Mastering the Patient Conversation

Create realistic expectations to achieve the most satisfying outcomes.

BY ARTHUR B. CUMMINGS, MB ChB, FCS(SA), MMed(Ophth), FRCS(Edin)

The first item on the mission statement of my practice, Wellington Eye Clinic in Dublin, Ireland, is this: Patients' satisfaction is our top priority. Time and experience have taught me that the biggest reason for patients' dissatisfaction is when they expected more from the postoperative result than what was achieved. We strive, therefore, to provide patients with an accurate indication of what to expect as the outcome or result of an anticipated surgery. This is achieved through a comprehensive dialogue between surgeon and patient. Like most other surgeons who offer premium IOLs, we follow the mantra "underpromise and overdeliver." If the patient experiences a surprise outcome postoperatively, may it always be a positive surprise.

UNDERPROMISE, OVERDELIVER

The number one complaint from patients is that outcomes differ from what they expected. With all the hype of improved outcomes in cataract and refractive surgery, it is easy to get overconfident and promise too much. The patient conversation must be about creating realistic expectations, including, whenever possible, simulating the postoperative effect with contact lenses.

Despite the fact that multifocal lens designs have improved significantly—and to date I do not have a single patient in whom I have explanted a multifocal lens—my initial approach is monovision. My colleagues and I have treated approximately 6,000 patients with monovision. I favor this modality because it does not compromise the eye's optics. In the distance eye, the light coming from distance is focused on the macula, whereas the reading eye has the light from near focused on the macula. If the patient's brain can comfortably suppress the vision from the eye that is not being used, monovision is a good solution. In my experience, however, approximately 25% of men and 15% of women cannot overcome the neural compromise. It is for this group—patients who have tried monovision with a contact lens trial and found it to be unsuitable or who did not like the look of monovision when it was demonstrated during clinical examination with the phoropter—that I feel multifocal IOLs make the most sense.

CONVERSATIONS WITH MOTIVATED PATIENTS

When the topic of multifocal lenses is raised, it is usually a familiar concept, because the patient will have read educational material in the waiting room and potentially watched an animated video (Eyemaginations, Inc., Towson, MD) on multifocal lenses. At this point, I have a motivated patient in front of me who knows that monovision is not the ideal solution for him or her and who is keen on achieving greater spectacle independence.

Before I discuss multifocal lens options, I broach the topic of monovision again. I usually say something like the following: "If you had three eyes, I could give you the solution you are looking for. I would make one eye good for distance, make the second eye good for reading, and make the third eye good for intermediate distances such as the computer screen. If you were a good candidate for monovision, your whole range of vision would then be in focus. Unfortunately, you do not have three eyes, and therefore one distance will always be compromised. It is important to know that nothing we can do currently will give you the vision of an emmetropic 20-year-old. It will always involve some kind of compromise."

I continue the conversation by explaining that multifocal lenses have improved greatly over the years and that the latest models are likely to work in the right candidate. To know if the patient falls into this category, I implement a trial with multifocal contact lenses prior to multifocal lens surgery whenever possible. This is the ultimate safety net for me; patients who do well with multifocal contact lenses also do well with multifocal IOLs.

BILATERAL IMPLANTATION

Success with multifocal IOLs depends on how the brain perceives images. I explain to the patient that multifocal lenses are made up of rings with different powers and that these rings focus light coming in from all distances onto the retina. The brain determines whether to look up close, intermediately, or far.

Patients undergoing unilateral surgery are forewarned that results are not optimal until the second eye is treated. The moment the second eye is treated, there is a synergistic effect, and within days patients notice an increased range of vision. I show patients an example of the binocular clinical defocus curve (Figure 1), typically for the AcrySof IQ Restor IOL +3.0 D (Alcon Laboratories, Inc., Fort Worth, TX), because this is my lens of choice. I tell patients that I expect them to achieve good distance vision, to have good reading vision at approximately 40 to 50 cm, and to have adequate intermediate vision. The binocular defocus curve graph acts as a visual aid to demonstrate that some aspects of vision, namely distance, are better and some are more functional, namely intermediate vision. I also warn patients that side effects such as glare and halos at night can occur, but that these tend to decrease with time. As mentioned earlier, I have not yet explanted a multifocal AcrySof Restor lens.

If patients are adequately educated and know exactly what to expect, it is far easier to satisfy their needs. I warn patients that, to get the maximum effect and performance from the IOL, their refraction must be close to emmetropia and they must have minimal astigmatism. This is normally possible following lens surgery, but on occasion there is some residual astigmatism or spherical refractive error. For these patients, my colleagues and I perform corneal laser refractive surgery to achieve emmetropia and greatly enhance the performance of these lenses. Patients are informed that there is no charge for fine-tuning laser surgery. This practice not only encourages us to get the intraocular surgery right the first time, but it also produces good ambassadors for the clinic because patients find it generous that enhancements are included in the price of the procedure.

WHAT COMPROMISE IS BEST?

Whether dealing with monovision or multifocal patients, I always say the following to a presbyopic individual: "Whatever we do surgically, once you have reached the age of 45 years and older, visually speaking you are compromised. If you have perfect distance vision, you need glasses for reading. If you have perfect reading vision, you need glasses for distance. If you have monovision, in which one eye is for distance and one eye is for near, or you have multifocal implants, each of these solutions represents a compromise. It is my job to figure out which one of these compromises suits you best."

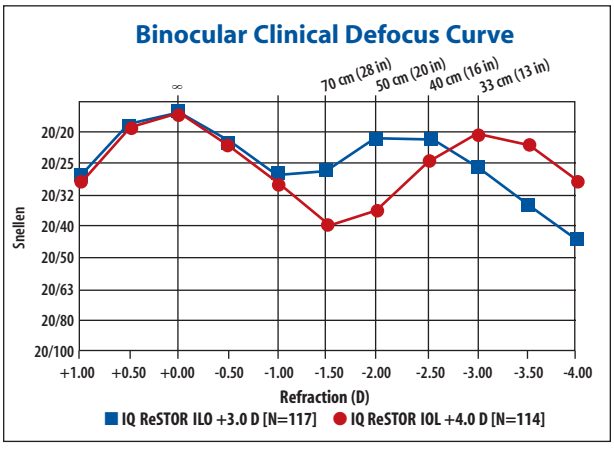

Figure 1. Binocular clinical defocus curve.

When patients undergo presbyopia-correcting surgery, they must have realistic expectations that coincide with what we can currently achieve. Patients with realistic expectations perceive their postoperative results as miraculous. The only patients who are less than satisfied are those who expected more than we delivered.

CONCLUSION

I often tell patients: "When we have the technology to implant an IOL that functions like the 20-year-old natural crystalline lens, that will be the ultimate solution in terms of correcting presbyopia. Until then, the multifocal lenses that we currently have are the closest thing to mimicking this through very clever technology, but they are not perfect."

When patients understand and can accept the compromises of current premium lens technologies, they will enjoy their postoperative results. After the consultation, patients should have a good understanding that their outcomes are not going to be perfect. But they should also understand that, of all the compromises to be considered, this particular compromise suits their needs best. There is no question that it takes more time and input to prepare patients for surgery with multifocal lenses, however, it turns out to be extremely rewarding for both doctor and patient when the patient is elated with the outcome. ■

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