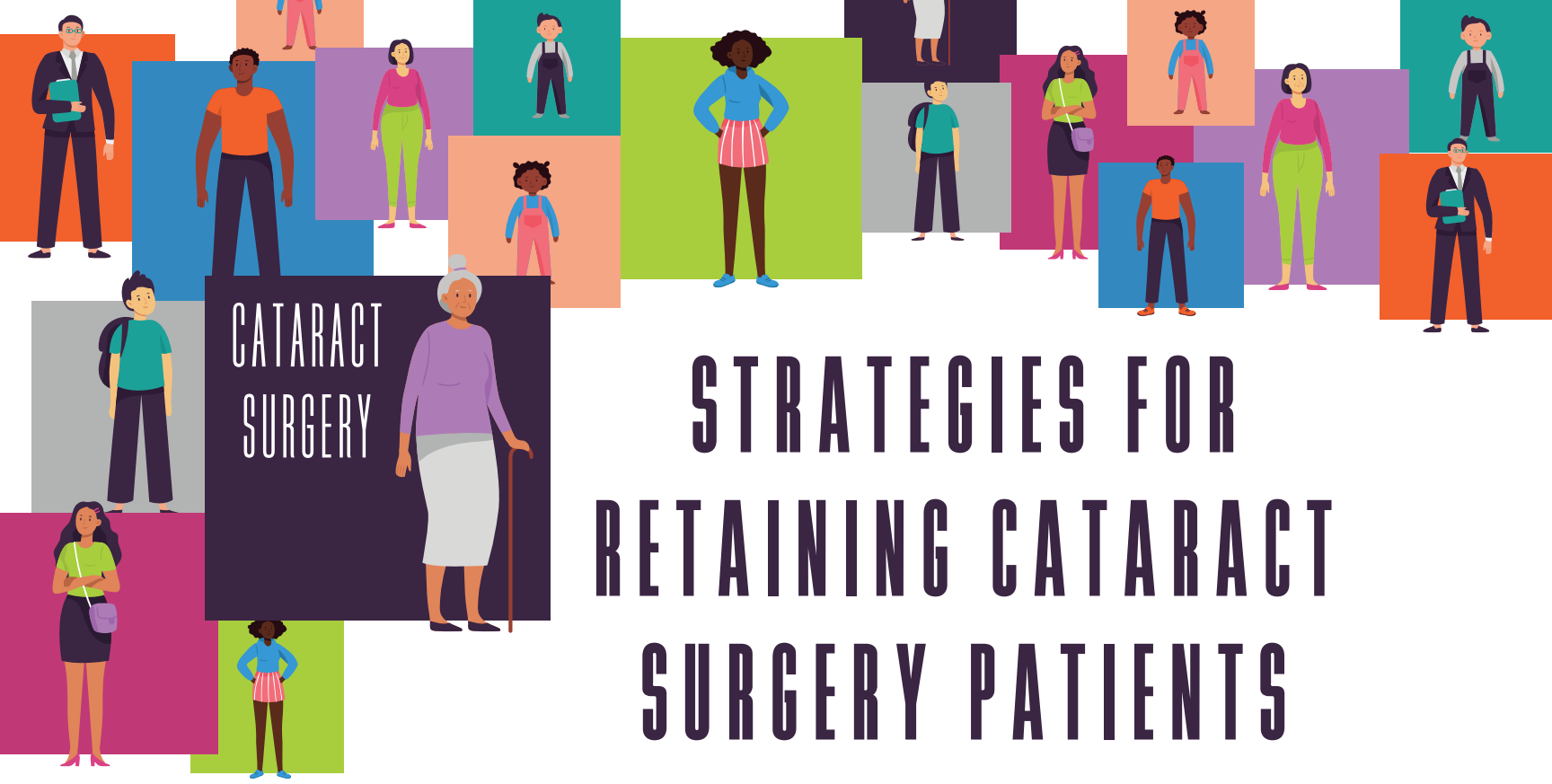

STRATEGIES FOR RETAINING CATARACT SURGERY PATIENTS

Three core principles.

BY AMY LIN, MD

Patients have many choices when it comes to cataract surgery. The first is their choice of cataract surgeon. The following three principles can help a practice retain patients.

NO. 1: BUILD TRUST

▸ **Existing patient base.** Building patient trust in the practice before they develop cataracts can pay dividends. I inform patients of their early cataracts but also reassure them that surgery will not be required for several years. I emphasize that the decision to undergo cataract surgery is theirs, not mine. They will know it is time for surgery when they have difficulty performing their daily activities and changing their glasses prescription does not improve their vision. I also mention that I perform cataract surgery (some patients have assumed that I do not).

▸ **Second opinion.** Sometimes, patients visit my practice for a second opinion because they feel pressured by another ophthalmologist to undergo surgery but are not convinced that the procedure is currently necessary. If I find that their BCVA is 20/25 or better and they have no visual complaints, I update their glasses prescription and invite them to return in a year. I mention that I am happy to see them sooner if they experience a significant decline in their vision in the interim. I am careful, however, not to disparage the other ophthalmologist. I explain that there are many acceptable approaches to recommending cataract surgery and note that I tend to be conservative. Patients have appreciated my honesty and often return to me for follow-up. These individuals frequently become my cataract surgery patients.

▸ **Referrals.** When a patient is referred to me for cataract surgery, I complete my evaluation, make a recommendation, and send a letter to the referring provider. I use this approach whether the doctor is an optometrist, a retina specialist, or an internist. If my recommendation is observation, the referring doctor usually appreciates my honesty and continues to refer patients to me. Has a referring doctor ever disagreed with my recommendation and sent a patient to another cataract surgeon for surgery? Perhaps. I sleep better at night, however, knowing that I recommend what I believe is best for each patient.

NO. 2: USE ACCESSIBLE LANGUAGE

When patients are ready for cataract surgery, we have a frank discussion about the procedure and the choices to be made. In my experience, the use of medical jargon quickly alienates patients. Instead, I use terms that they can understand and imagine I am speaking to a nonmedical friend or family member (see *Advice for Avoiding*

ADVICE FOR AVOIDING MEDICAL JARGON

- **SIMPLIFY** the cataract procedure by explaining its two main parts: removal of the cloudy lens and placement of an artificial lens to improve vision

- **EXPLAIN** the concept of monovision as the best of both worlds of near and distance vision

- **BRIEFLY DISCUSS** multifocal IOLs as one option that can provide a range of vision at an additional out-of-pocket cost

- **DESCRIBE** the potential side effects of glare and halos as something they may see around lights at night

- **EXPLAIN** astigmatism in layman's terms and discuss how glasses and toric IOLs address the issue

Medical Jargon). I explain that cataract surgery has two main parts: removal of the cloudy lens and placement of an artificial lens to improve vision.

Next, patients choose whether they want their best vision to be at near or distance. I also explain the concept of monovision as having the best of both worlds but with some asymmetry or lopsidedness to their vision. I add that there are lens implants (multifocal IOLs) that can provide a range of vision but that an additional out-of-pocket cost is required. I describe the potential side effects of glare and halos around lights at night with multifocal IOLs and explain that, although improved, postoperative vision is not the same as youthful vision. If astigmatism is a concern, I explain the condition in layman's terms as simply a measurement that is in their current glasses, and I discuss how glasses and toric IOLs address the issue. I do not push premium IOLs. I leave the choice up to each patient.

My explanation of possible postoperative complications is brief because I find that an extensive discussion can overwhelm patients. I also describe issues that are unique to the patient that could affect the results of their surgery. Issues include Fuchs dystrophy, keratoconus, macular degeneration, or a history of refractive surgery. I do not want these patients to compare their results to those of friends and neighbors whose UCVA was perfect after cataract surgery.

NO. 3: SET REASONABLE EXPECTATIONS AND ACKNOWLEDGE CONCERNS

It is important to walk patients through what they can expect after surgery. I start with the first few postoperative hours. I counsel patients to anticipate temporary but extreme blurring of vision and foreign body sensation. After surgery, I remind them that these phenomena are normal and temporary. Postoperatively, if they do not experience any pain or discomfort, they are pleasantly surprised.

At every postoperative visit, I acknowledge any patient complaints and express my support—even if they have forgotten something they were told. I do not brush off their concerns; I address them and discuss options for improvement. For example, I may recommend the use of artificial tears for ocular irritation or remind patients that their vision should improve after they receive new glasses. If a patient experiences a complication such as a ruptured posterior capsule or vitreous loss, I discuss the issue frankly and see the patient more frequently. I find that patients appreciate the empathy and support.

CONCLUSION

Once the postoperative healing process is complete, I send patients back to their referring doctors or, if they have been in my practice from the start, continue seeing them annually. A reputation for honesty, personableness, and skill can go a long way toward building a successful cataract surgery practice. ■

DIGITAL EXCLUSIVE

For a European perspective on this topic, scan the QR code to read an article by David Shahnazaryan, MD, FRCSI (Ophth), FEBO

READ IT NOW

AMY LIN, MD
- John A. Moran Eye Center, University of Utah, Salt Lake City
- amy.lin@hsc.utah.edu
- Financial disclosure: Consultant (Kala Pharmaceuticals)