Compassionate Communication

Strategies for building relationships with newly diagnosed patients and those with progressing glaucoma.

Optimism and Confidence
Reassure Patients

By Henry D. Jampel, MD, MHS

When communicating with a patient newly diagnosed with glaucoma, the physician should be clear, honest, and optimistic. He or she should inform the patient of the severity of his or her disease and the likelihood of sustaining noticeable vision loss in his or her lifetime. Naturally, fear of blindness is an important concern, but in my experience, patients rarely ask, “Will I go blind from glaucoma?” I reassure patients with mild to moderate disease that, if properly treated, glaucoma will not cause blindness. For patients with severe disease at diagnosis, I do not provide false hope. Rather, I emphasize that, by strictly adhering to treatment, they can minimize the likelihood of further vision loss.

I like to be confident that a patient’s glaucoma has worsened before communicating this information to him or her. Demonstrating worsening glaucoma on automated perimetry usually requires repeat testing, and the glaucoma community is still learning what constitutes worsening using imaging. I tell the patient that he or she may have some worsening but that I hope further testing will not confirm it.

When I am confident that the glaucoma has progressed, I will remind the patient that he or she has been monitored so that further damage can be detected as soon as possible. I discuss the rate of worsening, and if it is slow, I emphasize how a slow rate of progression may preserve his or her vision. The patient and I discuss strategies to prevent further worsening. With these approaches, I believe most patients should be able to finish their office visit feeling hopeful that, with an appropriate therapeutic plan, their disease progression can be slowed or halted.

Henry D. Jampel, MD, MHS, is Odd Fellows professor of ophthalmology at Wilmer Eye Institute, Johns Hopkins University School of Medicine in Baltimore. Dr. Jampel may be reached at (410) 614-2339; hjampel@jhmi.edu.

Individualize Care and Education

By Richard J. Madonna, OD, MA

How glaucoma manifests varies from patient to patient, and each responds to his or her disease differently. Because glaucoma is an individualized disease, the most effective means of educating a newly diagnosed patient must be customized to that person. When I encounter a patient with newly diagnosed disease, I impart certain key messages, and I take cues from the patient as to how much he or she comprehends. For instance, a patient with normal IOP and small patterns of visual field loss requires a different clinical course and educational focus than a patient with previously undiscovered advanced disease.

I begin the educational process by dispelling common misconceptions about glaucoma. The Internet is clinicians’ ally, but it is also a repository of misinformation. Many patients come to the clinic after having already researched glaucoma on their own, in which case a large portion of the educational process may be spent discussing what he or she has read. It is worthwhile to have printed materials to guide patients to verified and reliable sources of information.

Many patients have a family member with the disease and are familiar with some of the terms that I discuss with them. More and more of my patients know that glaucoma is a disease of the optic nerve rather than think it means high pressure, which I partly attribute to greater public awareness of the disease. One of the first questions I ask patients is about their family history. Their answer reveals a potential risk factor, but at the same time, the question allows me to be a good steward of the public health aspect of glaucoma management. Specifically, the patient may have a brother or sister in
need of an eye examination, and discussing the genetic component of the disease may prompt needed action.

Making sure a patient understands his or her own disease state is important to the success of treatment, but it can also be daunting for the patient to receive so much information at once while also hearing a potentially overwhelming diagnosis. After the first encounter, patients should understand the chronicity and severity of their disease, but they should also feel optimistic about the many wonderful treatment options, running the gamut from medication to laser therapy to surgery.

Many patients newly diagnosed with glaucoma think that blindness is inevitable. If I accomplish nothing else in the first encounter, I want them to understand that advances in eye care specialists’ understanding and glaucoma management mean that potential vision loss can be delayed for an extended period of time.

Richard J. Madonna, OD, MA, is a professor and chairman of the Department of Clinical Education and the director of continuing professional education at the SUNY College of Optometry in New York. Dr. Madonna may be reached at (212) 938-5818; rmadonna@sunyopty.edu.

Education and Communication Go Hand in Hand

By Steven L. Mansberger, MD, MPH, and Igor Estrovich, MD

Clinicians and their staff must educate patients efficiently and effectively in the setting of the modern, busy glaucoma clinic. We have identified several strategies for providing this education.

No. 1. Build a rapport. Rapport is defined as a relationship with mutual trust and emotional affinity. Glaucoma treatment is a partnership between the provider and the patient, and rapport helps to build this partnership. A simple way to establish a rapport with new patients is to ask about their occupation, hobbies, how long they have lived in the area, or their family history of glaucoma. A simple, efficient way to build a rapport with returning patients is to ask, “What is new since I last saw you?” We may be surprised to hear about a recent injury, a great trip, or something else. If nothing is new, we proceed with other history taking and the examination.

No. 2. Maximize eye contact. Electronic medical records can make it difficult to maintain consistent eye contact with patients. Eye contact builds trust, however, and helps clinicians discover nonverbal clues to the patient’s understanding and emotions. If patients cannot make eye contact with their physician, some of them do not feel heard, and they will be dissatisfied with the provider. We use scribes to fill out medical records to allow us to give instructions and answer questions while making continuous eye contact.

No. 3. Include family members. Studies suggest that patients only retain 30% of the information provided by physicians.1 Family members help their loved ones remember details about the discussion, provide support, and reinforce the importance of adherence to glaucoma medications.

No. 4. Use a team-based approach to communication. The eye care provider cannot efficiently educate patients alone. We train and encourage our ophthalmic technicians to educate patients and answer questions about ophthalmic diseases, treatment, and postoperative care.

No. 5. Ask “What questions do you have?” Finish the examination by asking, “What questions do you have?” This question foreshadows that the visit is ending and allows the patient to ask last-minute questions. When the doctor (or scribe) has answered the patient’s questions, the doctor can exit gracefully.

Steven L. Mansberger, MD, MPH, is a senior scientist, vice-chair, and the director of glaucoma services at Devers Eye Institute in Portland, Oregon. Dr. Mansberger may be reached at (503) 413-8202; smansberger@deverseye.org.

Igor Estrovich, MD, is a glaucoma fellow at Devers Eye Institute in Portland, Oregon. Dr. Estrovich may be reached at iestrovich@gmail.com


Success Starts With Education Upon Initial Diagnosis

By Leo Semes, OD

Last week, I saw a 67-year-old patient lost to follow-up who had suffered ocular trauma to his left eye 8 or 9 years earlier. He reported being diagnosed with glaucoma and offered treatment 7 years ago but said he did not follow up. Clinical findings included IOP in the normal range, distinct damage to the left optic disc consistent with glaucoma, and a corresponding, significant, inferior visual field depression that was greater in the left eye than the right. The working diagnosis was normal-tension glaucoma, and he agreed to treatment to minimize the likelihood of further damage. The patient appeared to be...
in shock as I handed him sample eye drops. He acknowledged being familiar with installation techniques, because he had used eye drops after cataract surgery on his left eye.

It became abundantly clear to me that this patient deserved a better explanation of his condition than when he had been diagnosed earlier with glaucoma. The questions he asked were quite telling in that regard:

- “How long do I have to use the eye drops?”
- “Will the eye drops make my vision better?”
- “Why won’t changing my glasses prescription improve my vision?”

I described glaucoma as a chronic condition that would require continuous treatment and monitoring, and I assured him that we would become good friends over the years. I explained that the goal of therapy is to stabilize the damage and prevent further deterioration.

The patient’s question about glasses was the juggernaut. I explained that spectacles focus light, especially at near, but that his optic nerve was not where light focuses. In addition, I used the tip of my pen clicker to illustrate the diameter of his optic disc, and I explained that preserving tissue in that area was the goal. Finally, I designated him as a very important member of the team effort to preserve his vision.

This case reminded me of the importance of thoroughly explaining glaucoma to patients at the time of their initial diagnosis. It is critical to impress on them the vision-threatening consequences of untreated glaucoma. The doctor-patient relationship is a partnership. It is incumbent on practitioners to set patients up for successful treatment at the time of the initial diagnosis, and that all starts with proper education. Patients are not going to know what to do or how important it is to follow doctors’ recommendations unless practitioners make that message clear.

Leo Semes, OD, is a professor of optometry and director of externships at the University of Alabama, Birmingham. Dr. Semes may be reached at leopsemes@gmail.com.

Choices Give Patients a Sense of Control

By Julia Song, MD

Whether my new patient is a glaucoma suspect; has advanced, uncontrolled glaucoma; or is referred to me as a glaucoma suspect (either due to enlarged optic nerve cupping or elevated IOP to rule out glaucoma) or for assessment of a narrow anterior chamber angle, my goal is to be reassuring. For patients with advanced glaucoma who are referred for surgical intervention, I explain that their doctor has sent them to me to have their glaucoma checked.

At the start of the examination, I explain what IOP is. I use a model to educate patients about ocular anatomy. For those with narrow, occludable anterior chamber angles, I describe the pathway of aqueous outflow and explain that glaucoma is a concern when the drain is blocked. Then, I systematically review in detail each of the basic glaucoma tests (visual field, nerve fiber layer, and central corneal thickness). I point out any scotoma found on visual field testing as well as any nerve layer thinning and try to explain the clinical significance of each. When patients want more details, I delve more deeply into the specifics of the location of the visual field defects and how they correlate with the structural nerve fiber layer thinning.

Whether damage is present or not, I explain that the goal of glaucoma treatment is to prevent further impairment. After I have explained each test individually, I summarize all of the tests’ findings. I reiterate that it is difficult to determine whether a person has glaucoma without the tests, especially when I am addressing glaucoma suspects or ocular hypertensives.

If a patient needs treatment, I describe all of the available choices. I guide the person in the best direction, but ultimately, I allow him or her to choose. Giving patients a choice allows them a sense of control over their disease. If a patient needs surgery, I outline the options and types of surgeries, along with the advantages and disadvantages of each.

I always try to end a visit on a positive note, because most patients are anxious. I emphasize that glaucoma therapy in the United States is exceptional. I add that a physician’s duty is to help patients cope with their diagnoses and treatments. Clinicians can help by initiating a conversation about patients’ concerns and giving them a sense of control over their lives.

Julia Song, MD, is in private practice with DrSongVision in Pasadena and Long Beach, California. Dr. Song may be reached at (626) 844-9393; jsongmd@drsongvision.com.

Glaucoma Is Not Routine for Our Patients

By Joseph Sowka, OD

Glaucoma can significantly affect a patient’s life through visual disability, adverse effects, the cost of medications, the inconvenience of eye drops or necessity of surgery, the loss of independence, or just the burden of knowing that he or she has a potentially blinding disease. It is crucial that we
eye care practitioners deliver the diagnosis and message effectively and compassionately. Glaucoma may be routine to us, but it is not routine to our patients.

Whenever I make a conclusive diagnosis and have to deliver the message to the patient—regardless of whether it is the first visit with a newly diagnosed patient, a follow-up with someone whose glaucoma has progressed, or after several visits of data collection—I do not want to worry about clearing the other rooms. I want to focus on having a dialogue with him or her when I can take time to answer questions. The patient, therefore, may have to wait a bit while I finish up with others, but then he or she will have my attention.

I start by asking patients to tell me what they think glaucoma is, and I listen. I then explain the disease in layman’s terms and clear up any misconceptions. I tell patients my diagnosis and how I came to my conclusion, and then, I immediately launch into a discussion about all of the wonderfully effective treatments that are available to preserve vision. Most important, in my opinion, is to keep the conversation upbeat and to stress what I can do to preserve their vision. I explain to patients that glaucoma is a potentially blinding disease but that, thanks to the variety of treatment options, most patients likely will not become visually disabled. I will also often ask patients if they are currently happy with their vision and functioning at this moment, and most respond that they are. I then tell them that my plan is to keep them seeing as well as they currently are, and most are happy and relieved to understand that they most likely will not go blind.

I emphasize that people at greatest risk of blindness are those who go undiagnosed or do not follow their doctor’s recommendations. I also believe that it is important to give patients printed educational materials to take home. I encourage patients to write down questions and bring them to their next appointment, which is typically in a few weeks to evaluate the outcome of a trial of eye drops. I also encourage them to call my office with questions.

Some patients’ glaucoma will progress. When this happens, we typically already have a long-established relationship. I tell them that either the optic nerve has changed or that the visual field has worsened. Usually, with effective therapy, the change will be minimal and the rate of progression slow so as not to threaten their normal functioning. I explain that progression may be part of the disease process and that, together, we will monitor any change over time. I then explain that I am going to amplify their therapy to preserve their vision during the coming years.

Joseph Sowka, OD, is a professor at Nova Southeastern University College of Optometry in Fort Lauderdale-Davie, Florida. He is also the department chair, chief of advanced care services, and director of the Glaucoma Service. Dr. Sowka may be reached at jsowka@nova.edu.