

Marketing Laser Cataract Surgery

Patients are willing to pay more for the refractive results they want.

BY SHAREEF MAHDAVI AND RICHARD L. LINDSTROM, MD

Marketing is everything that you do to attract patients to your practice or to a procedure. In terms of the marketing of cataract surgery, historically, it has not required much effort on the part of the surgeon. Patients would present to the practice with visual complaints and be diagnosed with having cataracts. Another reason cataract surgery required little marketing in the past is that a third party, such as Medicare or private insurance in the United States, for example, and not the patient, paid for the cataract to be removed and for a lens to be implanted.

Many surgeons have developed relationships with referral sources such as optometrists as a feeder system for cataract surgery, obviating the need to spend money on external marketing. A handful have advertised a particular form of cataract surgery: in the late 1980s, that was single-stitch and then, later, no-stitch. Because the patient came in, was treated, and someone else paid nearly all of the fee, however, there was little need for surgeons to differentiate themselves from one another. Also, because so many patients were in need of the procedure, the market was clearly defined. In that sense, it was not a free market; rather, it was a controlled market from both the regulatory and the reimbursement standpoints.

Times have changed, and the definition of a cataract has evolved. What a cataract is in the United States compared with a developing nation is vastly different. Patients'—that is, consumers'—expectations have risen greatly for everything. And technology has improved to deliver on these expectations.

WHAT HAS CHANGED?

Two major changes have happened to cataract surgery. The first, which has nothing to do with cataract surgery, is LASIK. The second major change occurred in 2003, when the first presbyopia-correcting implant was approved.

LASIK. This procedure represented ophthalmic surgery performed by an ophthalmologist—the same person who performs cataract surgery—but was completely paid for by the patient. Patients went in for the surgery, and in about the same time as it took to have a cataract removed, they

came out and did not need glasses. The rise in demand for LASIK to become the most widely performed elective surgical procedure, both in the United States and worldwide, has demonstrated that consumers are willing to spend their own money to surgically improve their vision.

Because of LASIK's success as a self-pay procedure, by the mid to late 1990s there were higher expectations for cataract surgery. As our profession involves vision correction, we tend to overestimate patients' understanding of their eyes, vision, and ophthalmic surgery. The reality is that many people do not understand the differences among ophthalmic procedures; instead, they only understand their own desire to see better.

Premium IOLs. The introduction of an IOL that was dramatically different in terms of the functionality it could provide once again changed the game. Surgeons had a product that they could potentially promote to patients to create awareness of its existence. At that time, if US surgeons participated in Medicare, it was against the law for them to bill more for this new technology.

For approximately 2.5 years from the US Food and Drug Administration's approval of the Crystalens (Bausch + Lomb), the first presbyopia-correcting IOL, to the US Centers for Medicare and Medicaid Services (CMS) ruling, US doctors could market this technology only to a private-pay cataract patient. Then, CMS ruling 05-01 was introduced, and it separated out the functionality of the IOL that corrects for presbyopia. Surgeons were now able to offer this technology and service to patients at a separate fee that they could choose to purchase. This represented a LASIK-type component to cataract surgery. An elective factor had been added to the country's most commonly performed surgical procedure. This provided more reason for doctors to consider marketing their practices.

The problem that arose was that most cataract surgeons were ill-equipped to promote these new-technology IOLs, to create awareness, to have patients come to the practice, and to convert that interest into an actual procedure. The results speak for themselves: In the United States, only seven of every 100 patients who come in for cataract surgery opt to have one of the three currently available presbyopia-correcting

IOLs. When astigmatic and toric IOLs are included, this rate is about 15%, according to data from Market Scope.¹ In 2007, a new CMS ruling stated that surgeons could treat astigmatism using whatever tool they wished and charge for that separately. This ruling represented yet another reason for surgeons to promote a specific service.

Again, however, most surgical practices were not prepared to make this transition. Why? The old cataract surgery model has been one of efficiency. This is the opposite of what is required when the surgeon is dealing with an elective procedure where the expectations of the customer are already higher because of the role LASIK has played on the market. The efficiency model of a cataract facility, everything from the counseling to work-up to the procedure and the postsurgical treatment, was never designed to be a high-end experience. That is part of the problem. We now have the laser for cataract surgery, and the need for marketing is essential if we are going to make this opportunity successful for patients, surgeons, and manufacturers.

CREATING AWARENESS

Surgeons do not need to market cataract surgery, but they do need to create a base level of awareness that a laser can now be used to perform part of the procedure. (See *Personal Marketing Strategies for surgeons' thoughts on marketing laser cataract surgery*.) That effort is not about advertising; this is different from LASIK, where demand must continually be nurtured to generate interest among the spectacle- and contact-lens-wearing population. Laser cataract surgery is not about creating awareness outside of the practice's four walls; rather, it is about educating the patients who come into the practice. In fact, very little advertising will be needed for this category, because 3.3 million cataract procedures will be performed (in the United States) each year regardless.

We now have a situation in which we want to learn everything from the past and apply it to the future. We do not want the low penetration we saw with premium IOLs. We do not want price wars and commoditization similar to what happened in LASIK. The femtosecond laser offers a golden opportunity to increase the value of cataract surgery for surgeons and patients. Therefore, surgeons and industry should focus on market conversion rather than expansion. The business objective around conversion is twofold. In the near term, it is about improving the conversion of cataract surgery to premium cataract surgery, where much greater value for the services performed is communicated, accepted, paid for, and realized by both the patient and the surgeon. Several key steps have already been taken in the United States, notably the ruling by the CMS allowing surgeons to charge patients separately for premium IOLs, advanced measurements, and enhancements, as mentioned previously. Collectively, these are part of the transition to labeling cataract surgery more

accurately as a refractive procedure.

In the longer term and with more widespread adoption, laser cataract surgery should become a commonly accepted option for patients who see its value and are willing to pay for it. As with any elective procedure, those providers who most effectively educate patients will succeed. This will continue to hold true as long as doctors collect fees directly from patients, because the doctor-patient relationship is also one of doctor-customer.

We must recognize that *laser* is a magic word with consumers. Again, the femtosecond laser already has set a well-established precedent for eye surgeons with added value and patients' willingness to pay for it (eg, LASIK flaps). The adoption of the femtosecond laser for LASIK flaps is worth noting: At its launch in 2001, nearly 100% of flaps were made with a mechanical microkeratome. By 2011, more than 70% of flaps were being made with a laser.¹ We have a good indication that patients are willing to pay out of pocket for an improved version of their cataract surgery. A 2009 survey interviewed about 300 patients who were in the process of deciding on cataract surgery. When asked if they would be willing to pay for a procedure that would allow them to see without glasses, 85% requested more information, and 25% said they would spend at least \$2,000 an eye.²

We expect that laser cataract surgery will be more popular than LASIK. Consumers willingly pay for what they value, and they value their health. The demographic of the aging baby boomers and their desire to have the best will certainly play a role. There is a built-in demand curve of 3.3 million patients (in the United States). The technology itself has already been proven, in contrast to phacoemulsification, for example, which took 2 decades of refinement. The laser technology—and the application of the technology—is only going to improve. More important, however, is the unmet need. Close to 100% of LASIK patients see 20/40, and 90% see 20/20 postoperatively. Only 50% of cataract patients have a postoperative visual acuity of 20/20. LASIK-like outcomes must be applied to cataract surgery to convince patients to pay for it. The femtosecond laser's ability to provide better results and a safer procedure has to be part of the message.

BUILDING THE CATEGORY

Most important with laser cataract surgery is that we want to develop and grow a healthy category.

It is clear that the future of laser cataract surgery is directly tied to the reaction of the baby boomer generation. This group has transformed virtually every industry it has touched over its lifetime; cataract surgery will be no exception. The first boomers turned 65 in January 2011, and this large demographic will create growing demand for cataract surgery, improved outcomes, and a more concierge-like experience. Their expectations, which have been well

defined over the years, have several key implications for this category, which are described in detail below.

No. 1: Do not differentiate based on technology. One of the major mistakes in the commercialization of laser vision correction occurred when manufacturers and surgeons attempted to draw distinctions based on what type of laser was being used. This approach was not meaningful to consumers and served to confuse and delay their decision-making. Instead, the discussion should be based on the benefits to the patient, which are similar across all manufacturers. The built-in demand described earlier is already in place; consumers and patients simply need to be educated on how laser cataract surgery is different and what advantages it offers compared with traditional cataract surgery. Thus, it is crucial that doctors refrain from touting specific technological features (liquid interface, real-time imaging, etc.), as these hold little value for the consumer. In short, emphasize the benefits that focus on lifestyle enhancement.

No. 2: Do not bash current technology. Phaco has made cataract surgery a highly safe and effective procedure. It will continue to exist for the foreseeable future, and it is imperative to the new category that surgeons and staff do not degrade a procedure that has been successful for more than 40 years.

No. 3: Do not call it cataract surgery. This new category should have a name that distinguishes it from what is currently known as cataract surgery. The procedure should be renamed laser cataract surgery or refractive laser cataract surgery. A name will help the procedure develop its own badge and begin to separate it from traditional cataract surgery and the trend toward commoditization, which has been highly detrimental to the LASIK category.

No. 4: Stop using the term *cataract*. The term *cataract* no longer accurately describes what is happening inside the eye. The word is used to justify reimbursement more than to document the clinical degradation of vision. Harvey Carter, MD, of Dallas, was the first surgeon we heard use the phrase *dysfunctional lens syndrome* with his patients. This is more than just clever; it is an example of effective communication in relevant terms. Dr. Carter continues to be one of the leading implanters of presbyopia-correcting IOLs in the United States. Atlanta-based surgeon J. Trevor Woodhams, MD, began describing cataract surgery to his patients as the end rather than the beginning of a disease process that happens to most people; it takes place over a period of years, he explains, and significantly affects vision, first with the stiffening of the lens (presbyopia) and ultimately with the clouding of the lens. Vance Thompson, MD, in practice in Sioux Falls, South Dakota, adds the notion of gradual and progressive degradation of the quality of vision.

These surgeons have learned that calling what someone has a cataract makes it harder for the patient to understand his or her condition. That term may have served

well when the diagnosis and removal of a cataract was defined by regulations and paid for by another entity. Now, and in the future, this medical milestone will be increasingly defined by lifestyle requirements and paid for directly by the patient—at least the refractive portion. Eric D. Donnenfeld, MD, puts it this way: “Just as presbyopia becomes associated with middle age, the term *cataract* becomes associated with old age.”

Today’s aging baby boomers refuse to be thought of as senior citizens because people now routinely live into their 80s and 90s. In this emerging context, one’s 60s can, therefore, hardly be thought of as old age. The convergence of longer life spans and the potential to improve refractive outcomes will stimulate demand for laser cataract surgery.

MARKETING TO SURGEONS

The biggest challenge of bringing laser cataract surgery to the market successfully is the surgeon’s mindset. You may perform a great stab incision and make a wonderfully round capsulorrhexis without fail. This is not, however, about the doctor; it is about the patient and what he or she wants and his or her perception of value. The femtosecond laser in making the LASIK flap was a small advancement in terms of its clinical significance, but it was huge from the consumer’s perception. People pay for insurance to reduce risk all the time. Laser cataract surgery, in one sense, represents a reduction of risk to the consumer. It will also be more consistent, so we believe its outcomes will be better.

Not all surgeons are going to be involved in offering this technology at the same time. The early adopters will want to use it as a marketing advantage to continue to differentiate themselves in their community. They are looking to set standards. The majority of the market—the two-thirds of surgeons who represent the middle of the bell curve—will be attracted to laser cataract surgery when the procedure has clearly become the standard. We believe the transition to laser cataract surgery will take about 1 decade. This means that surgeons have plenty of time to prepare and plan, and the dynamics of the market will push them along.

The demand among the early adopters is so strong that the first 100 to 200 lasers will easily be placed in practices, in spite of the unknowns surrounding demand, regulation, and a sustainable business model to ensure that the economics work for the practice or surgery center. The rest of the surgeons will watch and wait. (*Editor’s Note: CRST Europe’s Chief Medical Editors Sheraz M. Daya, MD, FACP, FACS, FRCS(Ed), FRCOphth; and Khiun F. Tjia, MD, share their thoughts on early adoption in a Point/Counterpoint starting on page 44.*)

To position the laser to appeal to this group, manufacturers must emphasize refractive-like outcomes with the cataract procedure. If surgeons believe that this is what their patients want, they must participate. For those performing LASIK, it is a natural addition to the practice.

TAKE-HOME MESSAGE

- Surgeons do not need to market cataract surgery, but they should create a level of awareness that a laser can be used to perform part of the procedure.
- LASIK-like outcomes must be applied to cataract surgery to convince patients to pay for it.
- Surgeons' inability to adopt a refractive surgery mindset is one of the biggest barriers to market penetration of laser cataract surgery.

There has to be a medical necessity established in order for a surgeon to perform cataract surgery. Laser cataract surgery is based on establishing a refractive goal for the patient. We contend that the laser itself is not part of cataract surgery but rather part of the refractive set of tools that can be used to enhance the outcome of a cataract procedure. Does the patient desire to depend less on glasses after cataract surgery for distance and near vision? If the answer is yes, then cataract surgery is a refractive procedure. If the answer is no, it is the end of the discussion. Remember, however, we expect that 80% of patients will be interested. Times have changed, and the laser has allowed surgeons to treat and manage astigmatism too. Once a patient's goal is to be less dependent on glasses, then it becomes a matter of the tools. The femtosecond laser is convenient, safe, and elegant.

Surgeons' inability to adopt a refractive surgery mindset is one of the biggest barriers to market penetration of laser cataract surgery. The consumer, however, is really the decision maker. If the value of laser cataract surgery is described for them appropriately, they will buy it. This was shown in the experience with the first 100 IntraLase (Abbott Medical Optics Inc.) customers: Fees were raised for LASIK by an average of nearly \$400 per eye, and patients overwhelmingly accepted this price increase for the perceived benefits.³

PACKAGING THE TREATMENT

Surgeons who add laser cataract surgery to their offerings should examine their current fee schedule and consider giving higher prominence to the benefits that can be achieved by taking a refractive approach to cataract surgery. Be clear: This option is for patients who are seeking a refractive procedure—a medical necessity obviously is the base. It should be packaged in terms of lifestyle, as this is refractive surgery, not cataract surgery.

Laser can be considered as code for accurate, precise, and safe. Doctors need to take a serious look at how their entire process is set up and examine and develop a marketing protocol that is as robust as their clinical protocol for performing surgery. The marketing protocol is everything from what communications are sent in advance to patients, what goes on the website, and how is the phone answered to how is the initial consultation, diagnosis, and

TABLE 1. DR. LINDSTROM'S MODEL FOR LASER CATARACT SURGERY

- Tier 1 (\$) = see well at distance without glasses
Tools: femtosecond laser and monofocal aspheric IOL
- Tier 2 (\$\$) = see well at distance without glasses (astigmatism)
Tools: femtosecond laser, toric IOL, or limbal relaxing incisions
- Tier 3 (\$\$\$) = see well at all distances without glasses
Tools: femtosecond laser, accommodating or multifocal IOLs, limbal relaxing incisions, and corneal surgical enhancement if needed

work-up handled, and then preoperative instruction. The entire process must be made more customer-friendly to be in line with patients' increased expectations.

Practices will most likely have to hire staff to counsel patients. These people should be expert communicators—not necessarily experts in the technology or those who have a long tenure in ophthalmic practice. Hire people who have backgrounds in retail, hospitality, or education. The role of early adopters of this technology is to be leaders in the community and help other surgeons, optometrists, and manufacturers understand the impact of this technology. The first surgeons to incorporate laser cataract surgery into their practice have a responsibility to help educate the professional community.

Make sure that patients understand—before, during, and after the procedure—its value. Continual communication is required, and this too is a change in thinking. Understand that each patient probably has friends who are at a similar age and are going to face cataract surgery. Why not have patients play the role of ambassador? This is vastly different from the standard, traditional cataract model that was one of efficiency and factory precision.

Given that people are living much longer today than they did a generation ago, the question can become, "Do you want to have great vision for the next 20 years?" Laser cataract surgery delivers on this promise. It is worth the investment. This game is going to be won or lost based on how well surgeons educate the cataract patients coming into practices.

Regarding how to price laser cataract surgery, once again, use LASIK as your guideline in terms of value to the patient. The fee for a refractive procedure is decided by the surgeon, and it is subject to market forces. There are many different models possible: (1) one price and everything is included, (2) two or three combinations with the surgeon choosing what is included in each, or (3) an à la carte menu from which the patient chooses. High myopia, astigmatism, and other factors might warrant a higher price.

Dr. Lindstrom's model will likely be based on the complex-

PERSONAL MARKETING STRATEGIES

Surgeons and centers share their thoughts on introducing laser cataract surgery into practice.

By Boon Siong Lim; R.J. Mackool, MD; Richard J. Mackool, MD; Erik L. Mertens, MD, FEBOphth; and Julian D. Stevens, MRCP, FRCS, FRCOphth

BOON SIONG LIM

Before introducing laser cataract surgery at Vista Eye Specialist last October, a task force was established in consultation with our surgeons to develop a strategy to incorporate the new technology into practice. Our experience as the first practice in Malaysia to offer bladeless LASIK with the Intralase femtosecond laser (now Abbott Medical Optics Inc.) in 2003 was invaluable in this process, as it represented the first time we had to work to overcome patient concerns and misconceptions. Below we recount our efforts to introduce and market laser cataract surgery to our patients.

We were also the first in our region to perform laser cataract surgery, and with that came pressure to identify a unique brand name that would garner attention as well as present the main concept of the product. After a brainstorming session, we decided on the name *no-blade cataract surgery* as a follow-up to our no-blade LASIK brand name, which was instrumental in the successful launch of Intralase in our region. The *no-blade* term, aimed at reducing the fear associated with bladed surgical techniques, was simple to understand and clearly defined the difference from a conventional phacoemulsification technique.

By likening the LenSx Laser System (Alcon Laboratories, Inc.) to the Intralase technology—an accepted technology in the LASIK market—in our campaign, we took the fear away from patients of using a new, unproven technology to perform a crucial surgery. With the wide use of femtosecond LASIK and its proven results and safety, the link between using femtosecond lasers for refractive surgery and cataract surgery reduced the time we needed to educate patients about the technology. It also quelled patients' initial fears and raised the acceptance level of laser cataract surgery. Our slogan, "No-Blade LASIK since 2003, Now No-Blade Cataract Surgery," was chosen to reflect this.

Whenever something new is introduced, comparisons with older techniques are bound to occur. Because traditional blade cataract surgery and phacoemulsification is widely performed and the results are acceptable, general resistance to something new, especially one that comes with a premium price, can be expected. Another concern is overcoming the myth and misunderstanding that phacoemulsification is already laser cataract surgery.

We find it helpful to illustrate to patients how cataract surgery has evolved, clearly defining the techniques and technologies used over the years and how they have made a difference in patient care and comfort, surgical quality, and safety.

Emphasizing how laser cataract surgery is different from what the general population accepts as a laser (ie, phaco) is important. Using a chronological timeline, we depict the evolution of cataract surgery, from couching to intracapsular cataract extraction to extracapsular cataract extraction to phaco, and finally the evolution toward laser cataract surgery in 2009.

Our efforts to introduce laser cataract technology into practice were successful in overcoming patient fears. By making a parallel of the unknown (ie, laser cataract surgery) with something already common (ie, femtosecond LASIK) and by clearly defining the difference with what is being offered (ie, the difference between laser cataract surgery and conventional surgery with phacoemulsification), we booked 200 cases before officially launching the procedure and completed 125 cases in the first 2 weeks of certification. Nine months later, our conversion rate is 42% of all cataract cases, of which 68% include premium lens implantation.

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R.J. MACKOOL, MD; AND RICHARD J. MACKOOL, MD

We have not done external marketing of laser cataract surgery at the Mackool Eye Institute and Laser Center. Prior to each consultation, we provide patients with written material that describes our positive experience with femtosecond laser technology, including the precision and benefits of the method and its ability to simultaneously correct astigmatism, create surgical incisions, and facilitate cataract removal. We also include an overview of IOL options and opportunities for reduced spectacle dependence.

We have found that our ability to offer patients the most advanced technology, including laser cataract surgery, is very reassuring to them. Their knowledge that we perform procedures that are on the cutting edge increases their confidence in our recommendations.

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PERSONAL MARKETING STRATEGIES (CONTINUED)

ERIK L. MERTENS, MD, FEBOPHTH

Marketing laser cataract surgery in Belgium can legally be done through the practice's website and informational brochures as well as by word of mouth or by educating one's own cataract patients. Before marketing strategies are put in place, however, one must focus on creating awareness.

Creating awareness among patients that cataract surgery can be done with a femtosecond laser begins with thorough explanation of the procedure's advantages. At Medipolis, we achieve this with written and oral information. Our professionally trained patient counselors explain the potential benefits of this new technology. Thus, we educate our patients that this new laser device lifts cataract surgery to a higher level. It is important to explain that conventional cataract surgery with phacoemulsification is still a good procedure, but we can do even better now using a laser to facilitate integral steps of the procedure.

Our counselors stress to patients the softness of the procedure—which tool will give a more precise outcome, a scalpel or a laser?—and describe how the laser is more gentle on the inner tissues of the eye, producing less endothelial cell damage. Additionally, they communicate to patients that using laser cataract surgery encourages greater accuracy in lens surgery because the incisions and manipulations inside the eye are no longer created by hand, and that corneal astigmatism can be corrected simultaneously, without touching the cornea with a knife.

I am amazed to see how many patients are already embracing this new technology and benefiting from their newly improved eyesight in all circumstances after laser cataract surgery.

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At Moorfields Eye Hospital, the majority of our patients seek refractive correction rather than purely the treatment of cataract. As demand for the benefits of laser cataract surgery already exists, we feel it unnecessary to attract a new type of patient via external marketing. Rather, our strategy is to focus on educating patients who have already been drawn to the practice because of our reputation as a high-end provider of both refractive and cataract surgery. We provide information to patients that highlights the benefits of this new procedure and explains the key differences between laser cataract surgery and what we refer to as traditional, entirely manual phacoemulsification. The benefits are reiterated at all stages of the patient's journey, and not just by the surgeon. We feel it is vital to have members of the team who can confidently communicate with the patient about the new procedure.

As recommendation is our biggest referral source, we continually gather patient feedback. We will also be watching closely to see how many future patients come to the practice asking for laser cataract surgery based on word-of-mouth referral. ■

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ity of the refractive outcome goal (Table 1). To set a price, determine what the local market will bear and also what is fair. Factors to consider include the surgeon's increased skill and time required, the costs of the technology, and a longer global period that aligns with refractive surgery follow-up (1 year) rather than the traditional cataract surgery follow-up (90 days).

CONCLUSION

The use of the femtosecond laser will be reimbursed as one component or tool for laser cataract surgery, and the femtosecond laser will also elevate the premium IOL channel. Patients are willing to pay more for the refractive results and quality of life they want; therefore, the femtosecond laser will have a similar value proposition in cataract surgery as it did in corneal surgery.

There is a much higher receptivity to laser cataract surgery than there is to the premium IOL because it is easier

to understand. This is a great opportunity for ophthalmic surgeons to fulfill an unmet need. And that, in fact, is the history of economic progress. ■

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