SOMETIMES THE SURGEON IS THE PROBLEM

When you perceive barriers to success with premium IOLs, maybe you should be looking in the mirror.

BY AMANDA CARDWELL CARONES, MPH

Research suggests that physicians lose their ability to communicate effectively over time.[1] It's not surprising; practicing medicine is not easy. With the physical, mental, and emotional demands of practice coupled with stressful reimbursement challenges, it's no wonder that many doctors lose their ability to demonstrate empathy with patients.

Despite this, in most of the ophthalmology practices I visit as a practice management consultant, surgeons are still the primary deliverers of patient information and education regarding surgical options. If we believe the research just noted, surgeons are quite likely the worst people in the practice to do this.

Let's face it, you didn't become an ophthalmic surgeon because you like to talk to patients; you became an ophthalmic surgeon because you want to operate. When monofocal IOLs were the only option for lens replacement, cataract surgery consultations were easy. But those days are long gone, and today's consultations have become much more complex.

THE THREE MAJOR BARRIERS

A lack of soft skills and an inability to effectively engage with and convert patients lead physicians to frequently cite three perceived barriers to success with premium lens conversions.

▸ Barrier No. 1: **"I don't have enough time."** This one is true. *You* don't have enough time. Your time is the most expensive time in the clinic, and for every minute you spend explaining procedures and techniques to one patient, you are losing the potential to see another patient. As the range of treatment options expands, however, the necessity to understand your patients' personal visual preferences continues to grow, requiring touchy-feely conversations with patients that you probably don't enjoy.

Solution No. 1: ***Delegation of patient education is essential.*** Your staff can become an extension of you. To accomplish this, you must expend effort aligning the team to use consistent patient-friendly terminology and educating staff members on your decision tree. In turn, the staff members must work at understanding each patient's visual lifestyle so as to prepare him or her to visit with the surgeon. If all is done properly, the patient is prepped throughout the diagnostic workup with knowledge about the procedure and potential solutions and is waiting for you, the surgeon, to make a final recommendation on which solution is best for his or her specific needs.

▸ Barrier No. 2: **"My patients can't afford it."** To be fair, some patients can't. But making the decision to not discuss options based on a patient's home address, type of work, or attire is simply unfair and, some might argue, discriminatory.

Solution No. 2: ***Give all patients the option.*** It is not your responsibility to decide what patients can or cannot afford. Only they know their ability and willingness to pay. Outside of medicine, any time consumers decide whether to invest money for something, they subconsciously consider the equation V = B - C, where the difference between the *benefits* (B) provided and the *costs* (C) thereof gives us the *value* (V) of a potential investment. How great or how little that value amounts to is a personal matter. This is why some people upgrade to the newest smartphone as soon as it launches and others do not.

The job of the medical professional is to understand each patient's medical situation, understand what his or her desired outcome would be, and figure out which solution most closely satisfies those needs. The patient's job is then to determine the value and whether he or she wishes to invest or to choose a less expensive option. Investing in vision is an option that all suitable patients should have.

▸ Barrier No. 3: **"My patients just aren't interested."** Some surgeons tell me that, in order to be more efficient, they try to understand up front whether a patient is willing to pay for premium options. Some ask the patient outright. Others provide a generic picture menu depicting the vision delivered by various lenses. If patients say they are interested, the surgeon goes into an explanation of everything that is

available and lets the patients decide how to proceed. If patients say no, only the basic solution is presented.

Solution No. 3: ***Hold off on having the conversation about cost.*** Essentially asking, "How deep are your pockets?" may be an acceptable approach for someone planning a vacation or buying a car, but it is not an acceptable approach in medicine. Patients—whether coming to you with a cataract or for a refractive surgical procedure—are scared. You are the one who will be cutting into their eyes, and, in their minds, this carries the risk that they will become blind.

When facing a procedure that will affect their vision for the rest of their lives, patients are first and foremost concerned about their outcomes. Money is a secondary consideration—one that should be addressed after you understand what the patient would like to achieve and what he or she is a candidate for.

When patients first enter your practice, they don't have the knowledge to decide what is right or wrong for their eyes. The most they probably know is that, during a surgical procedure, their lens will be removed and replaced with a new one. Patients don't have the training to choose between different options. To refer back to our equation, they may know the *cost* for premium options, but they cannot estimate the *value* without understanding the personal *benefits* and the compromises. Asking them if they are willing to pay before educating them is doing a disservice to the patients as well as your practice.

MOVING BEYOND THE BARRIERS

Moving beyond these three barriers requires a mindset change for everyone in the practice. Consider the following: Your patients are not having cataract surgery; they are having lens replacement surgery *because* they have a cataract. Embracing this philosophy makes it possible to create a consistent patient-centric educational process that begins before the patient arrives in the clinic and continues after the patient leaves. It removes the guesswork of when and with whom to discuss options.

In the overall patient journey, the patient spends significantly more time with your staff than with you. Patients tend to relate better to staff members, speaking more openly with technicians and counselors who engage with them rather than with the surgeon. There is less intimidation and less doctor-induced anxiety.

Staff members have more time and, therefore, opportunity to build trust and rapport and to instill confidence, but they must be trained on what to say and when to say it. You cannot build a patient-centered practice without first building the team. It requires team development, consistent training, and ensuring that every member is aware of and aligned with the valuable role he or she plays in the patient experience.

In the same way that you trained to perform delicate ocular surgery, your staff must train to engage patients in discussion about how they use their vision on a daily basis and what they would like from their vision in a perfect world. They must assess patients' motivations and willingness to compromise in order to achieve spectacle independence. And they must be able to demonstrate the personal benefits that a patient may experience by choosing different options.

All of this information must then be transferred from the staff to you so that you can make a final recommendation for which procedure will deliver the best visual outcome for each patient. An experienced practice development consultant such as myself or even some ophthalmic companies can provide assistance in training your staff and implementing this process.

PERSONAL EXPERIENCE

In the purely private practice I manage with my husband, Francesco Carones, MD, in Milan, Italy, we use a structured approach to educating patients. The surgeon is the final decision-maker, but he or she is not the primary educator. We introduced this format about 7 years ago. Not only do we continue to achieve double-digit growth in surgical volume year over year, but our conversion rate to presbyopia-correcting IOLs (extended depth of focus or trifocal) averages between 75% and 83%, and 65% of these implants also correct for astigmatism (personal data).

This approach, when executed correctly, demonstrates that the surgeon doesn't need more time; that patients can afford premium IOLs; and, most important, that patients are interested in them. When they understand the personal benefits they can experience with premium IOLs, and they perceive the value, they are willing to invest in obtaining more vision than a basic procedure may provide.

CONCLUSION

Your staff can help to increase the number of premium lenses you implant. Bring them on board with your vision, educate them, delegate to them, and build your team around the philosophy that you are not performing cataract surgery, you are performing lens replacement surgery—and some of those patients just happen to also have cataracts. ■

1. Ha JF, Longnecker N. Doctor-patient communication: a review. *Ochsner J*. 2010;10(1):38-43.

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