YoungMD Connect asks

GAINING EXPERIENCE WITH PREMIUM IOLS DURING RESIDENCY

YMDC member Brian M. Smith, DO, interviews John P. Berdahl, MD, on how to maximize experience with premium technology during residency.

YMDC Asks links members of YoungMD Connect,* a mentorship and educational platform for aspiring and young ophthalmologists, with *CRST* editorial board members and other faithful contributors to discuss a topic of interest to young and future surgeons.

Brian M. Smith, DO: Industry partners often offer premium IOLs to residents for free, allowing us to practice with them in training and offer them to patients at no extra cost. At what point in training should residents start offering premium lenses to patients?

John P. Berdahl, MD: Residents should start using premium IOLs as soon as they feel confident in their ability to achieve positive outcomes. Residents' confidence is often less than they deserve.

Consider a patient with 4.00 D of astigmatism. If a resident does not offer a free toric IOL to the patient, the patient is condemned to 4.00 D of astigmatism for the rest of their life. Somehow, this might feel noble to the unconfident resident. I would argue, however, that an attending physician present during the surgery could help the resident overcome any challenges that arise during the procedure, such as capsule issues or concerns about lens centration.

Patients deserve a chance to eliminate their astigmatism. There is nothing inherently wrong with residents using a toric lens in their first 10 cases. When it comes to multifocal and other types of lenses, however, things become nuanced. Beyond the multifocality of these lenses, glare and halos can result from lens decentration or phimosis. It is more difficult to achieve optimal outcomes with these lenses. I recommend residents wait until they have completed around 30 to 50 cases before incorporating multifocal IOLs into their procedures—and always under the supervision of an attending physician.

Dr. Smith: What pearls do you have for residents who may not feel comfortable discussing premium IOLs with patients?

Dr. Berdahl: If you don't believe in yourself, no one else will believe in you, either. Don't apologize for being a second-year resident when talking to your patients about their surgery. Explain that one exciting aspect of their procedure is the availability of advanced technology lenses that usually come with a high cost but that you can offer for free as a resident.

Better than simply mentioning the free IOL is to educate them on and emphasize the benefits of advanced technology lenses. I often say, "How do you want to use your eyes for the rest of your life? We have a good chance to decrease your likelihood of requiring glasses." Tell them which lens would you choose if it were your own eye.

Dr. Smith: What are some common mistakes that residents and fellows make with premium IOLs?

Dr. Berdahl: There are several, including the following.

▶ **No. 1: Not offering premium options.** Imagine visiting an orthopedic surgeon who does not inform you about the various hip replacement options. How would you feel as a patient? Surgeons in training sometimes think it is noble to keep premium treatment options from patients, but this is the most significant mistake I see residents make.

▶ **No. 2: Insufficient preoperative patient education.** Another mistake is not properly defining victory and postoperative success with patients. For example, if you are implanting an extended depth of focus IOL, tell the patient, "The best possible outcome with this lens means you do not have to wear glasses for distance except for visually demanding tasks, such as driving at night. You will need glasses to read a newspaper but not for using your cell phone." For multifocal lenses, victory might mean needing glasses only for visually intense activities, but the patient should expect rings around lights.

▶ **No. 3: Not having an exit strategy.** Be prepared to finish by making a LASIK or PRK enhancement available or an IOL exchange if a patient is unhappy and the IOL is the cause.

▶ **No. 4: Not knowing how to interpret topography.** Get an OCT scan and have at least two sources of astigmatism measurements to develop your treatment plan.

Dr. Smith: Certain institutions restrict collaboration to specific industry partners or companies and permit the use of only their IOLs. As a resident working in a hospital, you therefore may be limited to using lenses from a single company. Once you complete training, how would you explore the alternative lenses offered by other companies?

Dr. Berdahl: We as physicians took an oath only to patients. Our primary focus must therefore be to do what is right for the patients we serve. Advocate for them and strive to provide them with the most appropriate treatment, whether that involves a toric lens or a product from a company not partnered with your institution. When obstacles arise, make every effort to overcome them

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rather than accept defeat without trying to do what is best for the patient.

In terms of selecting the appropriate lens, surgeons may encounter less difficulty once they can make independent decisions. Some manufacturers may have programs that supply lenses for physicians to use without charge and without billing the patients for the lenses. This prevents the risk of an inducement.

Ultimately, the priority should always be to do what is best for the patient in front of you. Advocate for your patients to receive the most appropriate treatment possible.

Dr. Smith: Do you think the attending surgeon's background, whether it is refractive, cornea, or anterior segment, impacts the effectiveness of the training residents receive?

Dr. Berdahl: A resident has the golden opportunity to observe and learn from different attending surgeons. Some may have reservations about the use of presbyopia-correcting IOLs while others believe the technology can improve a patient's quality of life significantly. Residents should seek the opinions of their attendings and form their own opinions on patient care.

My advice to residents is to challenge their attending surgeon and engage them in thoughtful discussion about the best course of treatment for each patient. This also helps the attending surgeon grow and allows the resident to become comfortable with the responsibility of decision making.

Dr. Smith: As a cornea, external disease, and refractive surgery fellowship director, do you have any advice on how residents can prepare themselves to apply for those fellowships?

Dr. Berdahl: Have a clear understanding of your personal strengths and values. It is crucial to me that applicants are authentic and self-aware. Both are necessary for a successful match. Know who you are and how to articulate it, and strive to make a meaningful impact. Rather than pursue research projects solely to build your résumé, use the time to contribute to the profession in a way that aligns with your values, whether that be through education, advocacy, research, missions, or policy.

Be genuine in your approach and seek to make a real difference in ophthalmology.

I also recommend that fellowship applicants gain significant experience in cataract surgery and hone their skills. They should not be pursuing a fellowship simply because they did not receive adequate training during their residency. ■

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