Supplement to

June 2010

Cataract & Refractive Surgery TODAY

Produced under an educational grant from Abbott Medical Optics Inc.

The Presbyopia Challenge

Making the right choices for today's presbyopia-correcting IOL patient.

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Making the right choices for today's presbyopia-correcting IOL patient.

Giving Our Patients the Vision They Seek

We must learn how to meet patients' changing expectations if we hope to capitalize on the growing cataract population.

Ophthalmologists in the US will be facing an unprecedented shift in demographics in the near future. According to 2009 data from the US Census Bureau, approximately 3.4% of the US population will turn 60 years or older every year for the next several years (Figure 1).[1] This means that 10 years from now, more than 30% of the US population will be older than 70. Between 2009 and 2014, a report in the *Archives of Ophthalmology* projects that cataract procedures in the US will grow 3% annually (Figure 2).[2] With people living longer these days, it is obvious we are going to have an unprecedented tidal wave of patients who will require cataract surgery in the relatively near future.

Currently, presbyopia-correcting lenses represent 7% of the IOLs implanted in the US.[3] Despite some current flattening due to the economic recession, refractive IOLs' impact on the market should be much greater. I believe that one factor in this poor showing is surgeons' failure to close the refractive loop. Just as refractive surgery did not experience exceptional market share until the advent of LASIK and its "wow" factor, we refractive cataract surgeons need to focus on giving patients what they want. Patients do not enter our offices asking for a particular technology; they come in asking for freedom from spectacles. We need to provide spectacle freedom at all distances and under all lighting conditions as often as possible. If we can deliver glasses-free vision, we can satisfy our patients. Satisfied patients will refer their friends, and the refractive IOL category will continue to grow.

> "We need to provide spectacle freedom at all distances and under all lighting conditions as often as possible."

So, how can we take advantage of this opportunity to give more of our patients the visual performance they seek? In the following pages, read about how distinguished ophthalmologists have approached the issues of spectacle freedom, quality of vision, managing patients' expectations, developing a strategy to manage emmetropia, and creating a premium experience for refractive IOL patients.

We have designed this monograph with an interactive component. We have assigned a particular topic to each physician in a question & answer format. To

"Satisfied patients will refer their friends, and the refractive IOL category will continue to grow."

get the most value from this excercise, review the answer options and the physicians' discussion about each one. Then, decide for yourself which answer is best (there is space for you to mark your choice if you wish). You will find the authors' choices in the answer key on page 11.

We hope that the insights these experts share will help you better navigate the refractive IOL landscape.

—Steven J. Dell, MD

1. U.S. Census Bureau. 2009 National Population Projections (Supplemental). Projections of the Population by Selected Age Groups and Sex for the United States: 2010 to 2050. Available at: http://www.census.gov/population/www/projections/summary-tables.html. Accessed May 24, 2010.
2. Data adapted from: The Eye Diseases Prevalence Research Group. Prevalence of cataract and pseudophakia/aphakia among adults in the United States. *Arch Ophthalmol*. 2004;122(4):487-494.
3. Harmon D. The global IOL market. St. Louis, MO: Market Scope LLC; June 2009.

US POPULATION GROWTH ANALYSIS

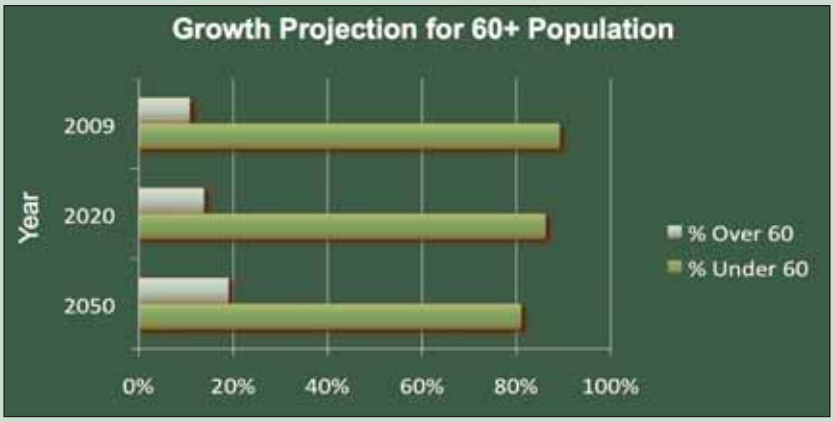

Figure 1. Approximately 3.4% of the US population will turn 60 years or older every year for the next several years.[1]

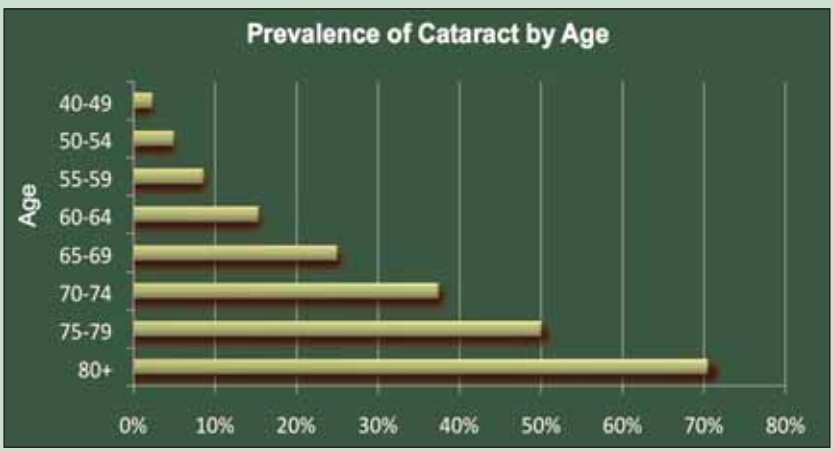

Figure 2. US cataract procedures are estimated to grow 3% annually.[2]

Contents

Spectacle Freedom and Quality of Vision

The visual goal of most cataract patients today is to achieve an improved quality of vision and freedom from spectacles in all lighting conditions (independent of pupil size). Quality of vision with IOLs is becoming more complicated to assess now that surgeons have multiple lens designs to choose from, including multifocal and aspheric versus spherical monofocal lenses. Quality of vision is obviously related to the quality of the optics, but it is also a result of the quality of the materials used in the lens.

Mark Packer, MD, *Eugene, OR*

Question 1: Which of the following technology features contributes MOST to pupil-independent freedom from glasses?

A. Apodized surface
B. Fully diffractive surface
C. IOL material
D. Asphericity

My answer is _____

A. APODIZED SURFACE

The performance of apodized optics depends on the pupil's size. An apodized optical surface does not bring the multifocal correction out to the periphery. Thus, when the pupil constricts in low lighting conditions, patients implanted with an apodized IOL can experience problems with their near vision.

B. FULLY DIFFRACTIVE SURFACE

A fully diffractive optical surface provides for reliable pupil-independent visual performance, regardless of lighting conditions. The patient will enjoy quality distance and near focus regardless of the size of the pupil (Figure 1). Although asphericity does play a role in pupil- independent vision at night, clearly, a fully diffractive surface is the better answer.

C. IOL MATERIAL

The type of material used in an IOL, although important for image quality and light transmission, does not play a role in pupil-independent vision.

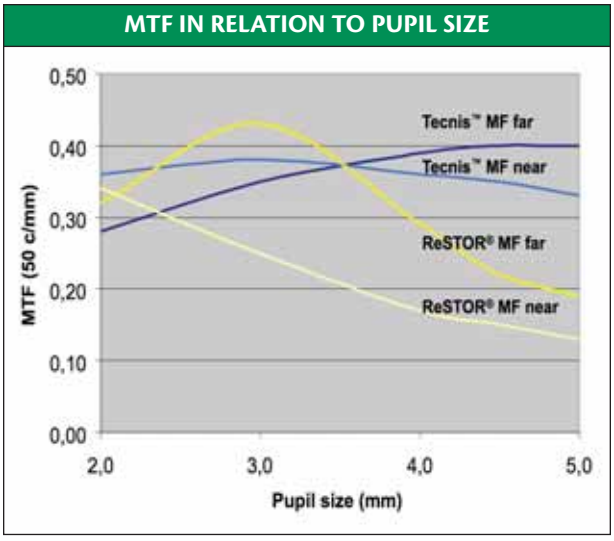

Figure 1. MTF graphs of near and far optical performance of the Tecnis Multifocal IOL (Abbott Medical Optics Inc., Santa Ana, CA) and the AcrySof ReSTOR IOL (Alcon Laboratories, Inc., Fort Worth, TX). MTF graphs created using the ACE model.

D. ASPHERICITY

This is an interesting option. A small amount of corneal asphericity does create some pupil-independent visual performance at night. As the pupil gets larger, the refraction does not shift, and some asphericity will prevent the patient from experiencing "night myopia." For overall visual performance, however, studies have shown that zero aphericity is best (like in a healthy 19-year-old eye).[1] There is approximately +0.27 µm of spherical aberration present in the average cornea, so the ideal optic would have negative asphericity to bring the total ocular sphericity as close as possible to zero (Figure 2).[2]

Question 2: Which of the following lens design and material attributes affect quality of vision?

A. Spherical/chromatic aberration correction
B. Light transmission rate
C. IOL material
D. All of the above

My answer is _____

A. SPHERICAL/CHROMATIC ABERRATION CORRECTION

Studies simulating adaptive optics have demonstrated that the best quality of vision occurs when a patient's spherical aberration is very close to zero and when the longitudinal chromatic aberration is corrected.[3,4] Removing the crystalline lens leaves the patient with +0.27 µm mean corneal spherical aberration. So, an IOL's ability to correct spherical aberration is essential to providing patients with optimal vision. Multiple peer-reviewed publications and clinical investigations have demonstrated superior functional vision with aspheric IOLs.[5] My group published the first such study in 2002, which revealed that the mesopic contrast sensitivity with an aspheric IOL was equivalent to the photopic contrast sensitivity with a spherical IOL.[6] Since that time, adoption of aspheric IOLs in the United States has grown to encompass about 80% of the market.[7]

B. LIGHT TRANSMISSION RATE

Light transmission is very important. The higher the percentage of incoming light that reaches the photoreceptors, the better the patient's vision. In addition, the spectrum of light transmission has important implications for vision and health. Yellow IOL chromophores provide no tangible clinical benefits in exchange for the photoreception losses they cause. They fail to decrease disability glare or improve contrast sensitivity. Most epidemiological evidence shows that environmental light exposure and cataract surgery are not significant risk factors for the progression of age-related macular degeneration (AMD). Thus, the use of blue-blocking IOLs is not evidence-based medicine. Most AMD occurs in phakic adults over 60 years of age, despite crystalline lens photoprotection far greater than that of blue-blocking IOLs. Therefore, if light does play some role in the pathogenesis of AMD, then (1) senescent crystalline lenses do not prevent it, so neither can blue-blocking IOLs that offer far less photoprotection, and (2) all pseudophakes should wear sunglasses in bright environments. Pseudophakes have the freedom to remove their sunglasses for optimal photoreception whenever they choose, provided that they are not encumbered permanently by yellow IOL chromophores. In essence, yellow chromophores are placebos for preventing AMD that permanently restrict a pseudophake's dim light and circadian photoreception at ages when they are needed most.

(Courtesy of Douglas Koch, MD, and Li Wang, MD, PhD.)

MAGNITUDE OF SA AND DIOPTRIC EQUIVALENT

Average Postoperative Ocular SA	6 mm	4 mm
+ 0.45 µm (standard IOL)	-0.35 D	-0.15 D
+ 0.27 µm (no SA in IOL)	-0.21 D	-0.09 D
0 µm (Tecnis)	0 D	0 D

Figure 2. The effect of pupil size on IOLs with varying amounts of spherical aberration.[2]

C. IOL MATERIAL

If the IOL's material is not clear, then the patient will not have a high quality of vision. For example, any vacuoles or glistenings trapped in an optic can potentially scatter the light rays and reduce visual quality. A study by Mitooka reported at the 1999 ASCRS meeting found contrast sensitivity loss associated with heavy glistenings.[8] Olson also conducted a study in which he found that the visual acuity loss in patients with level 2+ glistenings or greater was significant (*P*=.01).[9]

D. ALL OF THE ABOVE

Each of these attributes of lens implants has important implications for optical performance. We know that correcting aberrations provides higher peak modulation transfer at physiologically important spatial frequencies, better peak contrast sensitivity, and therefore improved functional vision. Maximizing spectral light transmission is an advantage, because it increases visual function. Finally, maintaining clear optical material without vacuolization or glistening formation reduces forward scatter and aids visual performance. It is hard to pick just one of these important items.

1. Artal P, Alcon E, Villegas E. Spherical aberration in young subjects with high visual acuity. Paper presented at: The XXIV Congress of the ESCRS; September 13, 2006; London.
2. Data adapted from: Koch D, Wang L. Three myths about aspheric IOLs. Presented at: The Aspen Invitational Refractive Symposium; March 7, 2010; Aspen, CO.
3. Artal P, Manzanera S, Piers P, Weeber H. Visual effect of the combined correction of spherical and longitudinal chromatic aberrations. *Opt Express.* 2010;18(2):1637-1648.
4. Werner JS, Elliott SL, Choi SS, Doble N. Spherical aberration yielding optimum visual performance: evaluation of intraocular lenses using adaptive optics simulation. *J Cataract Refract Surg.* 2009 ;35(7):1229-1233.
5. Dick HB. Recent developments in aspheric intraocular lenses. *Curr Opin Ophthalmol.* 2009;20(1):25-32.
6. Packer M, Fine IH, Hoffman RS, Piers, PA. Prospective randomized trial of an anterior surface modified prolate intraocular lens. *J Refract Surg.* 2002, 18:692-696.
7. Leaming D. 2009 Survey of US ASCRS Members. http://www.analeyz.com/Analeyz%20ASCRS%202009.htm. Accessed May 18, 2010.
8. Mitooka K. Poster presented at: The Symposium on Cataract, IOL and Refractive Surgery; April 1999; Seattle, WA.
9. Olson RJ, quoted in Charters L. Lens material and design do affect visual outcome. *Ophthalmology Times.* April 15, 2000; http://visionrx.com/library/eyeonevents/innov_lens_material.asp. Accessed May 18, 2010.

Managing Patients' Expectations

Managing patients' expectations for their postoperative outcome can mean the difference between satisfied and dissatisfied patients. A critical component of succeeding with refractive IOLs is being prepared to address a variety of concerns and arguments from prospective patients.

Farrell "Toby" Tyson, MD, *Cape Coral, FL*

Question 1: What is the best way to handle this patient? "I hate my reading glasses because I think they make me look old. I'm interested in one of those presbyopia-correcting lenses you mentioned, but can you guarantee that I won't need these glasses anymore?"

A. Negotiate a guarantee
B. Target a monofocal IOL
C. Set realistic expectations and recommend a lens
D. Present all the options and let the patient decide

My answer is _____

A. NEGOTIATE A GUARANTEE

I never offer my patients guarantees. Only approximately 5% of my patients ask about a guarantee with refractive IOLs. I hesitate to implant a multifocal IOL in people who ask this question, because it is a red flag that they will be difficult to please and will likely be unhappy with any result. I feel these individuals are usually best served with a monofocal aspheric IOL such as the Tecnis 1-Piece lens (Abbott Medical Optics Inc.), which is a single-focus, no-compromises lens. I explain to the patient that this lens will give him the very best technology to be able to see at distance.

B. TARGET A MONOFOCAL IOL

Targeting a monofocal IOL may be a viable option in a patient who wants freedom from spectacles; some people do very well with those lenses. I would not consider a monofocal lens simply based on the patient's asking this question, however; my decision would depend on the results of their preoperative examination and other factors. It is important to address the issue of a guarantee with refractive IOL patients.

"The best policy for managing refractive cataract patients' expectations is to underpromise and overdeliver."

C. SET REALISTIC EXPECTATIONS AND RECOMMEND A LENS

In my experience, when patients ask for a guarantee relating to refractive IOLs, it is best to explain to them what these lenses can do and then try to ascertain their visual goals. I explain to my patients that the refractive IOLs I use are the most technologically advanced implants currently available. I tell them that after the surgery, they should expect to be able to function without glasses most of the time, but I can "guarantee" that there will be times they will need to use spectacles. I explain that although I cannot give them 18-year-old eyes, I am confident that the lens I recommend will be able to improve their vision (Figure 1).[1] I always recommend a lens to my patients to let them know which IOL will be the best fit for their lifestyle. Patients are looking for guidance, but I back up that guidance with my reasons for the individual IOL selection.

D. PRESENT ALL THE OPTIONS AND LET THE PATIENT DECIDE

Presenting the patient with too much information and leaving the decision up to him or her often results in confusion, which leads to indecision. Also, providing education about the various lens options is not the best use of the surgeon's time in the lane. I have found that patients generally want their physicians to recommend a procedure for them, and then the surgeon can introduce the patient to the IOL counselor.

(Courtesy of Elizabeth Davis, MD.)

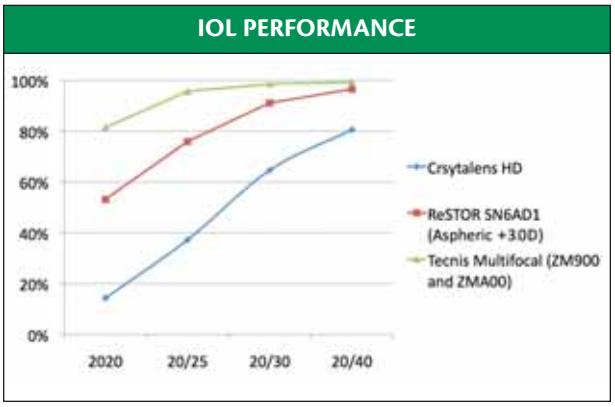

Figure 1. Analysis of refractive IOL outcomes as reported at 1 to 3 months in the DataLink IOL registry for near UCVA with the Crystalens HD IOL (Bausch & Lomb) (n=2,641), the AcrySof ReSTOR IOL +3.0 D (Alcon Laboratories, Inc.) (n=391), and the Tecnis Multifocal IOL (n=145).[1]

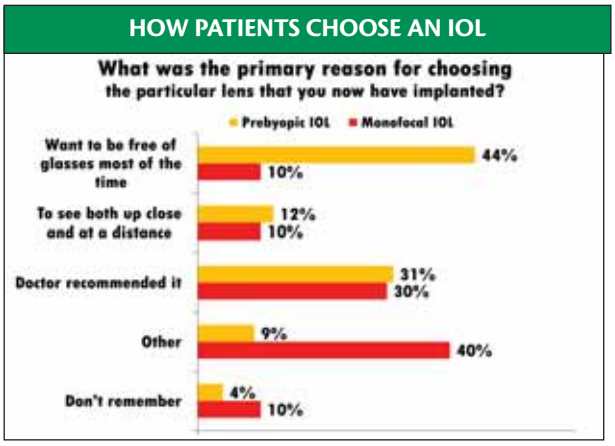

Figure 2. A 2007 telephone survey of patients diagnosed with cataracts (n= 62) revealed which type of lens implant they chose and why.[2]

Question 2: What is the best way to handle this patient? "It sounds good, but I had a friend a few years ago who got some of these expensive lenses, and he complained a lot about halos, especially around lights at night. Since I do a lot of night driving, I'm really concerned I'll have the same kinds of issues with these lenses."

A. Discuss technological improvements and recommend a lens
B. Provide the patient literature to review at home
C. Assure the patient there won't be any issues
D. All of the above

My answer is _____

A. DISCUSS TECHNOLOGICAL IMPROVEMENTS AND RECOMMEND A LENS

Many potential cataract patients are interested in presbyopia-correcting IOLs (Figure 2),[2] but they have some reservations about the technology and having to pay money out of pocket. It is important to explain the latest IOL technologies to refractive IOL candidates and recommend a lens for them. Many patients know friends who have older-generation refractive lenses and may complain about visual symptoms, and they are concerned about experiencing the same problems. The best strategy is to inform these individuals that there have been some significant advances in refractive IOL technology in recent years. As for concerns about glare and halos, I always reassure my patients that these symptoms, if they experience them at all, will lessen with time as their eyes heal and their brain adapts. Patients simply need to know what to expect from their postoperative vision with whichever lens they choose.

B. PROVIDE THE PATIENT LITERATURE TO REVIEW AT HOME

Giving the patient information about the various IOL options to review at home can be an important part of preoperative counseling, but it should not take the place of it. Take-home packets should provide enough information that the patient has educated questions ready for his or her preoperative consultation.

C. ASSURE THE PATIENT THERE WON'T BE ANY ISSUES

This option is promising too much. We have all heard it before, but the best policy for managing refractive cataract patients' expectations is to underpromise and overdeliver. I tell patients that I will do everything in my power to minimize any postoperative visual symptoms they may experience.

D. ALL OF THE ABOVE

You want to avoid giving any guarantees about postoperative visual performance without offending the patient. Explain that there are no guarantees in surgery, but that their postoperative vision will almost certainly be better than their preoperative vision.

1. Davis E, Kezirian G. DataLink comparison of visual performance in 3 Presby-IOLs. Paper presented at: The Aspen Invitational Refractive Symposium; March 6, 2010; Aspen, CO.
2. Cataract Surgery—Attitudes, Awareness & Satisfaction Survey. Denver, CO: Elective Medical Marketing; March 2007.

Targeting Emmetropia for Your IOL Patients

For patients to be satisfied with their refractive implants, they need to feel their expectations were met. Achieving this goal requires a combination of IOL selection and proper lens calculations. Post-IOL enhancements are necessary in approximately 15% to 20% of my refractive IOL patients.

Steven J. Dell, MD, *Austin, TX*

Question 1: What are the most reliable criteria to use when determining if a patient needs an enhancement after refractive IOL implantation?

A. Residual refractive error of more than ±0.50 D
B. Patient is dissatisfied with his vision
C. Patient is unable to read without glasses
D. Patient did not achieve 20/20 distance UCVA

My answer is _____

A. RESIDUAL REFRACTIVE ERROR OF MORE THAN ±0.50 D

This option is possible; I find some, but not all patients require an enhancement if they have ±0.50 D or more of residual refractive error. However, many patients with even higher levels of myopia are perfectly happy, especially if the dominant eye is emmetropic. Myopia can be a problem with multifocal IOLs because it obviously interferes with good distance acuity, but it also pulls the reading distance in very close. Hyperopia, generally, is poorly tolerated by accommodating IOLs, since much of the accommodative function will be consumed achieving good distance vision.

B. PATIENT IS DISSATISFIED WITH HIS VISION

Patient satisfaction is the best criteria for determining the need for a postoperative enhancement. If the patient is unhappy with his or her vision, it is important to understand the issue(s) and address them proactively. Approximately 15% to 20% of my refractive IOL patients require a secondary enhancement. I target emmetropia in these individuals, and my experience has been that laser vision correction is the best option for achieving emmetropia.

C. PATIENT IS UNABLE TO READ WITHOUT GLASSES

Although our goal is to provide spectacle independence, it is important to remember the patient's preoperative goals for the surgery. Sometimes, what may look like a poor outcome on paper may make the patient very happy, and vice versa. It is wise to talk with our patients after their surgery and determine whether or not they are happy with their vision.

D. PATIENT DID NOT ACHIEVE 20/20 DISTANCE UCVA

Again, the patient may be 20/25 and happy, or the result may be better than his or her previous vision. Visual satisfaction is determined on a case-by-case basis. However, the patient must thoroughly understand the new visual reality awaiting him after any proposed enhancement. This education may require a trial with frames or even contact lenses. Unfortunately, there are patients whose visual goals simply cannot be met with any optical device, and sometimes this does not become apparent until they are bilaterally pseudophakic. Chasing an unobtainable goal with laser vision correction is not an appealing endeavor.

CYLINDER REDUCTION WITH AND WITHOUT INTRAOPERATIVE WAVEFRONT ANALYSIS

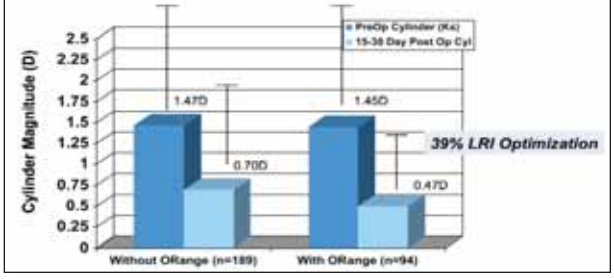

Figure 1. LRIs are an important tool for achieving postoperative emmetropia. Now, technologies such as intraoperative wavefront analysis (ORange; WaveTec Vision, Aliso Viego, CA) can improve LRI accuracy.

Question 2: Which of the following is the MOST important element needed to achieve patient satisfaction with refractive IOLs?

A. Obtaining the intended postoperative refractive outcome
B. Matching technology to patients' needs
C. Achieving the patient's expectations for spectacle independence
D. All of the above

My answer is _____

A. OBTAINING THE INTENDED POSTOPERATIVE REFRACTIVE OUTCOME

Attaining emmetropia after refractive cataract surgery is critical to giving these patients satisfactory results. It is helpful to have a surgical strategy in place for achieving this outcome consistently and minimizing the need for postoperative enhancements. Optimizing your IOL calculations, incorporating astigmatic management (Figure 1), and managing residual refractive error are all important components of such a strategy. Because it is not always possible to hit emmetropia at the time of the lens implantation, however, learn to correct residual refractive error soon after the initial surgery with limbal relaxing incisions or other methods (Figure 2[2]). Also, counsel refractive IOL patients to expect a postoperative enhancement in order to help set their expectations and minimize their disappointment if they do need a secondary procedure.

B. MATCHING TECHNOLOGY TO PATIENTS' NEEDS

Matching an IOL technology to the patient's visual needs is important, and the surgeon and IOL counselor must learn what daily activities are most important to the individual. However, the latest lens technologies are more forgiving than the first-generation versions. Many of today's presbyopia-correcting IOLs can give patients a broader range of visual performance than they could previously. In fact, refractive IOL recipients' satisfaction with their implants has been steadily increasing in recent years.

C. ACHIEVING THE PATIENT'S EXPECTATIONS FOR SPECTACLE INDEPENDENCE

Patients' expectations for their postoperative vision must be managed preoperatively, and I believe the surgeon should play the premier role in establishing these expectations with the patient. Research I performed in 2007 demonstrated that the single greatest determinant of a patient's postoperative satisfaction was the proximity of their final refraction to the preoperative refractive target.[1] With the improved IOL technology available today, this indicator is even more critical. As a general rule, patients are first and foremost concerned with high-quality distance acuity, followed by near acuity. I ascertain the individual's visual priorities with a preoperative questionnaire, supplemented with a directed discussion of their visual goals. The timing and the financial implications of a potential postsurgical enhancement need to be clear in the patient's mind prior to surgery. Patients who have undergone previous keratorefractive surgery need special counseling, because their odds of hitting the refractive target are lower.

D. ALL OF THE ABOVE

We know that success with all refractive IOLs rests on hitting the refractive target. Missing the refractive target means that the patient's satisfaction level suffers. With older-generation multifocal IOLs, matching the lens technology to the patient's needs was particularly important. Because the current-generation lenses, like the Tecnis Multifocal IOL, are much more forgiving and have a broader range of visual performance, this is less of a concern. Of course, meeting the patient's expectations for spectacle independence is an important component of succeeding with these lenses. We still have to manage our patients' expectations preoperatively so that they know what to expect from these lenses. My job as the surgeon is to set that tone.

1. Dell SJ. Matching patient needs with the appropriate IOL in cataract and refractive lens exchange surgery. Paper presented at: The Annual Meeting of the ASCRS; May 1, 2007; San Diego, CA.
2. Data adapted from: Ferrer-Blasco T, Montés-Micó R, Peixoto-de-Matos SC, et al. Prevalence of corneal astigmatism before cataract surgery. *J Cataract Refract Surg*. 2009;35(1):70-75.

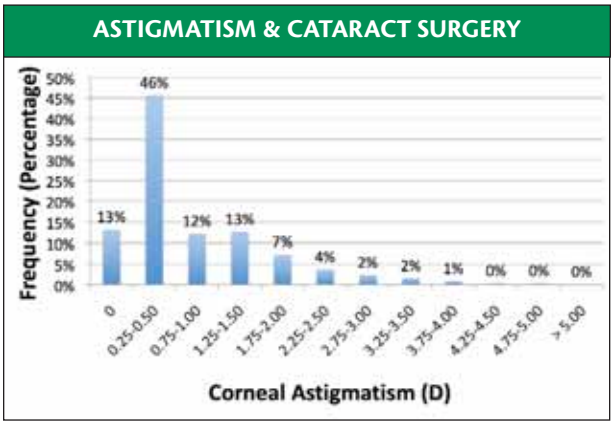

Figure 2. Seventy percent of cataract patients have >0.50 D of preoperative astigmatism, and 39% have >1.00 D.[2]

Creating a Premium Experience

Certain things influence the success of a refractive cataract practice more than others. Do you have to be located in an affluent area to succeed financially? The choice of which refractive IOLs to offer in your practice will ultimately impact your success with these lenses. Is it better to offer all types of refractive IOLs, or to stick with a few favorites?

Kerry Assil, MD, *Beverly Hills, CA*

Question 1: Does your choice among the different refractive IOL technologies have any impact on the success of your practice?

A. Yes, patients recognize the IOL brand names
B. No, marketing is more important
C. Yes, a choice of technologies leads to happier patients
D. No, it is all about pricing

My answer is _____

A. YES, PATIENTS RECOGNIZE THE IOL BRAND NAMES

Although our patients express some interest about the technologies we use in their procedures, they will never sufficiently recognize refractive IOL brand names to the point of significantly impacting our practices. Patients are more influenced by word-of-mouth endorsements about the IOL technology and their acquaintances' experience at a particular practice.

B. NO, MARKETING IS MORE IMPORTANT

Marketing is an important component to the success of a practice, but it should stress that the practice prioritizes patient care and advanced technology rather than promoting brand-name devices. Still, word-of-mouth referrals account for the majority of my practice's new patients, and its impact will only grow as online social networking becomes increasingly popular. User review Web sites like Yelp.com and Angieslist.com are gaining viewership and will impact our volumes whether we like it or not.

> "The key is to identify the patient's visual needs and expectations and then match an IOL technology to those needs."

C. YES, A CHOICE OF TECHNOLOGIES LEADS TO HAPPIER PATIENTS

The key is to identify the patient's visual needs and expectations and then match an IOL technology to those needs. I have found that using top-quality lenses such as the Tecnis Multifocal IOL (Abbott Medical Optics Inc.) directly impacts the growth of my practice. I believe that refractive cataract surgeons are what we implant. If we implant products that leave our patients greatly satisfied, our practices will be strong (Figures 1 and 2[1]). If our implant choices provide our patients with only marginal

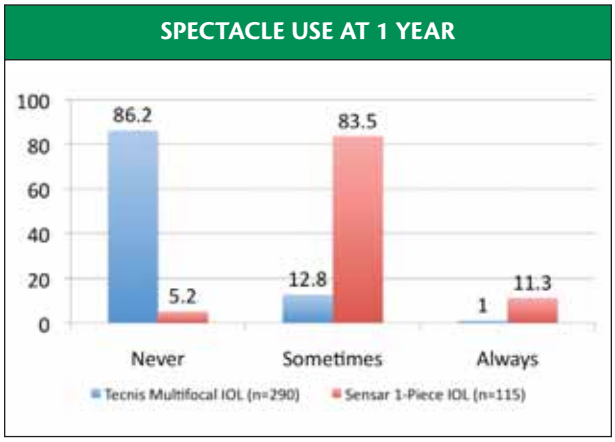

Figure 1. The Tecnis Multifocal IOL single piece lens significantly reduces dependence on glasses compared to monofocal IOLs.[1]

satisfaction, our practices will suffer. Word-of-mouth referrals can only be built on outcomes, which start with having a choice of IOL options to suit the patient's needs.

D. NO, IT IS ALL ABOUT PRICING

Ophthalmologists learned from marketing laser vision correction that ultimate success is much more about the patient's experience and surgical outcome than about how low a practice can price its procedures. Again, I think it is more important to stress the surgeon's expertise and the positive patient experience you offer rather than to compete on price.

Question 2: What is the most critical element of success for a refractive cataract practice?

A. Wealthy patients
B. Offering a diversity of services
C. Believing in the technologies you provide
D. Having a knowledgeable staff

My answer is _____

A. WEALTHY PATIENTS

I have a diverse patient base. Although my practice is in Beverly Hills, most of my patients come from outside this area. I believe my practice's success comes from how my team and I care for our patients and focus on their outcomes, which is something practices anywhere can do. It is important not to make assumptions about our patients' level of interest in a refractive cataract procedure.

B. OFFERING A DIVERSITY OF SERVICES

Offering a variety of services can help a practice survive today's tough economy, but it is important to consider what services you will offer. Simply adding cataract surgery to a refractive practice isn't enough; you need to select and commit to the proper technologies. While technological diversity is good, it is more important to focus on quality outcomes and the patients' experience.

C. BELIEVING IN THE TECHNOLOGIES YOU PROVIDE

I think it is clear that the quality of the IOL technology we implant makes a huge difference in patients' satisfaction. If you don't believe in the technology and services you provide, your patients won't, either. You and your staff must convey confidence in order to be successful. The covenant that we make with refractive IOL patients is to help them see without glasses, not to simply give

> "If you don't believe in the technology and services you provide, your patients won't, either."

them a particular lens. The lens technology that I most routinely employ is the Tecnis Multifocal IOL, which enables me to reliably help patients become more independent of their glasses. (This lens is now available in a single-piece platform for surgeons who prefer it.) I believe in this technology so much that I even implanted the Tecnis Multifocal IOL unilaterally in a 19-year-old who had a monocular cataract. This patient now favors the uncorrected acuity from her implanted eye over her other eye, which had no cataract and less than 1.00 D of refractive error. My outcomes with this lens platform are reliable.

D. HAVING A KNOWLEDGEABLE STAFF

Having a knowledgeable staff is important. It is critical that your team be able to effectively answer patients' questions. Simple knowledge isn't enough, though—they must be personable and be able to communicate with the patients with warmth and confidence.

1. Tecnis Multifocal IOL package insert.

PATIENT SATISFACTION

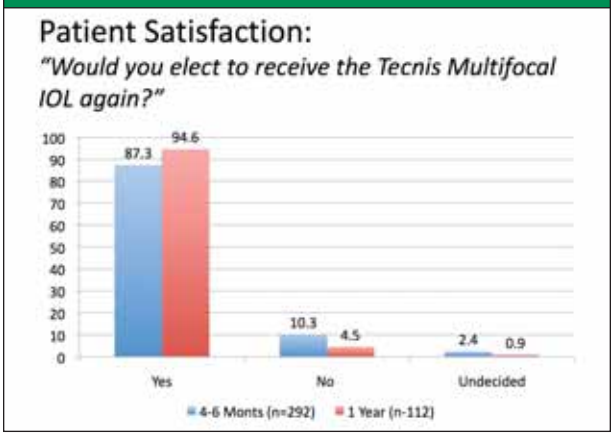

Figure 2. Patients' satisfaction with their choice of IOL will continue to increase over time.[1]

ANSWER KEY
Dr. Packer: B, D; Dr. Tyson: C, A; Dr. Dell: B, D; Dr. Assil: C, C

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