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By Liz Hunter, Senior Editor

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Contemplating The Workforce Deficit

As patient demand increases, fewer ophthalmologists are available to serve them. Here, we explore the compounding factors contributing to this crisis and the solutions needed to drive change.

Workforce projections within the field of ophthalmology have ebbed and flowed over the course of decades. Research in the 80s and 90s estimated a surplus of physicians, however, the longevity of patients has created an increased demand for age-related diseases, such as glaucoma, macular degeneration and cataracts—while the number of ophthalmologists declines.

According to a 2024 study published in *Ophthalmology*, the total ophthalmology supply in the United States is projected to decrease by 2,650 full-time equivalent ophthalmologists (12 percent decline) and total demand is projected to increase by 5,150 FTE ophthalmologists (24 percent increase) from 2020 to 2035, representing a supply and demand mismatch of 30-percent workforce inadequacy.¹

The shortage of ophthalmologists shouldn't come as a surprise to anyone, but the severity of the problem differs for a few reasons, including location, according to Jill Maher,

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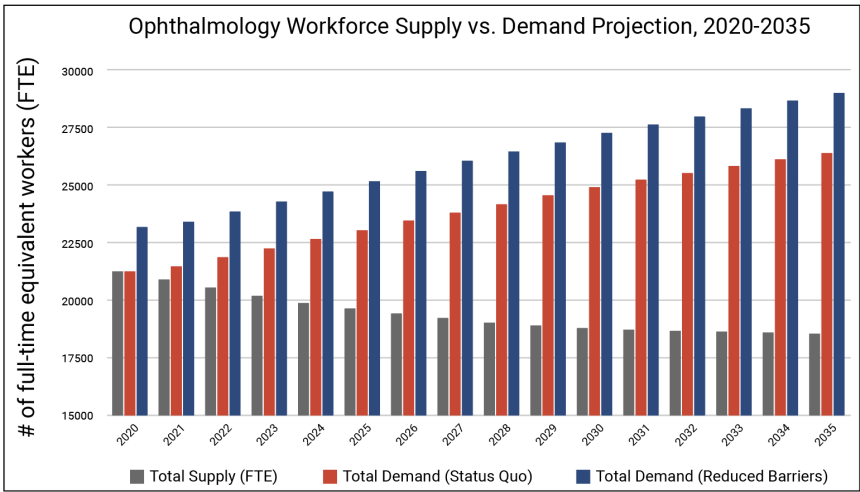
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MA, COE, the owner of Maher Medical Practice Consulting in Chicago.

“I’ve been recruiting for 10 years now for my clients, and I’ve seen a shortage of ophthalmologists for the past decade,” she says. “Generally speaking, when residents and fellows finish their training, they tend to move to the coasts—the East Coast, West Coast, or down south to Florida. Here in the Midwest, we’ve really felt the shortage, especially in rural practices, but even in urban, solo-owned practices.”



A 2024 study published in Ophthalmology projects a continued increase in demand for ophthalmology care while the number of full-time providers decreases year-over-year. (Berkowitz ST, et al.)

In that same 2024 study noted earlier, when the data were broken down geographically, the imbalance became even more pronounced, projecting a 77-percent workforce adequacy versus 29-percent workforce adequacy in metro and nonmetro geographies, respectively.¹

Concerning as it may be, ophthalmology isn’t an outlier. “All of medicine is facing similar workforce issues,” says Michael X. Repka, MD, MBA, a professor of ophthalmology and pediatrics at Johns Hopkins University School of Medicine, and president of the American Academy of Ophthalmology. “It’s hard to find primary care physicians in many areas, so this challenge isn’t unique to ophthalmology. If we look back 30 years, experts at the time predicted a surplus of physicians, and that forecast turned out to be wrong. As one of my colleagues used to say, it’s very difficult to predict manpower accurately—and almost inevitably, the projections will be wrong.”

Others feel these predictions must be digested within a broader, macroeconomic context. “We’ve seen significant

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workforce changes overall—unemployment trends, the rise of artificial intelligence and recent layoffs at major companies like Meta, Amazon and Google,” says Asim Piracha, MD, an associate professor at the University of Kentucky Department of Ophthalmology and University of Louisville’s Department of Ophthalmology and Visual Sciences who also works in private practice in Lexington, Kentucky. “These trends are an important context for any discussion about medical workforce shortages. It appears we may be shifting from historically low unemployment toward higher rates in the next few years. That’s an important backdrop because it could change the hiring environment. Over the past five years, unemployment has been so low that practices would take almost anyone who could fill a position. If unemployment rises, there may be a larger applicant pool, which could make it easier for practices to hire qualified staff.

“We may also see job losses due to automation, which will change the composition of the available workforce,” he continues. “I think that trend deserves attention because it’s going to affect both the current and future landscape of staffing in health care, including ophthalmology.”

Steven J. Gedde, MD, professor of ophthalmology and vice chair of education at Bascom Palmer Eye Institute in Miami, says tallying workforce projections isn’t as simple as counting how many ophthalmologists are being trained versus how many retire or leave the workforce. “To do it properly, you have to account for multiple moving parts: how many ophthalmologists currently practice, how many new ones are entering and exiting each year, and how their practice patterns evolve,” he says. “You also have to consider related providers—like optometrists—and how their roles overlap or differ.”

Then there are technological and societal factors.

“Telemedicine, for instance, has transformed access to care in some areas, and we’re only scratching the surface of what it can do,” he continues. “Advanced imaging, AI-based screening and remote monitoring are making it possible to manage certain eye conditions more efficiently. That could offset some workforce shortages—but it also requires infrastructure, training and oversight. Next are demographic factors. The U.S. population is both growing and aging. Unfortunately, many eye diseases—glaucoma, macular

degeneration, cataract—are age-related. As the population ages, demand for eye care will inevitably rise.

“All of these factors interact in complex ways, which makes accurate forecasting incredibly difficult,” continues Dr. Gedde. “But the consensus right now is that we’re not training enough ophthalmologists to meet projected future needs.”

In this article, we’ll explore the real-world experiences of practicing ophthalmologists to examine where these shortages will have the biggest impact and what potential solutions exist.

Subspecialties

There has been a trend over the past couple of decades for increasing subspecialization within ophthalmology. According to residency matching data, in 2019, 68 percent of graduating ophthalmology residents pursued subspecialty training compared with 34 percent in 1996.²

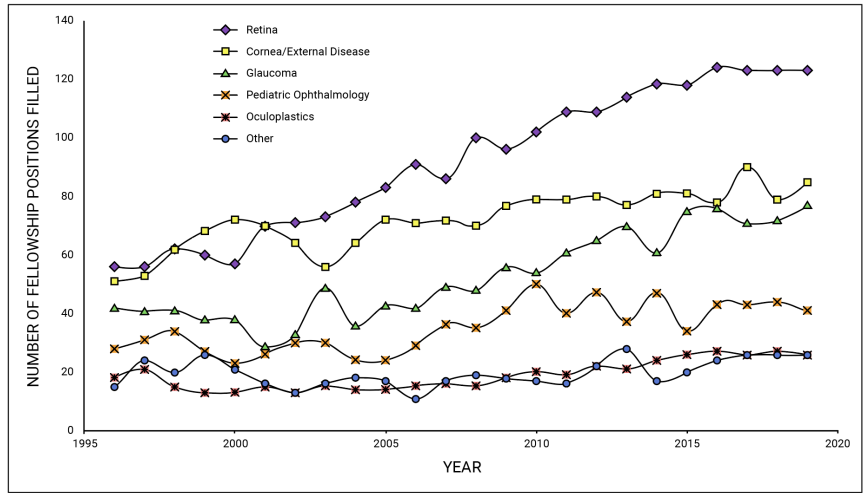
There are a few reasons for this. “One is the sheer explosion of medical knowledge. I remember reading a statistic that the body of medical knowledge doubled every 73 days in the year 2020,” Dr. Gedde notes. “Whether or not that number is exact, the underlying point stands: the pace of new information is staggering. It’s increasingly difficult for a generalist to feel confident covering the entire scope of a specialty. Subspecialization allows people to focus deeply and stay current in a narrower domain.”

However, this growth hasn’t been uniform across the board. “Some subspecialties—like retina or cornea—continue to attract large numbers of trainees, while others, notably pediatric ophthalmology and neuro-ophthalmology, are struggling to recruit enough new specialists,” he continues. “That imbalance poses a real challenge, especially as demand in those areas grows.”



Pediatric ophthalmology is often viewed as a less-desirable subspecialty, with residents citing concerns about compensation and managing parents as well as children. Photo: Getty Images.

Dr. Repka says these less popular subspecialties are trying to actively recruit and generate interest. “Pediatric ophthalmology, uveitis and neuro-ophthalmology, in addition to ocular pathology, have each launched an active recruitment campaign aimed at connecting with medical students and early residents to generate interest before they commit to other fields such as retina, glaucoma, comprehensive ophthalmology or cornea,” he says. “These efforts are focused on developing awareness. None of these groups needs to dominate the match; they only need a small increase in interest. The goal is to show that there are subspecialties within ophthalmology that may appeal to individuals even if other parts of the field are less attractive to them.”



Subspecialties that involve high-volume surgery opportunities, such as retina, have become more popular due to their earning potential. (Gedde SJ, et al.)

Many have wondered why certain subspecialties aren't as

appealing. “When I interview physicians, I often ask if there’s anything they don’t want to do in practice,” says Ms. Maher. “The number one answer is pediatrics. It’s more challenging—you’re not only seeing the patient but also the parents, so it’s almost like having two patients. On top of that, it’s the least paid subspecialty in ophthalmology. Reimbursement and compensation are the lowest. Because pediatric fellowships have been open and less desirable, many have been filled by international physicians. Now that’s becoming more difficult due to immigration challenges. It’s very disappointing, and it’s not talked about enough.”

Dr. Gedde explored this topic more thoroughly in his American Ophthalmological Society thesis. Published in 2022, he surveyed newly practicing ophthalmologists to find out why residents take certain career paths and if personality or lifestyle are contributing factors. “The final questionnaire was distributed through the AAO to over 2,000 newly practicing ophthalmologists. The response rate was around 32 percent, which is actually quite good for a physician survey—especially considering that doctors, as a group, are notoriously poor at completing questionnaires,” he says. “In total, we received close to 700 responses, enough to meaningfully compare groups—by gender, practice setting (academic vs. private) and subspecialty. The resulting data provided a fascinating look into the forces shaping how people choose and sustain their careers in ophthalmology.”

According to his findings, a higher proportion of female respondents entered academics than male respondents (36 percent vs. 26 percent, $p=0.009$). Female and male respondents pursued fellowship training with similar frequency (64 percent vs. 68 percent, $p=0.32$), but men were more likely to seek vitreoretinal fellowships (30 percent vs. 11 percent, $p<0.001$) and women were more likely to undertake fellowships in pediatric ophthalmology (21 percent vs. 8 percent, $p<0.001$), uveitis (10 percent vs. 2 percent, $p=0.002$) and neuro-ophthalmology (6 percent vs. 2 percent, $p=0.042$).²

Those we spoke with feel that compensation may play a significant role in choosing a subspecialty. “For the young doctors I interview, compensation is important, mainly because of their student loans,” says Ms. Maher. “Some overfocus on the starting salary without considering long-term potential. In many cases, compensation changes to a

percentage of production after two years. They don't always look ahead at what the opportunity could grow into, so hiring practices need to show them the potential."

"Subspecialties that involve high-volume surgical procedures—such as retina or refractive surgery—tend to offer higher earning potential," Dr. Gedde says. "Pediatric and neuro-ophthalmology, in contrast, are less procedure-heavy, which translates to lower average compensation. Second, these fields can involve more complex or time-consuming patient care. Pediatric ophthalmology requires extraordinary patience and communication skills—not just with the child, but with the family. Neuro-ophthalmology often involves lengthy diagnostic workups and coordination with other specialties like neurology and radiology. The intellectual rewards are huge, but the pace and reimbursement models don't always align with the financial or lifestyle priorities of many trainees."

Dr. Piracha agrees that compensation matters, but the reality doesn't always match assumptions. "I'm fellowship-trained in cornea and refractive surgery. It used to be that if a patient needed a corneal transplant—for conditions like Fuchs' dystrophy or keratoconus—it was straightforward. You did the surgery, the physician and facility were both reimbursed fairly, and the tissue costs were covered separately," he says. "Now, reimbursement structures have changed dramatically. Corneal procedures are bundled, meaning the surgery and tissue costs are paid as one combined fee. The problem is that donor tissue can cost around \$4,000, but total reimbursement might only be \$3,000. That means you actually lose money on every transplant."

"Many younger ophthalmologists who trained in cornea are now doing other types of work to stay financially viable," continues Dr. Piracha. "The same thing is happening in pediatric and neuro-ophthalmology. Reimbursements for their core services are so low that these fields are becoming less appealing. Doctors can't pay off student debt or maintain their practices if they can't cover basic overhead. So, in effect, the system is 'selecting out' these specialties. Fewer people are going into them, and those who do often can't sustain a long-term career without supplementing with higher-paying work."

Despite this, ophthalmology remains highly competitive.

“We’re about to enter match season, with the fellowship match occurring in December and residency matches in February,” Dr. Gedde says. “Every academic institution—including ours—is currently in the midst of interviews. The caliber of applicants is extraordinary; there are always far more qualified candidates than available positions. But that creates an interesting paradox. If ophthalmology is so competitive, and if we’re attracting such high-quality people, then why are we facing projected workforce shortages?”

Residency expansion is something often brought up in the context of shortages, he continues. “The short answer is that residency expansion is constrained by multiple forces—most of them structural, not philosophical. The problem is that the number of medical students has grown dramatically since then, but the number of funded residency slots hasn’t kept pace. So while the demand for training has increased, the funding mechanism hasn’t evolved to support that growth. Institutions can sometimes add positions by funding them internally—through their own hospitals, health systems or philanthropic support—but that’s a major financial commitment.

“Remember, each additional resident isn’t just a salary expense,” continues Dr. Gedde. “You also need the infrastructure: faculty supervision; operating room time; clinical volume; and administrative support. You can’t just add residents without ensuring the educational experience remains robust and accredited. Ophthalmology training depends heavily on surgical exposure. Residents need to reach a certain minimum number of cases to graduate with competency and confidence. If you increase the number of residents without increasing surgical opportunities, you dilute the experience. That’s something program directors are always conscious of.”

Dr. Repka says ophthalmology residencies have increased by almost 100 positions in the last decade. “Chairs and facilities are looking closely at that issue,” he says. “We’re also examining medical schools that don’t currently have ophthalmology departments or residency programs. Some of those schools may be excellent places to expand training opportunities.”

Cultural Changes

Career choices, no matter the type of work, are increasingly influenced by lifestyle. The term “controllable lifestyle” was first introduced in 1989 in a study of graduates from the University of Kentucky College of Medicine.³ This term applied to specialties that allowed physicians to control the balance of work hours with adequate personal time.

Anesthesiology, dermatology, emergency medicine and ophthalmology were among the top identified as controllable. Subsequent studies have led to the acronym “E-ROAD” for emergency medicine, radiology, ophthalmology, anesthesiology and dermatology, says Dr. Gedde.

“I also recruit for optometrists, and when they move from retail to ophthalmology, they’re thrilled—no evenings, no weekends,” Ms. Maher says. “Ophthalmology is an incredible specialty for working parents because they have evenings and weekends with their families.”

This has introduced a generational shift of sorts, bringing different values and expectations to medicine, which may introduce controversy between the baby boomers and millennials and Generation Z.

“The baby boomers were, broadly speaking, extremely dedicated and work-focused,” Dr. Gedde says. “They often equated professional identity with long hours and personal sacrifice. Millennials, by contrast, are much more attuned to issues like mental health, flexibility and personal fulfillment. They’re not less hardworking—they’re just more intentional about how they allocate their energy. They want to be excellent physicians and have meaningful lives outside of medicine. That’s a healthy evolution.

“I’ve seen that shift firsthand in residency and fellowship interviews,” he continues. “Applicants now routinely ask about wellness programs, parental leave policies and mentorship culture. Twenty years ago, those questions were rare. Today, they’re completely normal—and I think that’s progress. Institutions that ignore those priorities will find it harder to attract and retain top talent.”

In his experience, Dr. Piracha says the older generation—physicians in their 60s and 70s—traditionally put work first. “You stayed late, saw every patient and never questioned it,” he says. “I’m 55, and I’d say I’m somewhere between that old-school mentality and the newer generation’s emphasis

on work-life balance.”

The demographics of ophthalmologists are also influencing these shifts, namely the increased proportion of women entering the field, as well as those who are working beyond retirement age.

“The average ophthalmologist today is significantly older than in decades past,” Dr. Gedde says. “There are several reasons for that. For one, many ophthalmologists truly enjoy what they do and want to continue working. Ophthalmology is a rewarding field—you restore sight, relieve suffering and have strong long-term patient relationships—so a lot of people simply aren’t eager to retire.

“Those who own private practices also have the flexibility to determine their own retirement timelines since there’s no mandatory retirement age,” he continues. “And as I mentioned earlier, because more ophthalmologists now complete fellowship training, they enter the workforce later—so it’s logical that they also retire later.”

It’s impossible to ignore the impact gender has on the path and priorities of ophthalmologists. In 2019, for the first time, more women than men entered medical school in the United States, according to Dr. Gedde. “That was a pivotal moment, marking a demographic shift that’s continuing to reshape ophthalmology and many other specialties.”

In his research, Dr. Gedde found female ophthalmologists were more likely to select a career in academics than their male counterparts.² Female respondents were less likely to have children during training compared with male respondents and their career decision-making was more influenced by geographic location and work hours than males. Dr. Gedde and his fellow researchers also observed gender differences in the subspecialty areas that were selected. According to the paper, “Men were more likely to complete a fellowship in vitreoretinal disease and surgery, and women were more likely to pursue fellowships in pediatric ophthalmology, neuro-ophthalmology and uveitis. A higher proportion of female respondents practiced pediatric ophthalmology, and males more often focused on vitreoretinal disease and surgery, medical retina and anterior segment.”²

“This change is overwhelmingly positive—diversity

strengthens any field—but it also brings new considerations about work structure and flexibility,” he says.

For physicians with families, especially young children, it’s understandably more difficult to work long or irregular hours, notes Dr. Piracha. “That’s true in every industry, not just medicine. Even though men are more involved with parenting now than in previous generations, women still tend to carry more of that responsibility, which affects availability and work hours,” he says.

Ms. Maher says she doesn’t see this as a men vs. women issue. “Honestly, I don’t see a big difference between men and women in that regard,” she says. “I get requests for four-day workweeks and parental leave from both. But I’ll be frank—medical practices have been way behind in offering maternity and paternity leave. This isn’t a new issue. It should have been addressed decades ago. Practices are behind. I have both male and female ophthalmologists delaying start dates so they can spend time with a new baby. So, this isn’t just a maternity issue—it’s a paternity issue.”

“I think it’s critical that mothers—and all physicians, really—have the flexibility to balance work and family,” Dr. Piracha says. “It shouldn’t have to be an either/or choice. If the system doesn’t allow that balance, it’s not fair to individuals or to society. We need structures that support both professional excellence and personal well-being.”

Although some physicians still work as many hours as their predecessors did, it should no longer be considered the norm. “When physicians prioritize balance, they need better support in the office and operating room so that everything runs efficiently and they can be as productive as possible within the hours they choose to work—whether or not they have families,” says Dr. Repka. “We all have to recognize that reality. Even my generation experienced change; residents used to practically live in the hospital, but that’s no longer the case.”

Finding Solutions

The sources we spoke with say there are a variety of strategies that may help reduce the burdens of the shortages.

Among the most commonly mentioned is the optimization of team-based care, including more involvement from optometrists.

“Collaboration, when done correctly, is absolutely essential,” says Dr. Gedde. “I’ve always believed that ophthalmologists and optometrists share a common mission: preserving and improving vision for our patients. The key is ensuring that each professional practices within their appropriate scope of training and expertise.

“In many settings, optometrists already manage routine eye exams, contact lens fittings and stable chronic conditions like mild glaucoma or diabetic retinopathy,” he continues. “That allows ophthalmologists to focus on surgical and complex cases. The key is to balance these roles effectively while maintaining quality and safety. Collaboration, not competition, is what really benefits patients.”

“I actually think most practices should be MD–OD practices,” adds Ms. Maher. “Ophthalmologists need optometrists. It can be a great partnership if handled properly—if optometrists are treated as part of the medical team. When that happens, the practice can run very successfully. I’d estimate that about 70 to 75 percent of ophthalmology practices now have integrated optometrists, with varying degrees of success. Many solo ophthalmologists are doing this because they can’t afford another physician’s salary or can’t find a young ophthalmologist interested in joining a solo practice.”

An abstract presented at the 2025 ARVO Annual Meeting in Salt Lake City presented the long-term clinical outcomes of patients with glaucoma co-managed by glaucoma-trained optometrists and glaucoma specialists at a single tertiary care center.⁴ Over five years of follow-up, patients in a co-management system maintained stable glaucoma status and the model reduced the visit burden for glaucoma specialists, with few patients requiring treatment escalation.

“Working side by side with optometrists is a good thing,” Dr. Repka says. “Team-based care has long been an advocacy goal of the Academy. We recognize that optometrists provide an important service, performing much of the primary eye care that patients need.”

Hiring quality staff will also help ensure better efficiency for

ophthalmologists as the patient load increases. Dr. Piracha says this isn't an area to cut corners. "Ophthalmology isn't like many other fields. Staff need specialized knowledge—familiarity with complex diagnostic equipment, an understanding of eye conditions and attention to small details that affect patient outcomes," he says. "For example, my brother is a cardiologist, and in his office the workup process is straightforward: check vital signs, review reports and maybe order additional tests like an echocardiogram. In ophthalmology, however, most testing happens right in the office. That means staff accuracy directly affects both the doctor's workflow and the patient's experience.

"Previously, when I worked with less experienced staff, I noticed more errors and unreliable measurements," he continues. "Sometimes data didn't add up, but new staff didn't recognize the problem. For instance, if an IOLMaster measurement showed a discrepancy between two eyes because one was dry, an experienced technician would immediately recognize the issue and retake the measurement. A newer staff member might not. That impacted the quality of data, the accuracy of our decisions and ultimately the level of trust we could place in our testing."

It also increased his stress level. "When I can't fully trust the measurements, I have to double-check everything before surgery. In contrast, when I work with an experienced team, I know the data are reliable and can focus entirely on the surgery itself," Dr. Piracha says.

"In my current physician-owned practice, which has been established for over 40 years, we emphasize stability, safety, integrity and accuracy," he continues. "Those values are central to how we operate. We're very frugal when it comes to overhead expenses, such as supplies, contracts and efficiency improvements, but the one area where we deliberately spend more than our benchmarks is staff compensation. We pay our staff in roughly the top 10 percent of the market because we recognize their value. Retaining skilled employees saves money in the long run by reducing retraining costs, ensuring accuracy and maintaining consistent performance."

Although salary is a highly motivating and attractive aspect of any job, it's not the only thing that can attract talent.

“A few years ago, I gave a talk at a residency program,” Ms. Maher recalls. “One of the attendings asked the residents what they were most fearful about after finishing their program. Seventy percent said they were most fearful about seeing patients on their own. And this was a great program—it wasn’t the training. I think part of it is that ophthalmology is such a high-tech specialty, with constant advances in technology and procedures. These young doctors want to join a practice where they have that expertise and support from subspecialists.”

Dr. Gedde says early exposure to the subspecialties facing the biggest challenges could make a difference. “When residents or even medical students have positive early experiences with pediatric or neuro-ophthalmology mentors, they’re much more likely to consider those paths,” he says. “We also need to look at reimbursement reform and institutional support—finding ways to ensure these subspecialties are financially sustainable and valued within academic and clinical settings.”

Another strategy is creative hybridization. “For example, some physicians combine pediatric ophthalmology with strabismus or oculoplastics; others merge neuro-ophthalmology with comprehensive practice,” he continues. “These blended models can make the career path more appealing while still meeting clinical demand.”

Seeing a future opportunity for ownership could also motivate talented ophthalmologists. “If a doctor wants a specific location and the only options are private equity-owned, an independent practice might stand out,” Ms. Maher says. “I’m also seeing a small resurgence of young ophthalmologists wanting to own their own practice, either by building it or taking over an existing one. That entrepreneurial mindset is making a quiet comeback.

“Most, however, still prefer medium to large practices with multiple subspecialists and a path to partnership,” she continues. “But partnership means something different now than it did 20 or 30 years ago. Back then, physicians built practices through blood, sweat and tears. Now, younger doctors want some piece of ownership, even if it’s a small piece of the pie.”

Underrepresented areas will continue to need attention, say our sources. “Rural and very urban areas have always been

underrepresented,” says Dr. Repka. “That’s been consistent for as long as I’ve followed manpower surveys. To attract physicians to those settings, we have to make them more appealing. Incentives may be necessary, such as loan relief or differential compensation for caring for patients who are more likely to be underinsured or uninsured. Many physicians still want to help those patients despite the financial challenges.”

Dr. Gedde says the field needs to think more creatively about workforce diversity and distribution. “Some communities—particularly rural or economically disadvantaged ones—struggle to attract ophthalmologists,” he says. “It’s not just about how many ophthalmologists exist nationally, but where they choose to practice. Physicians who are underrepresented in medicine are more likely to practice in underserved areas. Unfortunately, ophthalmology is a specialty with one of the lowest proportions of URiM groups. Improving recruitment of URiM ophthalmologists, or creating incentives to practice in underserved communities, could make a huge difference.”

There’s a good deal of hope in technological solutions as well. Just as telehealth saw an uptick during the pandemic, many think these advancements could help fill the widening gaps.

“I think technology is going to play a transformative role, and ophthalmology is uniquely positioned to benefit from it,” says Dr. Gedde. “We’re a very technology-forward specialty to begin with—imaging, diagnostics and surgical precision are all central to what we do. So, in many ways, we’ve been preparing for this next wave for decades.”

Even if it hasn’t completely solved the existing problem, physicians say the technology needs time to improve. “We initially expected automation to significantly increase efficiency, but it hasn’t fully delivered yet,” Dr. Piracha shares. “However, I still believe we’ll see that progress. As technology improves, we’ll get faster, more accurate measurements and more efficient check-in and data collection processes. Once these steps become more automated—replacing paper forms with digital systems—we’ll be able to handle more patients without adding physicians.”

AI is already making inroads in areas like disease detection

and triage, says Dr. Gedde. “That doesn’t replace the ophthalmologist—it complements our work by identifying which patients need to be seen most urgently.”

Drs. Gedde, Piracha, Repka and Ms. Maher have no relevant disclosures.

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