THE VISION CARE INSTITUTE™ of Johnson & Johnson Medical Ltd

Age: the final taboo?

By Alison Ewbank

Communication is the key to getting more presbyopes to wear contact lenses. Discuss. This was the task for a panel of expert contact lens practitioners convened at THE VISION CARE INSTITUTE™.

Here's what they had to say...

TVCI Panel Members

Chair: Bill Harvey, Clinical Editor, Optician
Simon Donne, Simon Donne Opticians, Bedford
Peter Ivins, Peter Ivins Eye Care, Bearsden
Ros Mussa, Boots Opticians, London
Roger Pengelly, Vision Express, Dorset
Adnan Malik, Sims Opticians, Middlesex
Sarah Morgan, Eye Communicate, Lancashire
Brian Tompkins, Tompkins & Knight, Northampton

'The lens of the future and always will be' has been a maxim applied to any number of contact lens advances over the years. But one development which can truly be described as the lens of the future is the multifocal contact lens.

This is the breakthrough that will keep patients in contact lenses and extend the benefits of contact lens wear to more people. With an ageing population, the successful presbyopic correction also represents a key opportunity to grow the contact lens business.

The figures speak for themselves. While one in five spectacle lenses dispensed in the UK is a progressive lens, only one in 25 (reusable) contact lenses prescribed throughout Europe is a multifocal.[1] And although this segment of the contact lens market is growing, sales in the UK lag well behind its neighbour France, a country which accounts for more than four in 10 of all multifocal lens sales in Europe.[1]

Factors inherent in the French market may be the reasons for this difference. The traditionally high use of multifocal spectacles and early availability of presbyopic contact lenses, a lack of enthusiasm for monovision, and that most contact lenses in France are fitted by ophthalmologists who are themselves typically presbyopic, are just some of the factors that might be involved.

Yet despite the introduction of several new multifocal designs, UK practitioners are still to change their approach to discussing contact lenses with presbyopes. Last year an Optician survey[2] found that more than half introduced the topic only occasionally, and recommendation habits were similar to those found in the same survey in 2003.[3]

So is communication the key to increasing the number of presbyopes who wear contact lenses and what techniques can practitioners use to achieve this?

To explore these questions, Johnson & Johnson Vision Care invited a panel of experienced communicators from a variety of practice environments to a round-table discussion at THE VISION CARE INSTITUTE™. The aim was to examine practitioner behaviour when discussing presbyopia and contact lenses, and to share tips on how best to communicate with this age group.

When and how to start the discussion

Practitioners often wait until patients notice changes to their near vision before introducing the topic of presbyopia. But the consensus among the panel was to start earlier than this in order to pre-empt the patient's concerns, explain what changes to expect and show that you were in control of the situation. Chairman Bill Harvey said that the eye examination at any age should include an explanation that eyesight changes throughout life.

For Brian Tompkins, it was almost never too early to initiate the discussion. 'If you drip feed information over the years, patients will have a better understanding of presbyopia,' he said. Adnan Malik's approach was similar; he described his technique as to 'plant the seed' and then provide regular information at each visit.

Simon Donne measured accommodation routinely and let patients know if there had been any change, in order to prepare them for what was to come. 'That way you don't have to say "there's been no change". It's also easier to talk to a 30 year old about getting old than a 40 year old,' he said. When assessing children's accommodation, it was worthwhile explaining and demonstrating the measurement to accompanying parents, who may soon become presbyopic.

The age of the practitioner was also a factor in how to approach the topic. Peter Ivins observed that the dynamics of the age relationship were an important consideration to avoid causing offence. It was easier to discuss presbyopia if you were older than the patient, when you could relate it to your own experience, less so if you were younger, he said.

In fact there was general agreement that being presbyopic yourself was helpful in appreciating its problems 'It's like once you've had kids, examining their eyes becomes easier,' said Tompkins.

Several panel members had simulated presbyopia to demonstrate its effects to younger patients. Tompkins uses a pair of -8.00D lenses, while Sarah Morgan found the most effective method was instilling 0.5 percent tropicamide, an experience that could have a marked impact when used to show students, young practitioners and support staff what it meant to be presbyopic.

There was general agreement that presbyopia was a difficult concept to explain and that communication needed to be tailored and timed differently for myopes and hyperopes. For Donne, the -2.25D myope was the most difficult to deal with, while Ivins also found hyperopes tricky since they often regarded their pre-presbyopic glasses as 'reading glasses'.

What words to use and avoid

Opinions were divided over the wording to use when explaining the concept of presbyopia. Most were cautious about mentioning 'age' or 'ageing' directly and suggested some useful euphemisms and analogies. 'Nobody likes to be told they're getting older,' argued Ivins, who preferred to say 'you're losing accommodation'.

For Sarah Morgan, presbyopia was one of the most challenging conditions to explain and different types of presbyope required different stories. Practitioners needed to choose their words very carefully, she said. Her preference was to avoid mentioning accommodation – not a patient-friendly word – and opt instead for 'focusing power'.

Finding the right words: tips for discussing multifocals with presbyopes

'A natural process as we get older'
'You say you couldn't possibly wear contact lenses? Let's do it.'
'A lot of our patients are finding these lenses incredibly useful.'
'Would you like to try contact lenses instead of bifocals?'
'You've got an 80 percent chance of success with this lens but I don't know whether you're one of the 80 or one of the 20. Let's go on a journey to find out.'
'These are trial lenses – give me a call if you're uncomfortable with them'
'If you have any questions, I'm here.'
'Let me know how you're getting on.'
'Most of my patients with your type of vision are better with contact lenses for some things and with spectacles for others.'
'It's not a one-size-fits-all situation. One pair of glasses or contact lenses can't do everything – it's like not having just one pair of shoes.'

Tompkins' view was that just as patients could cope with having 'a yellowing lens' rather than a cataract, 'how eyes changed over time' was a good intro to any discussion of presbyopia. But his use of the term 'reading vision' was not favoured by Morgan. 'You don't read your bacon and egg but you can't see it if you're presbyopic!' she said.

Others suggested using the analogy of a celebrity who was youthful and attractive despite being presbyopic, such as George Clooney, to explain that the effects of age on the eye were not necessarily a handicap!

So was age really the final taboo, to be avoided at all costs? 'I never mention the A word,' remarked Malik, although he might explain that presbyopia was 'a natural process as we get older'. His preference was always to use the correct terminology rather than avoid technical words and he welcomed the inclusion of 'presbyopia' in a brand name.

Mentioning age depended not only on the likelihood of the patient taking offence but, again, on the age of the practitioner. 'You can't really say to the patient, "It's your age – get over it," if you're only 20 yourself!' said Donne. Younger practitioners might be tempted to say 'my dad has this problem', although this particular analogy was unlikely to be welcome!

How to manage expectations

Research has shown that while practitioners perceive price as the number one factor in the patient's choice of presbyopic correction, for the patients themselves recommendation is by far the most important consideration.[4] This suggests that patients reaching presbyopia are very much open to professional advice on which type of correction to choose.

Interestingly, adaptation to vision correction is also an issue for the practitioner, but not for presbyopes, who do not expect to have to adapt to their spectacles or contact lenses. Preparing them for any potential problems and setting realistic expectations is therefore an important part of the communication process.

Ros Mussa highlighted the need to explain carefully to patients the limitations of presbyopic contact lens correction, just as a dispensing optician would advise a patient who was collecting a pair of progressive spectacles. Her approach with multifocal contact lenses was to avoid 'promising the earth', and manage the situation by saying, 'These aren't going to be great for everything but for 80 percent of life they will be.'

Tompkins pointed out that many candidates for multifocal contact lenses had failed with progressive spectacles and might be anxious about failing again. 'Promise them 80 percent and deliver 90 percent, but don't be too worried about discussing the negatives.'

Describing contact lens practitioners as a 'breed of measurers', Morgan argued that they were trained to correct to the bottom line on the chart and the smallest print, rather than aiming for '20/Happy'. 'Don't forget that a majority of presbyopes do without spectacles most of the time,' she added.

For Morgan, there was danger of over-emphasising the limitations of multifocal lenses and telling patients in advance what they would not be able to do with them. Her approach was to put the lens on the eye without mentioning that it was a multifocal lens or for presbyopia. Tompkins' technique was similar: 'This is a way of correcting your close focusing,' he told the patient.

Although her strategy was to 'accentuate the positive and eliminate the negative', Morgan cautioned against being over-positive. Her suggested wording for setting realistic expectations but leaving it up to the patient to report any difficulties was to say, 'I'm hopeful these are going to 80 percent good – for the other 20 percent of situations, let me know what these are.'

'Limitations and compromise are two words I'm hearing a lot but no-one wants either in their lives. We're already telling patients what they won't be able to do with their lenses and they may be more aware of this than they are of the benefits,' she argued.

Ivins' view, as a presbyope himself, was more pragmatic. 'Everything after presbyopia is a compromise – we're managers of compromise for our patients once they're over 45. That's tough but they're going to have to get used to it.'

Ivins agreed that practitioners tended to be driven by acuity but vision was governed by a whole range of other measures. 'We should be saying to patients, "Get out there in the real world – now is that a better situation for you?" Patients live in the real world but practitioners live in the consulting room,' he said.

The consensus was that the best trial was to use an empirical fitting approach and stick to the fitting guide then let the patient take the lenses away and try them in their own environment, rather than making constant adjustments to the lens design or power at the initial fitting. Dispensing multifocal spectacles worked this way, so why take a different approach for multifocal contact lenses.

'Make sure the patient knows this is a trial, and give them the opportunity to contact you if they're uncomfortable, but you have to have the confidence to let them go,' said Malik. Practitioners could then see the patient after a few days, ask them about their experiences and make any necessary changes to the lenses.

There were various suggestions for assessing near vision and explaining presbyopia in the consulting room using real-world targets, the most common being the mobile phone or Blackberry, which were particularly useful with male patients .

Men required different communication techniques from women since they were not as used to touching

their eyes and were often assumed not be interested in contact lenses. It was important not to prejudge their attitude to trying multifocal lenses, said Tompkins, who gave all his presbyopic patients – male and female – the option to try contact lenses.

Similarly, old age should not be seen as a barrier to contact lens wear. Lifestyles were changing dramatically and presbyopes of all ages could benefit. Donne remarked that his oldest contact lens patient was 94 years and was wearing lenses when he died!

How to present the options

One of the key messages from the panel discussion was the opportunity to prescribe a combination of vision corrections for different situations. Variously described as 'the visual buffet' and 'the corrective cocktail', recommending a selection of products for a selection of tasks was universally popular.

Examples might be combining progressive spectacles and multifocal contact lenses, using over-spectacles for some tasks, or switching to single-vision contact lenses for activities where daily disposables were more suitable.

Tompkins was a particularly keen advocate of multi-correction options ('we can sell them more lenses!') but said practitioners needed to be more comfortable with admitting that more than one solution might be required.

In fact research had shown that most presbyopes saw multifocal contact lenses and progressive addition spectacle lenses as complementary and preferred to have both, considering this combination the best option to meet their vision needs.[5] The question was, when over-spectacles might prove necessary, should the practitioner mention this from the outset or could it make the patient less likely to succeed.

Some panelists found analogies with other personal items useful in explaining the need for more than one solution. Tompkins liked to ask patients how many pairs of shoes they had for different occasions, whereas Malik used handbags to make the comparison. For Ivins, a useful analogy was to ask if they had a laptop, an iPhone and a camera. All had functions in common but each had its own purpose.

Roger Pengelly felt than many younger practitioners, in particular, found it hard to relate to patients and to convey the benefits of different lenses. His suggestion was to discuss each option while the multifocals were settling on the eye then let patients make an informed choice. 'Don't make the decision for them,' he warned.

With emerging presbyopes in particular, it was important to present the various spectacle and contact lens options available and their relative benefits so this subject could be approached when multifocal lenses were on the eye to highlight the advantages of this option.

Malik made the important point that, when discussing choice of contact lens, comfort should not be neglected such that the discussion was only about vision. The benefits of the lens material should be mentioned. It was also worth emphasising the intrinsic benefits of contact lenses over spectacles, such as 'the frameless view'.

Aside from clinical issues, recommending multiple vision correction options had practice management implications too. Ivins pointed out that practice systems were often set up for old habits – fit lenses, send the patient out, get them back and check. Practices needed to consider how best to schedule appointments and the impact of refitting on their management systems.

Chair time was especially an issue for those working in multiple practice. Pengelly observed that independents could be more flexible than multiples in this regard, and Mussa said that if employees were penalised for increased chair time this could be a disincentive to recommending multifocal lenses. 'It does take more time and skill but patients feel they're getting a lot more from you,' she added.

For Ivins, it was question of profit per hour of chair time. It might be more profitable to spend time fitting multifocal lenses if the long-term return was greater, he said.

Donne agreed that there were other, less immediately tangible benefits involved: 'If you successfully fit your presbyopic patients it's going to be a good practice builder because they're going to be more loyal.'

How to improve communication skills

Even our panel of skilled communicators acknowledged that explaining the options for presbyopic correction was no easy task. Morgan commented that with multifocal lenses, as with persuading patients to change to silicone hydrogels, there was 'a big skill set to learn'.

Whether newly qualified or experienced, many practitioners needed help with communication. 'It's no wonder the penetration of multifocals is as low as it is at the moment, since there's so much to learn about communicating the benefits.'

Tompkins said that advising patients to 'upgrade' to new products was useful but Morgan preferred the word 'update'. 'Upgrading is associated with paying more money and you could be leading yourself into a price conversation, which many practitioners can't handle,' she said.

But Simon Donne was not convinced that such skills could be learned. Having spent all of his working life applying his sales skills and 'top-down selling', his assessment was blunt: 'Either you've got it or you haven't!'

Bill Harvey observed that more tuition in these skills was needed in the universities and beyond. 'Filming practitioners talking to patients can really change behaviour and THE VISION CARE INSTITUTE™ has a role to play in this type of education,' he said.

In Morgan's estimation, 10% of practitioners were great communicators and the others might benefit from communication training. The remaining 80 percent needed to hear ways of communicating and learn the language to use.

There was little doubt which category the panel belonged to and their message was clear. The success of multifocal lenses would depend on communicating effectively with presbyopes, carefully explaining the changes to their eyesight, conveying the benefits of the new lenses, and, not least, trying them on patients' eyes.

About the author

Optometrist Alison Ewbank is a former Editor of Optician and currently the journal's Special Projects Editor. She is also a freelance writer and her professional interests are contact lenses and anterior eye.

References

1. Euromcontact market share report Q1, 2011.
2. Ewbank A. Who fits contact lenses? Optician 2009;237:6204 16-21.
3. Ewbank A. Understanding the UK contact lens market. Optician, 2003;225:5904, 22-25.
4. Fylan F and Grunfeld EA. Visual illusions? Beliefs and behaviours of presbyope clients in optometric practice. Patient Education and Counselling 2005;56:291-295.
5. Neadle S, Ivanova V and Hickson-Curran S. – Do presbyopes prefer progressive spectacles or multifocal contact lenses? Cont Lens Ant Eye 2010; 33: 262-263

THE VISION CARE INSTITUTE™
of
Johnson & Johnson Medical Ltd