Benefits of a Refractive Coordinator-Counselor

After preoperative examinations, this refractive coordinator's responsibilities include counseling the patient.

BY RESI PAUWELS

Merriam-Webster's online dictionary definition of *coordinate* is: "to bring into a common action, movement, or condition." [1] Similarly, a coordinator is one who synchronizes and harmonizes. On the other hand, the definition of *counselor* is: "a person who gives advice or counseling."[2] These two responsibilities may seem unrelated, but both have important functions in the refractive clinic. As the refractive coordinator of Medipolis, in Antwerp, Belgium, I incorporate patient counseling into my duties of managing each individual's surgical course. This article highlights the techniques I use to bring these important principles into practice.

When a patient enters our clinic, he is typically taking his first step into the world of refractive surgery; he will have opinions, questions, and even doubts. After a brief introduction, including explanation of who I am and what I do, the questions I expect to answer include: "What is possible for my eyes?" "Is there a solution for my sight problems?" "Can I be helped?" "Will my questions be answered?" "Will my doubts be resolved?"

I host the patient as well as family and friends who accompany him and make sure they all feel at ease in our practice. I always treat patients and family as I would like to be treated in a doctor's practice. I make sure that they do not have to wait too long and that everything runs smoothly throughout the process. I ask the patient if I can put his personal belongings in a safe place so he does not have to carry them along during preoperative examinations. In the meantime, family or friends are invited to stay in the waiting room where I offer them something to drink. During the examinations, I check on the emotional condition of the patient.

TAKE-HOME MESSAGE

- Counselors should indicate an interest in the patient's professional and personal lifestyle.
- Counselors should act as an anchor for the patient's experience.
- The surgical procedure should be described in terms the patient can easily understand.

FROM COORDINATOR TO COUNSELOR

After any preoperative testing, the patient is taken to the conversation room; here, my function switches to that of refractive counselor. I talk to the patient in terms that are appropriate for the patient's individual level of education. One important piece of advice is to take an interest in the patient and his professional and personal lifestyle. I make sure I know each patient's name and that they know my first name too. Once a relationship has been established, patients feel at ease, and I encourage them to ask for me personally when they call the center. I act as an anchor for the patient's experience.

After consulting with the surgeon, I explain the available surgical options, including phakic IOLs, refractive lens exchange, and laser options if applicable. In my experience as a refractive coordinator-counselor, most patients are not familiar with the concept of the supplementary IOL. The exception to this is patients with high ametropia, who are usually aware of the concept and need only a fur-

ther explanation of the results and procedure.

One group of patients I spend extra time with is those who come into the practice wanting laser vision correction but whose testing suggests that phakic IOLs are the best solution. Patients in this group are frequently unaware of the existence of phakic IOLs; I explain the technology and why it is the right choice for the patient. Patients often assume that the phakic IOL is more invasive than laser treatment; I use my counseling skills to explain that the incision for a phakic IOL is only 2.2 mm (in comparison with creation of the large, round flap of cornea for LASIK). I describe the procedure in terms that the patient can easily follow, mentioning that the phakic IOL is placed in a cartridge in a rolled-up position and inserted into the eye through a 2.2-mm corneal incision in a procedure that takes 5 minutes. I tell the patient that his vision will be perfect from day 1.

EDUCATIONAL VIDEOS

All patients watch a video of the different stages of eyesight—from normal vision, to presbyopia, to cataract development. The video explains how colors and sight change slowly over time. It also covers IOL options, including monofocal and premium lenses. This video gives patients a clear view of what cataract is, and usually patients' facial expressions show they are convinced of the need for surgery. I say usually because elderly patients, especially those over the age of 80 years, tend to hold on to the feeling that they are too old for eye surgery. I have to explain that they will go blind if they do not have the operation. As a counselor, I try to ease their fears by relaying the common nature of the operation they are about to undergo. I am sure to mention that this operation has been done for many years and gets better as time goes on.

I tell these elderly patients, "The doctor always says you are never too old to have good eyesight." These patients need to hear that they will be able to more easily watch TV, read, and see their family members and friends after surgery. I tell them they will be disappointed they never thought of undergoing cataract surgery earlier. I always add positive feedback like that. At the end of this clarification, the patient will often say, "But what about my glasses? I am used to wearing them, and I want to keep on wearing them." I reassure them that they can continue to wear glasses if they want to by putting plain glass in the frame.

Cataract patients between the ages of 65 and 80 years need help deciding between monofocal and premium lenses. Some patients feel that they are too old for premium lenses. I tell them they have to think positive and that they can still turn 90 years old and enjoy the lens for many years.

LENS EXCHANGE

Many patients are familiar with the term *lens exchange*, but they usually associate it with older people and cataract. Because the aesthetic world is increasingly important, I tell patients that a lens exchange is also a viable option if they are between the ages of 45 and 65 years. They are surprised in most cases that we recommend this. I tell these patients that they do not have to wait until they have a cataract and that it is better to enjoy life with good sight while they are young instead of waiting until their vision deteriorates. I explain that they will not get cataract after refractive lens exchange and that IOLs survive for 60 years and eyes never have rejection symptoms.

PREPARING FOR SURGERY

Another role of the refractive counselor is to explain the surgical procedure, including step-by-step expectations for the day of surgery, what to do after surgery, what visual expectations should be after surgery, and the possible surgical risks and side effects. When patients have doubts, I advise them to wait before they undergo surgery. My job as a counselor is tell patients that there is a difference between being scared and not being sure; patients should understand that it is better to have a positive attitude toward the operation before committing to it. Patients do not like to be pushed into things.

After counseling patients, my task is again to coordinate the remainder of the administrative procedure. I ensure that every patient signs an informed consent form, and I create a list of medications the patient will use after surgery. I call the patient to confirm his appointment and remind him to start using drops or medicine before the operation if applicable. Patients appreciate that somebody thinks about them. It is also my responsibility to rehearse the surgical agenda with the surgeon.

On the day of surgery, I use my customer-care skills to host the patient. I make sure he feels at home in the clinic. The lounge-type waiting rooms are inviting, and the clinic offers the patient and his relatives coffee, tea, chocolates, biscuits, and fruit. They are free to watch TV or use the Internet.

Preoperatively, I look after the preparation of the eyes. I like to talk to the patient and reassure him as much as possible just before the start of the procedure. This relaxes the patient before he goes into surgery, which makes it easier for the surgeon too. After surgery,

it is important to be there if the patient needs to be looked after for all kinds of practicalities. Postoperatively, I explain the medication the patient has to use, schedule a follow-up appointment, and tell the patient that the surgeon will call the same evening or the day after the operation to check on his condition and follow-up on any concerns. I tell the patient that if he has any questions, he can reach the surgeon 24 hours a day, 7 days a week, for 1 month after surgery.

PEARLS AND PERSONAL EXPERIENCE

As a counselor, I try to follow the principle of talking in the mindset of the listener. I help each patient to make a decision based on what is best for his individual needs. In practice, that means first presenting the benefits and features of the procedure and second describing how the patient can achieve these benefits from the procedure. When that is not enough, the third responsibility is to explain the consequences of doing nothing. This can be further supported by prestigious references, such as mentioning some well-known people who had that procedure (respecting, of course, patient confidentiality).

I can now provide patients with an account of my own experience; on April 2, I underwent refractive lens exchange, and my daughter was also operated on at Medipolis. Sharing such information tells the patient that I have extreme trust in the surgeons at our clinic. I try to instill this same trust in the patient.

CONCLUSION

As a refractive coordinator-counselor, customer care is my No. 1 priority. I make the clinic more accessible for patients. They can call and ask for somebody they know. I can make the gap smaller between the surgeon and the patient. If something is not right or is bothering the patient, I encourage the patient to chat with me because it feels familiar to him—patients appreciate that, and they respond to a recognizable face and name. It builds trust and reassurance in the clinic and the surgeon, and patients leave our clinic with a feeling of being treated as a person and not as a number. ■

Resi Pauwels is the Patient Coordinator/Counselor at Medipolis, Antwerp, Belgium. Mrs. Pauwels states that she has no financial interest in the subjects mentioned in this article. She may be reached at tel: +32 3 828 29 49; fax: +32 3 820 88 91; e-mail: r.pauwels@medipolis.be.

1. Merriam-Webster Online. Coordinate. http://www.merriam-webster.com/dictionary/coordinator. Accessed April 13, 2010.
2. Merriam-Webster Online. Counselor. http://www.merriam-webster.com/dictionary/counselor. Accessed April 13, 2010.

(Continued from page 64)

TAKE-HOME MESSAGE

- Although lifestyle is still important, it is no longer fundamental in making the choice.
- Criteria are more objective than subjective; objective criteria must include aberrometry to measure quality of vision.

near vision as patients with multifocal lenses.

In our experience, most patients are able to achieve J3 near vision and generally need glasses for reading, with no accompanying glare or photic phenomena. Accommodating IOLs offer excellent vision in the long and intermediate ranges. Our experience with the Crystalens (Bausch + Lomb, Rochester, New York) is shown in Figures 5 through 7.

We recommend accommodating lenses for the following indications: patients who do not mind needing glasses for reading at times; patients who expect the best quality visual acuity for distance; patients with reduced macular function (macular visual field); young diabetic patients with no maculopathy; patients with drusen or the beginning of any other retinopathy; patients with floaters; patients with one eye; and patients with corneal opacity.

CONCLUSION

When presbyopia-correcting IOLs are properly recommended, patients' expectations are consistent with their visual results, the doctor-patient relationship is preserved, and surgery is perceived as the state of art.

We must know our patients well and be aware of their needs and requirements. We can thus meet our responsibilities, and patient can achieve his level of expectation. ■

Leonardo Akaishi, MD, is Director of the Hospital Oftalmológico de Brasília, Brazil. He states that is a panelist and member of the scientific advisory board for Abbott Medical Optics Inc., Alcon Laboratories, Inc., and Vistatek. He may be reached at tel: +55 61 34 42 40 00; e-mail: leonardoakaishi@uol.com.br.

Newton Andrade Jr, MD, a participant in the cataract fellowship program of the Hospital Oftalmológico de Brasília, Brazil. He states that he has no financial interest in the products or companies mentioned. He may be reached at tel: +55 61 8609 2020; e-mail: Newton.jr@globo.com.

Marcio Nutels, MD, is a participant in the cataract fellowship program of the Hospital Oftalmológico de Brasília, Brazil. He states that he has no financial interest in the products or companies mentioned. He may be reached at tel: +55 61 9199 1122; e-mail: munutels@hotmail.com

1. Akaishi L, Fabri PP. PC IOLs mix and match technologies: Brazilian experience. Paper presented at: World Ophthalmology Congress; February 2006; São Paulo, Brazil.