Best Practices

in Integrated Care

CRST
Cataract & Refractive Surgery Today

Volume 2, No. 8

BAUSCH + LOMB

Best Practices in Integrated Care

This ongoing series, now in its second year, is featured in each issue of *AOC* and its sister publication, *CRST*. The articles will clarify how eye care providers can best work together to provide patient-centered care of the highest quality possible.

STARTING WITH THE BASICS: HOW TO IMPROVE THE EFFECTIVENESS OF PATIENT EDUCATION

A team approach can help to ensure patients are not overwhelmed with details.

BY RYAN CORTE, OD

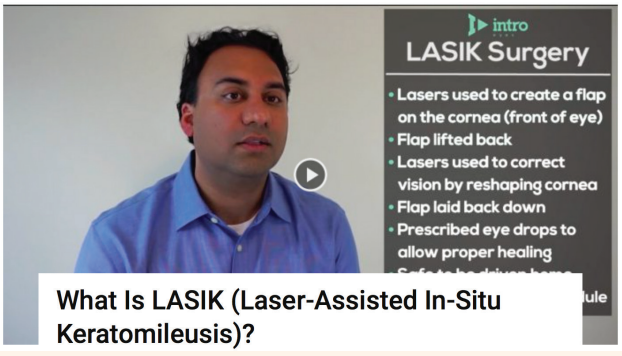
Education is an important aspect of what eye care professionals do when interacting with patients. Yet many seem to struggle with this fundamental aspect of delivering quality care. Perhaps one reason is we needlessly overcomplicate the approach to delivering education by overestimating what our patients know when they come through our office doors.

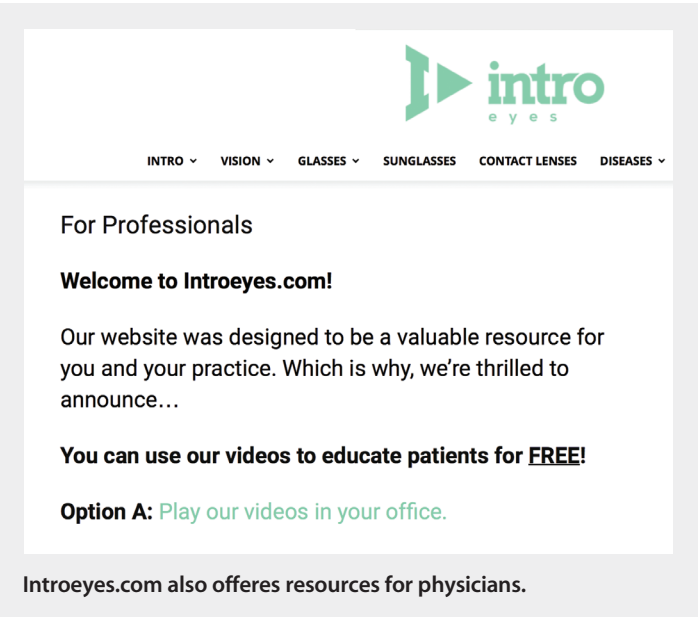
BACK TO BASICS

A few years ago, as I surveyed the landscape of online video-based ocular health resources that I could provide my patients, I quickly realized there was a disconcerting lack of quality educational videos available for public consumption. I recently decided to do something about that by starting the website Introeyes.com (*see next page*). My vision was that our videos would house good, basic, elementary education about the eye

INTROEYES.COM

SURGERY





Introeyes.com also offeres resources for physicians.

and how the services of qualified and trained eye care professionals can be beneficial. I viewed Introeyes.com as a chance to raise the level of general awareness among the public about our field and professions. My hope was that, when patients come to our clinics, we could start from a basic level of understanding and build upon it.

After recruiting a team of opticians, optometrists, and ophthalmologists, we have finally launched Introeyes.com. Although there are other websites that do an excellent job of providing the same kinds of information we do (see *Helpful Online Sources for Patient Education*), we have chosen to focus on offering concise, well-produced videos that focus on the very basics of eye care. I am particularly proud of the results, and I hope my colleagues will find the site useful.

A STRUGGLE TO EDUCATE

I get the sense that many of my colleagues struggle with educating patients. One of the themes I hear often when I talk to my peers is that they cannot seem to get patients to really understand the information they are trying to convey. I do not necessarily fault those who have difficulty with this aspect of patient care; after all, the medical conditions we describe can sometimes be the result of complex pathophysiologic mechanisms, and it has taken us years of training to understand the nature of the ocular diseases and disorders we seek to treat.

I think there is a connection between the lack of information available for public consumption and the problems my peers have explaining things to their patients. That is, there is a shortage of easily relatable and fundamental information available in the market. Therefore, when patients come into our offices, they may be starting from a point of zero understanding.

Worse, they sometimes come to our offices with misinformation digested from the internet.

Also, I sometimes wonder if many eye care practitioners are afraid to talk on a basic level to patients, and instead they load their educational sessions with jargon to make things sound more official. When we talk to patients, we probably tend to revert to the language we use when conversing with colleagues because we are comfortable with the terminology. The thing is some of this material is quite complex. The average patient needs this information conveyed at an elementary educational level. Even a patient with a doctorate in engineering could easily misunderstand the mechanics of accommodation and presbyopia.

It is not at all insulting to start basic, to "read" patients for their level of comprehension, and to ask during a conversation whether they want more details. In fact, quite the opposite: Starting by assuming the patient knows nothing and ramping up the details as appropriate respects the patient's time and provides great service in the process.

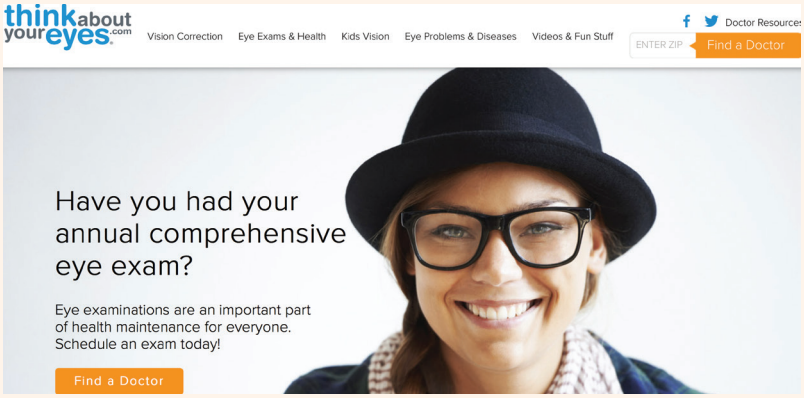
STEPWISE TEAM APPROACH TO EDUCATION

Another reason eye care professionals may struggle with patient education is if they feel a bit overwhelmed trying to cover all the information their patients may need. Instead of taking all this responsibility on oneself, it can be more effective to educate patients using a team approach. In our office, each member of our eye care team is responsible for educating patients about his or her own particular focus, as well as providing general information about what the next steps may be.

For example, patients start by filling out the standard review of symptoms form when they get to our office. Our technicians review these forms to obtain the chief complaint, but they also key in on information patients provide about their visual symptoms; each of those symptoms may be actionable information that prompts follow-through if the technician is prepared ahead of time. For example, if a patient reports that he or she has a cataract, information is provided about services we offer in our office, but the technician will also introduce the possibility of a referral for surgical evaluation.

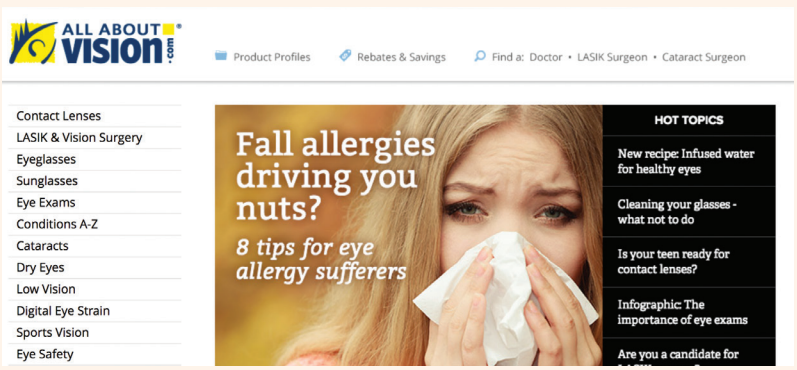
Then begins our system of handoffs. If there is

HELPFUL ONLINE SOURCES FOR PATIENT EDUCATION



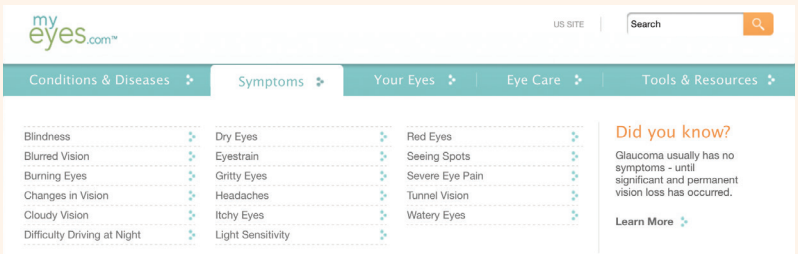
ThinkAboutYourEyes.com

Put together by the American Optometric Association, this attractive website provides a user-friendly library of articles and information that have been verified by medical professionals.



AllAboutVision.com

Online library source of articles and news. This website has been around since 2000, and its longevity is a testament to its utility.



MyEyes.com

Funded by Alcon, this site provides a nice overview of ocular diseases and disorders that patients may have questions about.

> "It can be more effective to educate patients using a team approach."

a need for eyewear consultation, our optician is called upon to lead the conversation. If a surgical consultation is required, our front office staff does an excellent job scheduling with a surgeon and letting patients know what they can expect as the next step. What I try not to do is overload my patients with too much information. This could end up either confusing them or conflicting with what he or she may learn later from the surgeon.

For the cataract patient, this means providing a starting point about the technology the surgeon may use, but, again, keeping it basic: "You may only be able to see in the distance after surgery and use some kind of reading prescription for close work," or, "You may be able to have vision that is pretty comfortable at all distances." Our sense is that overpromising about options could set a patient up with unreasonable expectations. In addition, so many variables go into intraocular lens selections that are best addressed by the surgeon directly. We want to give basic information first. And patients tend to learn more effectively when they are given digestible pieces of information in small doses. Education is cumulative.

We believe our system has other benefits as well. First, when staff members are responsible primarily for one area, they can become much more educated about their focus. It also gives each staff member a stake in the process and a feeling of engagement in the patient's overall care. Further, this arrangement helps things run more efficiently, as we limit bottlenecks that can occur as a result of protracted patient encounters.

CONCLUSION

Eye care professionals should not be afraid to get back to basics—to present information to patients under the assumption that they know absolutely nothing about the topic under discussion. There may come a time when greater public awareness about the eye and ocular health rises to such a level that we can start with more complicated topics and take a deeper dive into the nuances of the diseases and disorders patients are experiencing. Until that happens, we do a better service in educating patients if we start basic. This means giving them small nuggets of information at a time, taking a team approach to education, and providing them with resources that complement and reinforce the information we provide in the clinic.

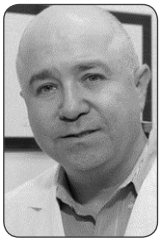
Ryan Corte, OD
- private practice at Modern Eye Care and Premier Family Eye Care in Charlotte, North Carolina
- cofounder and CEO of Introeyes.com
- cofounder of CovalentCareers.com
- drcorte@introeyes.com

Best Practices in Integrated Care

GOING BEYOND THE OBVIOUS IN PATIENT EDUCATION

Providing information to patients has intrinsic value, but it also serves to connect the provider with the patient.

BY ALAN GLAZIER, OD



As health care providers, we optometrists have an obligation to educate patients about their ocular health and the treatment options for their particular conditions. Yet there may be further benefits beyond the intrinsic value of the education itself. Patients tend to have better experiences and feel more confident in their providers when they leave an encounter knowing more than when they came in. In addition, providing good education helps patients connect with your practice and become familiar with your brand. Furthermore, having an informed patient base tends to lead to more efficient clinic operations.

Convincing eye care providers to think about patient education as a brand extension is not difficult once they realize the win-win nature of the endeavor: It is good for the patient and good for the practice. The difficulties most providers encounter lie in deciding what tools to use for patient education and learning how to use them effectively. This article details some of the methods we have found useful to offer patients the best information in the most helpful manner.

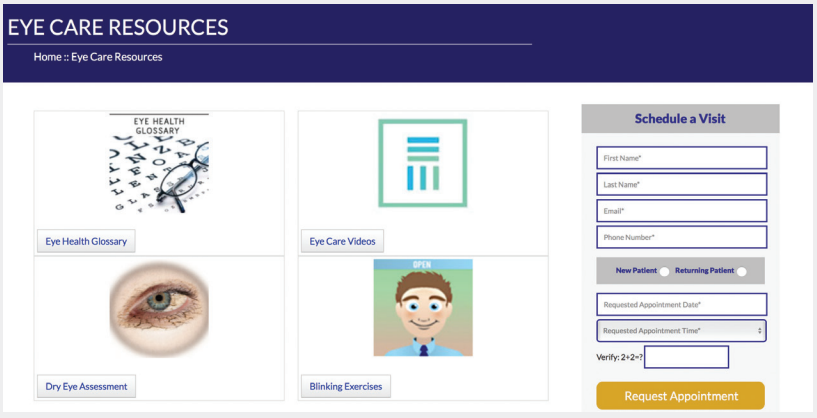


Figure 1. The practice's website is a form of passive marketing.

AN ACCURATE PORTRAYAL

In our practice, we view our website as our most natural extension to the community, a form of passive marketing (Figure 1). A website should have a look and feel that is conducive to the brand one is trying to portray; in other words, a sloppy and carelessly put together website will tell the public that your practice shares those qualities. Perception is reality, whether we like it or not.

Patients do not want to be surprised when they come through the clinic door. Your website, in addition to being a brand extension, also has to offer an honest representation of the services provided by your practice and reflect your overall practice philosophy.

In the digital era, many people are familiar with the concept of "clickbait." Some less-than-forthright content providers prompt users to click on a link based on an enticing headline, only to have the user arrive at a site that offers little in return. This practice is a variation on the old bait-and-switch technique, and it is used for the sole purpose of artificially inflating traffic to a website.

Those who fall victim to clickbait enticements feel duped and are reluctant to trust that source ever again. I mention this as an illustration of the dangers of offering patients something flashy on your website, only to have them enter your practice to find something completely different. When we are talking about ocular health, this is a subject infinitely more important than the latest angry cat meme. Therefore, the stakes are high for our websites to accurately portray what we intend to deliver.

DEALING WITH DR. GOOGLE

Also in relation to the Internet, it is worth considering the effect that our colleague Dr. Google

can have on patient education and patient relations. The Internet is a wonderful place where patients can find information on just about anything, and that can be both a very good thing and a very bad thing. Too many patients are willing to self-diagnose, and any preconceived notion can be verified using a search engine.

It has been estimated that 85% of people using the Internet use Google to look for information, and more than 150 million health care–related searches are performed every day according to Yelp's official blog and other sources. Eye care providers frequently encounter patients who enter the practice with their anticipated diagnosis already in hand, courtesy of Dr. Google. The question is, How do we address this when we encounter such a patient?

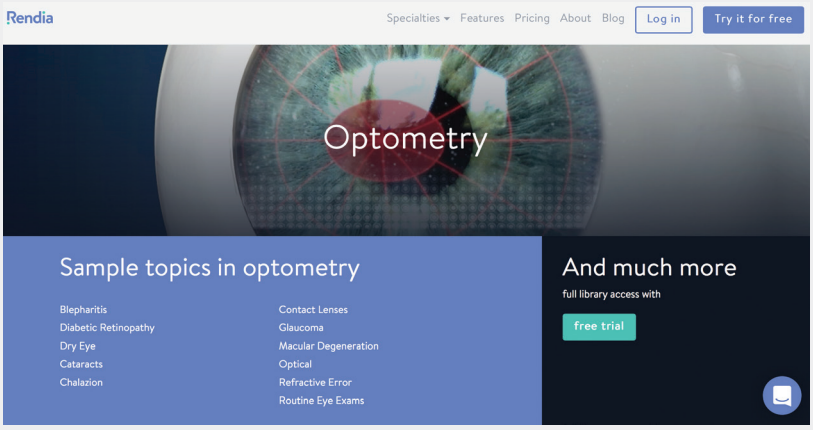


Figure 2. Video content serves as a helpful educational adjunct.

Every provider will have to figure out his or her own way to deal with this situation. I like to tackle the subject head on and to use levity to break the tension where necessary. I have developed a sense for when patients come into the practice after overusing the Internet. To break the ice, I make some comment about their having consulted Dr. Google before they consulted me. Then I try to disarm any preconceived notions by offering the patient better information.

I am not saying this approach will work for everyone. Each of us will approach the topic differently. Relating to patients is most effective when it is authentic. This simply encapsulates my approach to educating patients: I use humor to disarm and follow up by replacing misconceptions with reliable information.

EQUIPPING PATIENTS WITH GOOD RESOURCES

Anyone reading this article will relate to the scenario of the patient who comes into the office with a red eye and who is sure—absolutely convinced—that he or she has eye cancer. It can be a real drag to have to talk this patient off the ledge.

But flip the script for a second. Realize that this patient is going through a very natural process of trying to find an answer for a confounding problem. My best piece of advice when confronted with misinformation or misconception is to try to humanize the problem. Sure, it can be a time-suck to have to deal with sometimes wildly wrong assumptions. But then again, being misinformed is not a character fault. It just means the patient has not been introduced to the proper resources.

Part of providing patients with education is giving them a language they can use and understand. For example, I relate presbyopia to short-arm syndrome. I tell them that it is what their parents used to call "bifocal age." That allusion does not tell the whole story, but at least it plants a picture in the patient's mind. I can follow up on that with more information, tailored to the patient's level of comprehension.

For providers who struggle to present patients with education, there are resources that can serve as adjuncts. For instance, we make ample use of Rendia (formerly Eyemaginations) video content (Figure 2). This company creates exceptionally well-produced and informative education videos and information pieces spanning a plethora of ocular conditions. Such tools can serve as a bridge to connect with patients.

MAKING THE CONNECTION

I believe that optometrists should make every effort to provide patients with the information they need to participate in their own care, which, in turn, offers them the best chance for a successful outcome. However, there may also be situations where the connection fails. I am reluctant to do so, but there have been times (rarely) when I have suggested to patients that they find another provider because they just do not seem to be accepting the information I am providing. It is a difficult decision to turn a patient away, but, ultimately, it may be in the best interest of that patient to do so. Perhaps there is another provider out there who can make that connection that I could not.

I am sure that all of us can do a better job of communicating with and educating patients, and this may be an area that is ripe for new innovations and technologies to help us. Beyond all of that, providing for the ocular health of our patients is ultimately a people business. If we focus on putting the needs of our patients first, finding ways to communicate with them becomes a lot easier.

Alan Glazier, OD
- founder, Shady Grove Eye & Vision Care, Rockville, Maryland
- executive digital editor of EyetubeOD/*Advanced Ocular Care*
- founder of ODs on Facebook
- (301) 670-1212; AGlazier@youreyesite.com

Best Practices in Integrated Care

APPROACHES TO PATIENT EDUCATION AND MARKETING CAN DEPEND ON AGE

Surgeons explain their educational and marketing efforts that have been successful with patients of all ages.

BY ARTHUR B. CUMMINGS, MB ChB, FCS(SA), MMed(Ophth), FRCS(Edin); SOOSAN JACOB, MS, FRCS, DNB; SIMONETTA MORSELLI, MD; ANTONIO TOSO, MD; AND KARL G. STONECIPHER, MD

Social Media Advertising Gives a Boost to Marketing

This approach is effective and cost-efficient.

By Arthur B. Cummings, MB ChB, FCS(SA), MMed(Ophth), FRCS(Edin)

The Wellington Eye Clinic participates in a number of studies, and, every now and then, we have to recruit patients for a particular study. Traditionally, this has been done through referral channels and public relations (PR) work, placing articles in newspapers and buying time on the radio. Recently, we were about to start another clinical trial that would enroll patients with mixed astigmatism who were interested in refractive surgery. We were getting ready, as usual, to spend money on TV and radio advertising that would invite patients to seminars to speed recruitment and make their initial examinations more productive.

Our PR agency lined up a top-flight advertising company to help us plan this drive. I was expecting to be pitched big-budget items including TV and radio slots. Therefore, I was pleasantly surprised when we were informed that this would not be productive nor provide much value for money. The ad agency was firmly of the belief that the best approach would be to advertise on social media, with Facebook specifically being the preferred route. Not only is this route cost-efficient, it is also effective, it can be specifically targeted at the right age group with the appropriate interests and hobbies, and it can be increased or stopped at the drop of a hat depending on how recruitment is going. Ads on social media can also provide digital links to the study information on the practice's website, directly to the correct page.

This experience has changed my way of thinking about marketing in general. If social media advertising works best for driving recruitment for a study, then surely it will also provide the best return in routine marketing activities. Our experience to date is that this approach works just as well for the elderly as for the young. My children and the younger staff in the clinic tell me that Instagram and SnapChat are better than Facebook for reaching the younger generation, but we have not yet tried these two platforms for marketing purposes.

IN THE CLINIC

Once patients are in the clinic, the experience is much the same for all, young or old. We use Echo (Rendia, formerly Eyemaginations) to inform patients while they are waiting, and we have informational videos produced by our own practice that explain the procedures that we offer. The clinic's website is practically laid out and

navigable, so I always have it open when discussing options with patients. This way, all the relevant information is directly in front of us, beautifully presented and well laid out, and this assists me in spelling out the options as logically as possible.

I have the sense that younger patients I have the sense that younger patients have watched the informational DVDs that we send out more diligently than those in the older generation, but I may be mistaken about this. The informational DVD forms part of our consent process, so we insist that patients watch the DVD at least once. If they have not watched it before they arrive for their appointment, we show it to them in the clinic. While walking around the clinic from consulting room to consulting room, I notice that it is usually the older generation sitting behind the DVD players, while younger patients are using the free Wi-Fi and surfing the web while they wait to be seen.

INTERNET REFERRALS GROWING

The role of the Internet has grown enormously over the past 5 years. In 2010, word-of-mouth was responsible for 90% of our referrals, and the Internet about 7%. Today, word-of-mouth is around 72% and the Internet about 24%, meaning that Internet referrals have grown more than threefold in about 5 years.

Another trend is evident in the swing from PC-based applications to mobile-based applications. People engaging us via the Internet are now doing it mostly on smartphones, but also on tablets. It goes without saying that today's websites must be mobile-ready, otherwise you will simply lose out on market share.

Practices Must Inform Both in Person and Online

Indiscriminate use of the Internet can sometimes give rise to confusion.

By Soosan Jacob, MS, FRCS, DNB

Communication, to me, still carries the classical meaning of an exchange between two people. For doctors, successful communication with patients requires several things. First, information must be simplified so that the patient can be aware of all of the options available to him or her. Second, the fears and apprehensions of patients and their companions must be allayed. Third, patients must be encouraged to learn more about their diseases and treatment options. In the office setting, these things are accomplished mostly in a verbal fashion, and, in the online world, through digital means.

FACE-TO-FACE

In the office, it is important to give as much time as reasonably possible to the patient. Patients must be allowed to speak first,

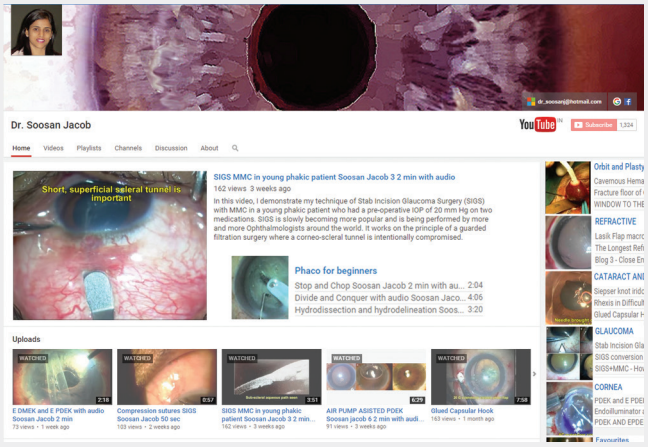


Figure 1. Dr. Jacob's YouTube channel.

in order to provide adequate background, and we must then discuss their problems with them. Because I head the department in a tertiary care hospital, patients generally come to me with all the required investigations done. However, if any are lacking, I ask for these to be performed as well.

I then spend time educating patients about their problems and the available methods to tackle them. It is important to let them know their options and the advantages and disadvantages of each. I generally find that a simple pen sketch helps most patients to understand easily. I also encourage patients to go to certain reliable sites on the Internet to find information to help them understand their diseases better. Finally, it is important to allow patients sufficient time to clarify all their doubts regarding their disease and their treatment.

DIGITAL INTERACTIONS

Face-to-face interaction in the office can be direct, personal, and tailored to each patient. Of late, however, many patients communicate with the doctor through electronic media, even before arranging an office visit. This communication can be in the form of emails, social media websites such as Twitter and Facebook, or comments posted on YouTube videos. Millennials use digital technologies much more than their elders. They are heavy users of social media, and these platforms offer good ways to reach out to them.

However, patients' indiscriminate use of the Internet can sometimes give rise to confusion. Potential risks, even low risks statistically, may be enlarged disproportionately in patients' minds. Therefore, these patients must be counseled more thoroughly and their fears must be allayed. In case of cosmetic and refractive surgeries, patients often must be counseled diligently to ensure that they have realistic expectations for the results of the surgery.

Digital communication provided by the surgeon or other members of the practice should aim to be scientific and precise.

It can be offered online in the form of scientific blogs, webpages, social media, videos, and other platforms. I often find questions from patients on my YouTube surgical video channel (www.youtube.com/user/DrSoosanJacob; Figure 1), and this is a handy platform to help patients and answer their doubts. I can also add pictures and links to other informative videos.

Whether engaged in person or through digital media, a satisfied patient is your practice's best ambassador.

Communication Changes in the Elderly

Adapt patient education strategies for those with hearing or visual problems.


By Simonetta Morselli, MD; and Antonio Toso, MD

Changes in communication abilities are commonly reported by the elderly. In a survey of more than 12,000 US Medicare beneficiaries aged 65 years or older, 42% reported hearing problems, 26% had writing problems, and 7% had problems using the telephone.[1] Ophthalmologic patients are also affected by decreases of visual acuity, and, therefore, they have many problems with visual communication. They are not always able to use media, draw examples of what they are seeing, or access the Internet to understand their pathologies.

With typical aging, some language skills remain intact—for example, vocabulary, grammatical judgment, and repetition ability are relatively stable with age—while other skills tend to decline. Dual sensory loss (ie, decreased vision and hearing acuity) is increasingly common with age, especially in the very old and those in institutional settings. In a survey of people with dual sensory loss, more than two-thirds reported frequent difficulty in conversation, especially in noisy situations or groups.[2,3] Poor hearing is often the cause of misunderstandings and negative reactions by communication partners, yet fewer than 24% of people who could benefit from hearing aids actually purchase them.[4]

Older patients normally are assisted during ophthalmologic examinations or surgery by younger relatives who are more skilled in communication. When we see an old, partially blind patient alone, it is difficult to explain what the pathology is and what the treatment will be. In these cases, we can use a lot of easy examples and simple words to explain the eye pathology. Sometimes these patients seem to understand, but oftentimes they tend to forget it all in a short period. In these cases, we often

> "With the younger person accompanying the patient, we generally use digital communication to help us explain the proposed surgery."

ask for a second consultation with a younger relative present in order to explain the situation better and to have a witness.

INTERNET FALLACIES

With the younger person accompanying the patient, we generally use digital communication to help us explain the proposed surgery or treatment. We normally use a laptop to show surgical or other types of videos in an attempt to explain the modalities of solving and caring for the patient's pathologies. Some patients arrive in our office with incorrect opinions and mistaken so-called facts about their pathologies that they have found on the Internet, and they often are convinced of the efficacy of equally incorrect solutions to their problems.

Especially when we encounter young patients, it is difficult to overthrow their Internet-acquired points of view. This is the reason we use our own personal videos and other resources to counteract these erroneous sources and explain and instruct the patient in the correct point of view.

In our office, we have a digital system to collect videos and pictures at the slit lamp, and we always send relevant images to patients by email in order to correctly establish the pathology in the patient's mind. Digital topographic analyses and digital fundus examinations can also be attached to patient emails. This is usually well appreciated.

AT A GLANCE

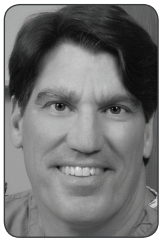
- Advertising on social media is cost-efficient, effective, can be specifically targeted at the right age group with the appropriate interests and hobbies, and can be increased or stopped depending on how recruitment is going.
- Millennials use digital technologies much more than their elders do. Because they are heavy users of social media, these platforms offer good ways to reach out to them.
- Allowing patients to send text and picture messages to their surgeon, in many cases, provides them with the means to resolve an issue without an office visit.

CONCLUSION

We try to customize communication with patients depending on their ages and attitudes, and this effort is generally well appreciated by our patients. We have a few communications tricks for dealing with elderly patients, which are detailed in the graphic on page 86.

Digital Media for Millennials and Boomers

Do we really need to differentiate?



By Karl G. Stonecipher, MD

How do you differentiate your market? What do you do differently to reach older and younger patients? The younger generation may need a slightly different twist than the older generation, but do we really have to change our course of action in marketing to millennials and baby boomers? I prefer, when possible, to use media that reach both older and younger patients. Remember, if grandma wants to stay in touch with her grandchildren, they all have to use some mutual platform.

Today, more important, both millennial and baby boomer generations are aware of the potential benefits of refractive surgery. In many cases recently, I have had grandparents who offer to pay for their grandchildren to have laser vision correction.

Any advertising option that works to reach both your cataract population and your laser vision correction population is media you want. One of my favorite advertisements for our practice was one that we placed in college newspapers several months before graduation season (Figure 2). This type of ad hits both populations, and when the parents or grandparents bring the child for surgery you can introduce them to your practice's other offerings.

DIFFERENT WEBSITES

Having said all that, we do differentiate some of our marketing based on age. I have one website designed for an older population (www.lensdefinedvision.com) and another defined for a younger population (www.laserdefinedvision.com). We hand out business cards with the URLs for both web pages on them so patients and their family members can see what we do. We also use social media to keep in touch with both older and younger groups because I want everyone talking about what we do.

A TEXTABLE DOCTOR

I have also changed my course of action in the office. I do not always have time to check email until the end of the day or early in the morning. Therefore, I have become a textable doctor. One might think this would be a challenge, but really it makes my life easier. Whether it is an emergency postoperative issue or a mundane problem, it is the most important issue for that person at that time.

I constantly have people sending me selfies of their problems. Now, I point out to patients that this is really not "the next best thing to being there," as the old Bell Telephone slogan said, but in many cases it allows us to resolve an issue without an office visit.

Before you decide to start doing the same, I would urge you to review the relevant laws for privacy and digital communication in your locality. It is likely that you need to document this patient encounter, even though it takes place through texting.

DIFFERENT STROKES

So remember, nowadays grandma and grandpa use text, Instagram, and Facebook, but they are not much on Twitter. The millennials really do it all. ■

1. Hoffman JM, Yorkston KM, Shumway-Cook A, et al. Effects of communication disability on satisfaction with health care: a survey of Medicare beneficiaries. *Am J Speech Lang Pathol.* 2005;14(3):221-228.
2. Heine C, Erber NP, Osborn R, et al. Communication perceptions of older adults with sensory loss and their communication partners: implications for intervention. *Disabil Rehabil.* 2002;24(7):356-363.
3. Heine C, Browning CJ. Communication and psychosocial consequences of sensory loss in older adults: overview and rehabilitation directions. *Disabil Rehabil.* 2002;24(15):763-773.
4. Garstecki DC, Erler S. Hearing in older adults. In: Shadden BB, Toner MA, eds. *Aging and communication*. Austin, Texas: ProEd; 1997: 97-116.

Arthur B. Cummings, MB ChB, FCS(SA), MMed(Ophth), FRCS(Edin)
- consultant Ophthalmologist, Wellington Eye Clinic and Beacon Hospital, Dublin, Ireland
- associate Chief Medical Editor, *CRST Europe*
- abc@wellingtoneyeclinic.com
- financial disclosure: Consultant (Alcon/WaveLight), chief medical officer (ClearSight Innovations)

Soosan Jacob, MS, FRCS, DNB
- director and Chief, Dr. Agarwal's Refractive and Cornea Foundation, Dr. Agarwal's Group of Eye Hospitals, Chennai, India
- senior Consultant, Cataract and Glaucoma Services, Dr. Agarwal's Group of Eye Hospitals, Chennai, India
- member, *CRST Europe* Global Advisory Board
- dr_soosanj@hotmail.com
- financial interest: none acknowledged

Simonetta Morselli, MD
- head of the Ophthalmology Department, S. Bassiano Hospital, Bassano del Grappa, Italy
- member, *CRST Europe* Editorial Board
- simonetta.morselli@gmail.com
- financial interest: none acknowledged

Karl G. Stonecipher, MD
- director of Refractive Surgery, The Laser Center, Greensboro, North Carolina
- member, *CRST Europe* Global Advisory Board
- stonenc@aol.com
- financial interest: none acknowledged

Antonio Toso, MD
- consultant, Vitreoretinal Surgical Department, Ophthalmology Department, San Bassiano Hospital, Bassano del Grappa, Italy
- antonio.toso@gmail.com
- financial interest: none acknowledged