Tailoring the Presbyopic Consultation

Strategies for an effective preoperative interview.

BY FRANK A. BUCCI, JR, MD

A typical, high-volume cataract practice efficiently "moves" information about the surgical experience from the practice (eg, the doctor) to the patients. Brochures, videos, and surgical counselors educate patients about their upcoming surgery in an effort to decrease their anxiety and the doctor's chair time. Combining high-quality cataract surgery with efficient patient flow in both the clinic and ambulatory surgery center will lead to excellent outcomes, high patient satisfaction, and economic prosperity.

The Centers for Medicare & Medicaid Services' ruling in 2005 introduced a new option for cataract surgeons and patients—multifocal/accommodating or presbyopia-correcting IOLs. Each cataract patient (by paying an additional fee) can upgrade to a premium IOL that can reduce or eliminate his need for reading glasses. According to recent unpublished surveys, high-volume cataract surgeons have reported increased chair time when having to discuss premium IOLs with cataract patients, which has resulted in disappointing conversion rates. The typical response of these successful cataract practices is to perform more of what they do well: transferring information from the practice to the doctor. They think patients need more high-quality information to make quicker definitive decisions. What results from intensifying the transfer of information from the practice to the patient? Frustration! The increased exchange of information amplifies patients' inquiries, which results in more chair time for the surgeon.

COMMUNICATING WITH THE PATIENT

The premium IOL component of the doctor/patient relationship introduces a new paradigm—elective surgery—in which the pathology/cataract model will fail. In the new model of elective IOL surgery, the quality of the preoperative decision making is directly related to, and dependent upon, the amount of valuable information communicated by the patient to the doctor. This can only occur if the doctor improves the quality of the doctor/patient relationship. The surgeon must educate himself as to who the patient really is and what he actually wants to achieve. Open-ended questions that elicit spontaneous patient responses from the patient, in combination with improved listening and observational skills, are the first steps toward acquiring the necessary knowledge for proper patient selection. The patient will give the surgeon all the information he needs, which should be combined with a thorough examination. Then, based on the surgeon's professional opinion, a definite recommendation to the patient is made as to what procedure will result in successful outcomes. Surgeons should not ask the patient to decide but rather lead him to the best alternatives based on what he has revealed during the preoperative consultation and examination.

WHAT TO LOOK FOR DURING THE PREOPERATIVE CONSULTATION

Some of the obvious characteristics that surgeons learn about during the preoperative interview include the patient's expectations (personality), visual function and demands, and economic and refractive status. The two most interesting and revealing characteristics are the patient's lenticular status (cataract vs clear lens) and his purpose for the consultation.

LENS CHOICE

The lens' status will frequently divide potential patients into subcategories based on age and culture. Lensectomy and younger cataract patients (baby boomers) are generally more demanding. They will compare their postoperative vision with their excellent preoperative corrected vision. The inherent visual improvement that comes with all cataract surgeries makes the entire process more forgiving in typical cataract patients. These older patients are more accepting by culture, have paid less, perform fewer demanding visual tasks, and are not as litigious as baby boomers.

REASONS FOR A CONSULTATION

The patient's purpose for the consultation may be the most revealing characteristic of a surgical candidate. Surgeons need to ask why is the patient seeking an evaluation. Is he pursuing the diagnosis and treatment for pathol-

ogy (cataract), or is he seeking spectacle independence? Even if the prospective patients were identical twins with identical examinations, the distinctly different intentions or purposes for the consultation cause a significant divergence in the course of the preoperative consultations.

Those seeking treatment for a possible cataract have little or no awareness of refractive options. Those seeking spectacle independence are usually very educated by the media, seminars, the Internet, word of mouth, or optometric consultations regarding their refractive options. If the patient who is concerned about having a cataract is told that one is not present, he is delighted and returns home telling his family that he does not need to undergo surgery. If the patient seeking spectacle independence is told he does not have a cataract, he is extremely upset that he has missed out on the potentially large discount for his presbyopia-correcting IOL.

If the pathology-minded patient is told that he does have a cataract, it may be initially difficult to efficiently present all the refractive options and economic realities. I implement what I call the *three core questions*. The answers to these questions quickly elevate the surgeon to a new level of awareness about his patient.

Surgeons need to ask the patient if he has any interest in achieving spectacle independence. Would he be willing to tolerate some light phenomena while driving at night to achieve this freedom? Would he be willing to pay something out of pocket to achieve this increased freedom from glasses? If the answer to the first question is no, the patient will likely receive an insurance-covered monofocal IOL (with or without monovision) at the time of surgery. If the sequence of answers is yes, yes, no, surgeons should then offer what I call the *opportunity*. The surgeon informs the patient that many presbyopes with bifocals who do not have cataracts will pay in excess of $4,000 per eye to achieve spectacle-free vision. Because he has cataracts, however, he will pay less than $2,000 per eye to attain the same visual results. Surgeons should not directly compare the cost of upgrading to a premium IOL to the free IOL that is provided by a patient's health insurance. If the patient's sequence of answers is yes, yes, yes, he will eventually choose an aspheric, toric, or presbyopia-correcting IOL.

If patients seeking spectacle independence does not have a cataract, surgeons then need to distinguish between the emmetropes and the non-emmetropes. If the patient is a non-emmetrope, will he undergo LASIK or a refractive lens? I start the differentiating process with the one fundamental question: if I perform customized LASIK to give a patient excellent distance vision with a need for reading glasses postoperatively, will that still make him happy? If I receive a strong yes from the patient, I will perform LASIK. If I receive a strong no, then I will discuss the essential aspects of refractive lens exchange with the patient and likely perform that procedure. If the patient responds with a weak yes or no, a discussion of the pros and cons of each procedure in a balanced fashion will commence. Surgeons should watch patients' body language and listen to their responses. Patients will lead the surgeon to decide which procedure is best for them. Quickly manipulating the patient into having a particular procedure is not recommended. Through a respectful exchange with the patient, by offering information and listening to his responses, surgeons can seek and perceive the truth about the patient. Who is he and what does he really want to achieve? The quality of surgeons' decision making will escalate the more they get to know the patient.

If the patient is an emmetropic presbyope, the surgeon's approach changes significantly, because this type of patient already has relatively good uncorrected distance vision. I strongly counsel down his expectations and explain that I am very respectful and cautious about performing intraocular surgery in patients with 20/20 uncorrected distance vision. I explain to the patient that, if he can fully grasp the high-risk profile of this surgery, I might offer him a presbyopia-correcting IOL in his nondominant eye, and I will likely require a significant period (months) of neuroadaptation after the patient's first eye surgery before I considering surgery in his second eye. I discuss every possible complication. After offering him the procedure in one eye, I then begin to withdraw the offer. I do this so I can closely observe the patient's reaction, which will reveal his true demand for spectacle independence. In my opinion, a strong, sincere desire to be free of glasses, versusany other patient characteristic, has the greatest correlation with postoperative success when implanting multifocal IOLs.

CONCLUSION

The new paradigm of elective IOL surgery demands that surgeons facilitate a genuine doctor/patient relationship. Three core questions, the opportunity, and the one fundamental question are only tools for stimulating the patient so surgeons can observe, listen to, and learn from patients. The basic underlying principle of this approach is that, if surgeons choose to listen to their patients, they will give surgeons the answers. ■

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