because everything is good and hopefully always will be because of care given them not seen because something is wrong; we are not interested in adverse changes we must strive to prevent such. We want to see people because they are free of problems not because they have problems.

57. Visual Training must be goal—oriented, goal—directed and goal— centered; patient must have and share their goals; the evidence of success is the attainment of the goal(s).

58. One may strive to "catch—up" but be concerned if you do. Always have something to be done.

59. Re: the assistant; be concerned if you have nothing to do; you're forgetting something or ignoring something; there is always something to do; it is never a problem if you must take a

break from what you are doing but be concerned if you feel you have caught up and have nothing to do.

60. The importance of the telephone diary; keep an accurate log of all incoming phone calls no matter who the call is for. Calls should be listed in numerical order as they come in. Purpose of call should be indicated; if patient, could be new, regular, progress case study, and any number of other purposes; depending upon purpose, the call will be followed by assistant questions; always check spelling of names and street addresses, etc. If call is specifically for the doctor or other personnel, it should be indicated; if call requires a transfer, then, it should be indicated then on the log; if call requires call back, record this and who is calling back. (Perhaps there should be additional info. here) Kept in notebook; when filled, file don't toss…

61. Answer question with a question, at least until you feel comfortable in answering any question; this is of particular importance with telephone calls. Many times, the real question is not initially asked, and one could possibly answer unknowingly an inappropriate question.

62. The three essentials all within the practice must always utilize: PRIDE, DIGNITY, AND DISCRETION

63. BENEFITS — no matter whether it be materials, a commodity or a service, the person buys only one thing — the BENEFIT of the material, the commodity, and/or the service. i.e. in final analysis the patient pays for and buys only the benefits to be obtained as a result of your time, skill and knowledge; patient will not and should not be expected to pay for time, skill and knowledge; that's a given.