Letters

A Refractive Convenience

In the June issue of *EyeNet*, David Diaz, MD, wrote a letter to the editor expressing his reservations about the term "premium IOL." It struck a chord as I, too, have been troubled by this. I had not previously considered the role of terminology in contributing to the portrayal of these lenses as superior to the standard monofocal lens, but I certainly agree.

Something that is even more troubling is the suggestion that these patients ought to be treated as "premium," as well. I heard it recommended at a conference that these patients could enjoy a different section of the waiting room and shorter wait times. Wait—isn't that discrimination?

Our patients and the profession of ophthalmology in general deserve that we uphold a standard of treating patients with universal equality and respect, regardless of their ability to pay more for a specific product. Although I'm certain it affects my "conversion rate," the most important message I convey to my patients during the discussion of toric/multifocal lenses is that this type of lens is not a medical necessity nor a better product, but rather a refractive convenience.

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Caveat Emptor

Kudos to Dr. Diaz for pointing out the commercialism behind the term "premium IOL" in his letter to the editor in the June issue of *EyeNet*.

I would like to add some comments about the commercialism and salesmanship surrounding the "sale" of these lenses by "eye care providers." Collectively, the term "eye care providers" now must include referring eye doctors (both ophthalmologists and optometrists) who are being educated by the intraocular lens sales force; by visiting MD-employed optometrists seeking referral business for their practices; and by continuing education programs being presented by the ophthalmologists themselves. Consequently, patients now arrive on the surgeon's doorstep, already convinced of the wonders of the new "premium" lenses.

And why are referring doctors becoming such enthusiastic devotees of these lenses? They now have come to realize that they, too, can share in the largesse of the system, which permits billing the patient another 20 percent for the additional "premium" lens fee and the astigmatic keratotomy (if it was performed)—on top of the 20 percent of the insured fee, per eye—for all their "extra work." Of course, that also includes the A-scans when the referring doctor "requests" them.

An article in *Optometric Management* urges referring doctors to "Maximize your diagnostic and therapeutic licensure. For example, you should perform A-Scans, and see *all* referred cataract patients *one-day postop*. These referrals are your patients. Determine and maximize the pre- and post-op care within your license. By doing so, you will increase profits. And when you write the prescription, you make a positive impression on the patient."[1]

As for the practices performing the surgery, watch the shenanigans as the need to pay for the femtosecond laser drives further commercialism. The cost of the "premium" lenses will likely go up, as will the "conversion rate," another term that smells merchant-like. By the way, it is curious that the capsulorrhexis performed by femtosecond laser, which is being touted as exquisite, can be quite efficiently performed by physician assistants (PAs) in the ORs of some of our finest ophthalmologists, a trend that seems to be catching on.

Caveat emptor!

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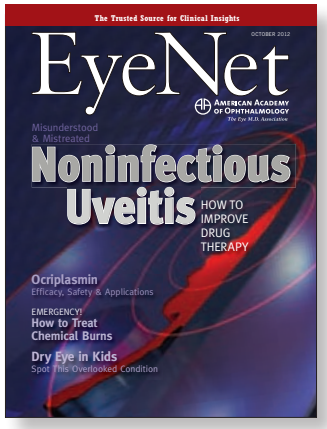
1 Kattouf R. *Optom Management.* 2012;47(2):24.



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