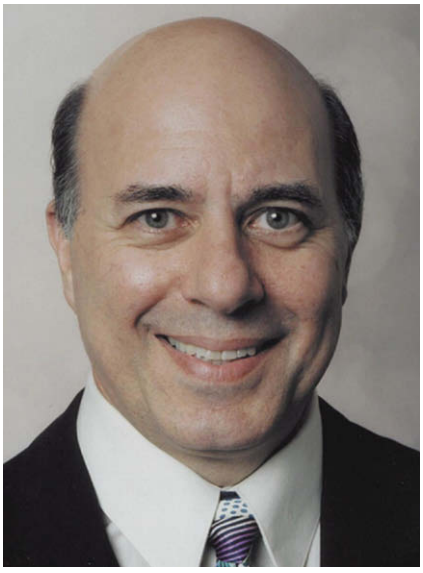
Paul B. Freeman, O.D.

The elusive low vision patient

Last month I wrote about how optometrists might help the many visually impaired remain functionally independent by maximizing their ability to see.[1] To accomplish this mission requires a comprehensive evaluation with a functional goal in mind. However, I am reasonably certain that such an evaluation is not offered to every visually impaired individual, at the very least to give them the opportunity to refuse any rehabilitative assistance. Part of the problem may lie in how we are defining these individuals.

According to the World Health Organization, the hierarchy of health problems is: 1) disease, 2) impairment, 3) disability, and 4) handicap. It may be that many of these visually impaired patients are characterized simply by the disease and perhaps the impairment, but are not queried as to the attendant disability (the inability to perform certain tasks). As a result, they are not asked the "right" questions to get them to an optometrist who can attempt to minimize the disability through vision rehabilitative management and therapy. A few examples might help to support this thought. In Allegheny County (one of 67 counties in Pennsylvania), the estimated number of visually impaired and blind individuals is approximately 41,000 (out of a population of approximately 1,282,000) based on data from the Pennsylvania Association for the Blind (2007). A quickly estimated calculation would suggest that it would take *many* eye care practitioners (not only those emphasizing vision rehabilitation) seeing *only* visually impaired patients all day, every day, to begin to make a dent in the numbers of this population. That being said, I have not talked to nor heard of anyone who is being overwhelmed by a demand for services for these visually impaired patients. In fact, even well-established centers offering a full range of optometric vision rehabilitation services seem to be underutilized. I recently received an e-mail regarding the expansion of vision services at Lighthouse International, which stated "the 104-year-old leader in vision health, opened VisionMax today (March 31, 2009), a comprehensive new vision healthcare center for all New Yorkers." This clinic will be offering "complete vision exams, prescriptions, contact lenses, designer frames and sunglasses as well as prevention and education information." To the casual observer, this might suggest that there are a lack of visually impaired patients being referred to Lighthouse International for rehabilitative services and, as a result, an expansion of eye care services beyond traditional rehabilitative services (for which this nonprofit agency is known) seems warranted. In further support of this notion, a 2007 Association for Research in Vision and Ophthalmology poster presented a retrospective review of 1,033 charts at a New York university ophthalmology faculty practice in which, based on their criteria, 97 of the patient charts reviewed were found to document a visual impairment, yet *only 2* were formally referred for low vision services.[2] *Only 2!!*

Many of us who work with visually impaired adults (or children for that matter) recognize that it is the inability to function (rather than the disease or, in fact, even the impairment) that disrupts the quality[3,4] and independence of the lives of these individuals. And if there is no apparent way out, they may develop a condition called "learned helplessness,"[5] exacerbating feelings of loneliness and depression. (In fact, in the 2008 American Eye-Q® results, respondents over 55 years of age who were asked, "Which of the following would concern you the most about developing serious age-related vision problems?" 48% said, "being able to live independently.") So how can we better identify these individuals who are in need of rehabilitative services?



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There is no typical presentation of a visually impaired individual; in fact, there can be any combination of physical and mental attributes. In a presentation titled "A Life in the Day of Mary Sparkle," which was offered at the 2006 Optometry's Meeting® in Las Vegas, I pointed out that the characteristics of a visually impaired patient could be: visually impaired but in good health, or could have multiple impairments and…might be married,

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single, widowed, or a caretaker, and…a vibrant, full-of-life and ready-to-see-the-world kind of person who wants to remain independent, or someone who is dependent and needs a lot of support and (depending on attitude and vision loss) is either ready for vision rehabilitation or in a stage of denial. The key, therefore, is in ferreting out the functional problems that these patients are having by using the knowledge of static visual acuity and its impact on reading, facial recognition, driving or other activities of daily living by asking… "Are you doing the things that you enjoyed before this decrease in vision?" And as nearly everyone who evaluates visually impaired individuals knows (and now anyone who has gotten this far in this editorial will know), the No. 1 functional loss for these patients is the inability to read, something that can be easily ascertained (either by questioning or by near visual acuity measurement) during an examination, and something that, for the most part, can be addressed through vision rehabilitation management.

"Health-policy planners define quality as clinical practice that conforms to consensus guidelines written by experts."[6] Both optometry and ophthalmology have consensus-driven clinical practice guidelines.[7,8] In fact, in ophthalmology's *Vision Rehabilitation for Adults*[7] it is quite specific: "All ophthalmologists have a minimum responsibility to recommend vision rehabilitation as a continuum of their care and to provide information about rehabilitation resources for patients with vision loss that impacts function." Optometry also stepped up to the plate by passing Resolution 1858 at the AOA House of Delegates in 2005 to resolve that "the American Optometric Association encourage every optometrist to continue to provide, comanage, or refer every individual with visual impairment for appropriate optometric low vision rehabilitation." (Of note, there is no implication in any of these guidelines about pre-selection of a patient based on age, presumption of success, or any other bias.)

It was reported by the U.S. House Select Committee on Aging as far back as January 1992 that "nearly one out of every six Americans age 65 or older is blind or severely visually impaired" and that "one out of every four elderly persons over the age of 85 is severely visually impaired." And while these numbers can be debated, the fact of the matter is that the visually impaired population is indeed growing. Based on this, it can safely be said that we all know somebody who is visually impaired, we will know somebody who is visually impaired, someday some of us will be visually impaired, or some of us are currently visually impaired. It would be a pleasure to someday write an editorial about how so many visually impaired patients (including some of us) are receiving the services they need from optometry, ophthalmology, and all of the other vision rehabilitation team members and, as a result, continue to maintain their functional independence.

References

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