Paul B. Freeman, O.D.

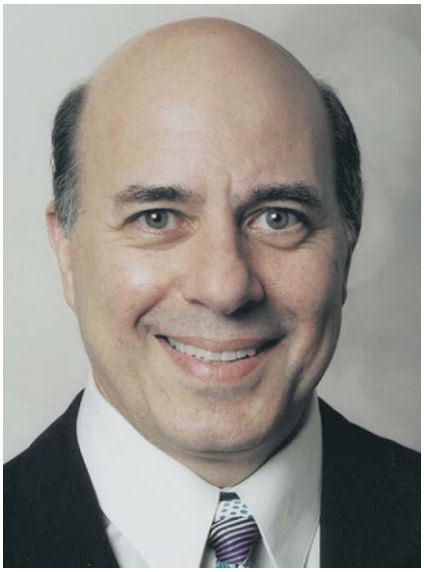
Vital data

How many times have you, either as a patient or a doctor, opened a pharmaceutical insert (a.k.a., label) for a prescribed medication, only to be overwhelmed by the information it contains? Labeling for medications has typically been "poorly organized; it is stuffed with often irrelevant information; it may include an important fact about safety in any of a number of places (categorized as a 'warning,' a 'precaution,' or an 'adverse effect'); and it often fails to distinguish between a drug's side effects and problems that may not even be causally related to its use."[1] Consequently, it is possible that medications were (or might still be) prescribed sometimes "despite important contraindications, even when these are spelled out in the label."[1] If there can exist this type of confusion within the health care community, one can only imagine the challenges faced by the patients who are taking these medications and who may be equally confused by the written information presented in the package insert. Certainly, patients cannot be expected to oversee the difficulties physicians might have in determining which medications are appropriate based on theoretical perceived outcomes. So how can we, as primary care practitioners, help our patients be advocates for themselves?

Simply stated, as eye doctors, one of the most important ways that we help our patients is to make sure that they can see as well as possible. And while that statement may seem very obvious, I submit that as the population ages, the resultant normal senescent physiological changes will lead to visual decrements resulting in functional deficits. Notwithstanding normal aging, with its loss of contrast sensitivity, requirements of more light, and some vergence difficulties (based partially on a loss of supportive accommodation), individuals who have decreased vision, not readily compensated for by the use of conventional spectacles or contact lens corrections, over and above the aforementioned "normal" changes, also need to benefit from our optical knowledge. And as the visually impaired population grows, this simple, but potent issue of seeing adequately should be recognized for what it is: potentially lifesaving.

At a minimum, as health care providers, we should be better able to wade through the morass of information presented in these pharmaceutical inserts. Even so, it can be time-consuming and confusing with respect to both placement of the information and print size. The Food and Drug Administration (FDA) agrees, and in June 2006, it will have initiated new drug label rules in an effort to help doctors and consumers make the best of the information presented, by standardizing the location of important information and by enhancing print of selected information. However, this will be a phased-in program, allowing 3 to 7 years for the package inserts of existing drugs to be modified, so not all inserts will immediately follow this format.

In a previous guest editorial,[2] it was suggested that information about over-the-counter drugs be made more accessible to the visually impaired population, including modifications in print size on drug labels. In addition, the AOA submitted a letter to the commissioner of the FDA in support of efforts to improve access to the print by *enlarging* the size of labeling and medication guides for patients to 10 point print.[3] And while this relative size magnification concept (and to some extent, contrast enhancement by making the enlarged print bolder) is being addressed somewhat by the FDA in the new drug label rules, enabling the discrimination of even enlarged printed material still takes the application of both ergonomic and optical considerations (i.e., focusing diverging rays of light emanating from print, independent of print size) based on best corrected visual acuities, contrast, and magnification. As optometrists, we are uniquely qualified to help patients gain visual access to medication instructions as well as to visually identify the actual medication, as some medications look a lot alike.



Paul B. Freeman, O.D.

Compliance with taking prescribed medications is based, in part, on the confidence the patient has in the doctor

1529-1839/06/$ -see front matter
doi:10.1016/j.optm.2006.06.013

prescribing the medication as well as the rationale the patient is given for that medication. While the managing physician is the initial source of information, the package insert provides additional support, and it is that unwavering written information that goes home with the patient. Unfortunately, despite the best intentions of a patient, comprehension can be negatively affected by *almost* being able to see the print due to size, spacing, contrast, etc.

No one can guarantee that our patients will remember to take their medications as they should, nor can we stop them from consulting multiple physicians, who might unwittingly prescribe potentially incompatible medications. But, by giving our patients the optical tools to see what they are taking, and encouraging them to read the important information regarding side effects and potential drug reactions that can occur by mixing both prescribed and over-the-counter medications, we are in fact acting not only as primary health care providers but as patient advocates.

Acknowledgment

The articles in this issue have been written by optometrists associated with the New England College of Optometry, Boston, Massachusetts. Thanks to Drs. Clifford Scott and Elizabeth Hoppe for their encouragement to all of the authors who submitted manuscripts to contribute to this month's *Optometry.*

References

1. Avorn J, Shrank W. Highlights and a hidden hazard-the FDA's new labeling regulations. *N Engl J Med* 2006;354:2409-11.
2. Sansgiry SS, Pawaskar M. Over-the-counter medication labels: are we ignoring the needs of blind consumers? *Optometry* 2004;75: 407-11.
3. AOA. AOA supports seniors struggling with the fine print. *AOA News* May 8, 2005.