WHEN TO SAY NO

How to screen patients for psychosocial red flags that predispose them to dissatisfaction.

BY PARAG A. MAJMUDAR, MD

I have been practicing ophthalmology for 20 years, so I can easily say that I am on the "back nine" of my career. With that experience come wisdom and a keen awareness of when things just don't seem right.

When I started practicing in 1998, the LASIK boom was in full swing. We ophthalmologists felt that we were invincible and could treat any patient who walked through the door. Ultimately, we learned more about corneal ectasia, and we devised a systematic approach to LASIK screening. Now we know that we do not need to—and should not—perform LASIK on every patient who seeks it.

A valuable lesson is that we do not need to operate on every patient who presents for surgery. I think we all feel this internal pressure to make every patient who comes through our door extremely happy. In some cases, however, not operating may be the best course of action because surgery may not be in the best interest of the patient.

THE PSYCHOSOCIAL FACTOR

I recently saw a patient in her early 50s who had come in for a LASIK evaluation. As I walked into the room and introduced myself, she made very little eye contact with me. That was the first sign that something was not right and that she might be upset about something. I learned that she had visited my office before but had left before seeing me. I asked her, "What happened that day? Was there an issue that we can improve upon?" From her response, I got the impression that she felt that we had done too much testing and that she had grown anxious, felt like the visit was not worth her time, and left.

From an ophthalmic standpoint, I thought the patient was a good LASIK candidate. She had moderately high myopia of -5.00 or -6.00 D and could have attained a successful outcome with cornea-based refractive surgery. After speaking with her, though, I sensed she might be dealing with more issues than just her ocular concerns.

Much has been discussed about the psychosocial factors involved in LASIK satisfaction. Studies have shown associations between poor outcomes and depression and suicide in patients affected by these psychosocial factors. When I evaluated this patient's medical history, I saw that she was taking a number of psychotropic medications. Her history, coupled with the fact that she seemed unable to handle what most would probably consider minor inconveniences at a doctor's office, made me concerned about how she would respond if her surgical outcome were less than ideal.

Most of us, especially in the early parts of our careers, are so focused on the physical examinations and outcomes that we sometimes overlook a patient's psychosocial function. It is a big hurdle to overcome. In this case, I asked myself, "What would I have done 20 years ago?" Given her physical candidacy, I would have proceeded with LASIK, and the patient might have done well. Now I recognize that we all have encountered patients who achieve successful visual outcomes but complain of intractable dry eye, glare, or halos or have some other emotional or psychosocial outcome that affects their satisfaction. Not only did I consider the prospect of years of follow-up visits by an unhappy patient, but I also thought about the patient herself. I did not want her to unnecessarily undergo a procedure that might make her less happy than she was wearing glasses or contact lenses.

20/HAPPY?

I think some patients are not just seeking improved vision but are also thinking that surgery will make them happy. This is also a common occurrence in plastic surgery. In either field, when outcomes do not meet these unrealistic expectations, patients mistakenly believe that the procedure failed.

A second issue is that vision is a critical component of people's lives. If something affects a person's ability to work or perform daily tasks in some way, that can lead to psychologic distress. I therefore think that we must make a concerted effort to screen candidates for intangible contraindications.

A third point is that not all successful patient encounters hinge on a perfect surgical outcome—hence, the concept of *20/happy*. Instead, much of our patients' satisfaction hinges on a great physician-patient relationship. Sometimes a first visit cannot achieve the necessary level of trust. In the case I described earlier, I did not feel enough of a bond with the patient after her first visit to recommend surgery. If I had thought the intangibles might be resolved in the future, I might have told her to come back for a follow-up examination, but I did not think that there was any way for me to make her happy based on her emotional situation.

Accurately assessing patient expectations is an art form. If a patient says, "I want to see 20/20 all the time," most of us are comfortable responding that this expectation is not reasonable. More complicated is recognizing when something about the situation is not quite right. Some red flags that may indicate unreasonable expectations include multiple consultations, a very type-A personality, extreme nervousness, failure to make eye contact, and agitation over minor inconveniences.

PATIENTS' RELATIONSHIPS WITH STAFF

Our staff members can provide invaluable information about our patients. They can put us on alert for potentially problematic patients before we see them. We can cultivate this teamwork by acknowledging that we all want to make the patient experience great but to let us know if anything on the patient's side is preventing that. For example, we want to know if a patient does not seem to deal well with minor issues, because it could signal problems if there is a minor issue after surgery.

HAVING THE CONVERSATION

Like many of us, I typically try to underpromise and overdeliver. I downplay surgery's potential benefits in terms of visual acuity and independence from glasses. If a patient still seems overdemanding, I gently communicate why the procedure will not be successful for him or her: "Mrs. Jones, I know you want to see for distance and reading and be able to see sheet music 24 inches away, but we do not have a procedure that can do that at this time. Maybe we ought to revisit this." Alternatively, I may try to explain that a patient may not be an ideal candidate for a given procedure by saying, "You know, your cornea is a little bit on the thin side" or "Your ocular surface may give us some problems."

There is usually a way to gently inform patients that we may not be able to deliver what they want. I would almost never tell them that I do not think they can handle surgery from a psychosocial standpoint. For the particular patient I have described, there had been some discussion about her being in her early 50s, with low to moderate myopia, and she had indicated that she wanted to maintain near vision for some tasks. I therefore told her, "LASIK may not be the best solution for you in terms of being able to deliver vision for distance as well as for some more near vision tasks. Maybe we ought to wait a year or 2 and let things stabilize, and then there may be more options in the refractive lens exchange arena that we can explore. There are always new lens implants coming out, and there may be potential for one procedure to accomplish multiple goals and tasks." I do not think she interpreted what I told her as condescending or an implication that I did not want to treat her.

If a patient is rude to the staff or threatens violence, a firmer approach is warranted. We can say something like, "I don't believe that ours is the right practice for you. I don't believe that we can deliver on your expectations, and I think it would be in your best interest to find another doctor. I hope you find a doctor who may be able to take care of you." This phrasing advocates for your staff as well as the patient.

CONCLUSION

We are not necessarily in the business of making patients see 20/20 or 20/15. We are in the business of making patients happy with their vision. Sometimes that means stepping back, evaluating the big picture, and asking ourselves, "Am I doing this to make myself happy or to make the patient happy? Can I successfully do that?" Answering these questions is a great first step toward achieving our collective goal of patient wellness. ■

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