Mastering Preoperative Interviews

If you choose to listen to your patients, they will give you the answers.

BY FRANK A. BUCCI, JR, MD

The typical large-volume cataract practice is usually efficient at educating patients about what to expect during cataract surgery. Surgical counselors distribute informative brochures and videos and talk to patients about their upcoming surgery in an effort to decrease their anxiety and, by extension, the doctor's chair time. Combining high-quality cataract surgery with efficient patient flow in both the clinic and ambulatory surgical center has traditionally resulted in excellent outcomes, high patient satisfaction, and economic prosperity for the practice.

THE NEW PARADIGM

The landscape of cataract surgery is changing, however. The reimbursement ruling by the Centers for Medicare and Medicaid in 2005 introduced new treatment options for cataract surgeons to offer their patients: multifocal or presbyopia-correcting IOLs (also called *premium refractive IOLs*). Every cataract patient may now upgrade to a premium refractive IOL that can reduce or eliminate his need for reading glasses if he is willing to pay out of pocket for it. High-volume cataract surgeons are experiencing greater chair time yet disappointing conversion rates with cataract patients when discussing premium refractive IOLs. Typically, these efficient, successful cataract practices respond to this problem by doing more of what they do well. They assume that their patients need more and higher-quality information about these treatment options in order to make definitive decisions quicker, so they provide new and greater quantities of information about presbyopic IOLs "so the patient can decide."

What results from intensifying the transfer of information from the practice to the patient? Frustration. The conversion rates to premium refractive IOLs remain poor. Giving patients more information only serves to confuse them further, thus increasing the number of questions they have and lengthening their surgeon's chair time. In addition, surgeons are surprised when the extra chair time fails to prevent excessive complaining by premium refractive IOL patients about issues that were discussed, such as halos.

What accounts for these challenges of premium refractive IOLs that are frustrating physicians? This treatment category introduces a new paradigm in cataract surgery—one of elective surgery. Within this new doctor/patient relationship, the pathology/cataract model fails. In the paradigm of elective IOL surgery, the quality of the surgeon's preoperative decision making is directly related to and depends on the amount of valuable information moving not from the practice to the patient, but from the patient to the doctor.

IMPROVING INTERACTION

The surgeon can only glean valuable information from his patient if he improves the quality of the doctor/patient relationship. He must educate himself as to who the patient really is and what this person wants to achieve. There are two important first steps toward acquiring the information necessary for engaging in proper patient selection. The first is asking patients open-ended questions that elicit spontaneous responses, and the second step is improving one's listening and observational skills. The patient will give you all the information you need to know—if you will let him. Combine this information with a thorough preoperative examination, and then make a definitive treatment recommendation to the patient that will lead to the high-

est levels of success based on your professional opinion. Do not ask the patient to decide about the details of his treatment; instead, lead him to the best alternatives based on the history he has revealed about himself in the preoperative consultation and examination.

FINER POINTS OF THE PREOPERATIVE INTERVIEW

Important Questions to Ask

Some of the obvious characteristics patients divulge in their preoperative interviews include their visual expectations (personality), visual demands (lifestyle), visual function, refractive status, and economic status. The two most interesting and revealing questions, however, are the patient's lens status (a cataractous vs clear lens) and his "purpose for the consultation."

Lenticular status frequently divides potential refractive IOL patients into subcategories based on age and culture (Table 1). Lensectomy and younger cataract patients (baby boomers) are generally more demanding. They will compare their postimplantation vision with their excellent preoperative corrected vision. The inherent visual improvement that comes with all cataract surgery makes the entire process more forgiving when cataracts are removed in elderly individuals. These older patients are more accepting by culture, have paid less for the procedure, perform less demanding visual tasks, and in general, are less exacting and less litigious.

The "purpose for the consultation" may be the most revealing answer a surgical candidate can give. We need simply to ask why the patient is seeking an evaluation. Is he pursuing a diagnosis and treatment for pathology (cataract), or is he seeking spectacle independence? Even if the prospective patients were identical twins with identical examinations upon presentation, any difference in their reason for consulting a surgeon causes a significant divergence in the course of the preoperative examination.

Patients 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 no cataract is present, he is delighted and returns home telling his family that he does not need "that growth" removed from his eye. 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 a presbyopia-correcting IOL.

If Cataract Is Present

If the pathology-minded patient is told that he has a cataract, it may be initially difficult to efficiently and effectively present all the refractive options and economic realities. With these patients, I implement what I call the *three core questions.* The answers to these questions are either "yes" or "no" and quickly elevate you, the surgeon, to a new level of awareness about the patient.

TABLE 1. CHARACTERISTICS OF POTENTIAL PATIENTS

Cataract	Lensectomy
• Late 60s, 70s, 80s	• 40s, 50s, and early 60s
• "Brokaw cataract" WWII	• "Boomer cataract" & clear lens
• Accepting by culture	• Demanding by culture
• Poor corrected preop VA	• Excellent corrected preop VA
• Reasonable expectations	• High expectations
• Pay less - expect less	• Pay more - expect more
• Less litigious	• More litigious
• Less computer	• More computer

1. Do you have any interest in achieving spectacle independence?
2. Would you be willing to tolerate some light phenomena while driving at night to achieve this freedom?
3. Would you be willing to pay an amount out of pocket to achieve this increased freedom from glasses?

If the answer to the first question is "no," then I will likely implant the patient with a monofocal IOL (with or without monovision) that is covered by insurance. If the sequence of answers is yes-yes-no, then we offer what I call *the opportunity*. We inform the patient that many presbyopes who wear bifocals but do not have cataracts pay in excess of $4,000 per eye to be free of their glasses. Because the patient has cataracts, however, he will pay less than $2,000 per eye to achieve the same outcome. We are careful not to directly compare the cost of upgrading to a premium IOL to the "free" IOL that comes with his health insurance. If the candidate's sequence of answers is yes-yes-yes, he will eventually choose a premium IOL.

If Cataract Is Not Present

If the patient seeking spectacle independence does not have a cataract, we then need to distinguish the emmetropes from the nonemmetropes. *If the patient is not an emmetrope, will he undergo LASIK or a refractive lensectomy?* I begin the differentiating process with the one fundamental question: "*If we use customized LASIK to give you excellent distance vision, and all you need is reading glasses after surgery, will that make you happy?*" If I receive a strong "yes," I perform LASIK. If I receive a strong "no," I discuss the essential aspects of refractive lens exchange with the patient and often end up performing that procedure. If I hear a weak "yes" or weak "no," I begin to discuss the pros and cons of each procedure in a balanced fashion. I watch and listen to the responses. Patients will lead you to an

awareness of which procedure is best for them. Do not quickly manipulate the patient into having a particular procedure—you will get burned. I advocate a respectful exchange with patients by offering information, listening to their responses, and seeking to perceive the "truth" about their needs. *Who is this individual and what does he really want to achieve?* With practice, the quality of your decision making will escalate. When you decide that you have enough valuable information and you are aware of which treatment option is best for the patient, then proceed to lead him in a balanced manner to the procedure that you have determined will best satisfy him.

Strategy With Emmetropic Presbyopes

If the patient is an emmetropic presbyope, my approach changes significantly. Because these patients already have relatively good uncorrected distance acuity, they are more difficult to please. I strongly "counsel down" their expectations. I tell them that I am very respectful and cautious about performing intraocular surgery in patients with 20/20 uncorrected distance vision. I explain that if they can fully appreciate the high-risk profile of this surgery, I might offer them a presbyopia-correcting IOL in their nondominant eye, and I will likely require a significant period (months) of neuroadaptation after their first implantation before even considering surgery in their second eye. I discuss every possible complication. After offering the procedure in one eye, I then begin to withdraw this offer. I closely observe the patient's reaction, which will reveal his true desire for spectacle independence. In my opinion, a strong, sincere desire for spectacle independence has the greatest correlation with postoperative success when implanting multifocal IOLs than any other patient characteristic.

CONCLUSION

The new paradigm of elective implant surgery demands that surgeons facilitate a genuine doctor/patient relationship. The *three core questions*, *the opportunity*, and the *one fundamental question* are only tools I use for stimulating patients so I can then observe, listen to, and learn from their elicited response. The basic underlying principle of my approach is that if you choose to listen to your patients, they will give you the answers. ■

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