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It's as easy as learning to fly a plane

Paul B. Freeman OD
freemankp@aol.com

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Abstract

Letter from the Editor-in-Chief

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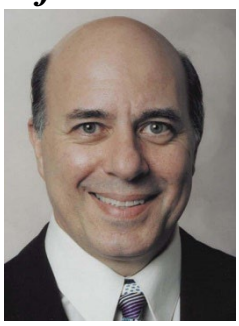
Letter from the Editor



Paul B. Freeman, OD
Editor-in-Chief

IT'S AS EASY AS LEARNING TO FLY A PLANE

"Until we have conquered this pathogen, I will continue to recognize and thank, in each issue of our journal, the frontline professionals and those workers who keep our lives moving forward while putting themselves in harm's way. My hope is that each time I begin with this, it will be the last time."[1(p1)] What an auspicious way to start a new journal! After the inaugural issue, the second issue was released around the same time that SARS-CoV-2 started to change the way we would live, affecting not only health care, but how we work, go to school, worship, shop, recreate, travel, and indeed interact at all levels, and yet even today it continues to plague us. And while it seems hopeful that we might soon be going from a pandemic to an endemic, this virus will constantly be with us going forward. With any luck, it will impact our lives less frequently and become more manageable, somewhat like the flu. However, there are still many questions to be answered: how to behave (social interaction, masking), whether this virus will mutate to throw us into another pandemic, and how "long COVID" will impact not only the eyes, but the entire person. Those challenging questions will continue to be discussed and researched by scientists and epidemiologists. My suspicion is that there will be no unified consensus, which will unfortunately continue to make each of us weigh the "facts" presented to us, and to act accordingly.

In a few of my editorials, I mentioned how this pandemic impacted visually impaired individuals, mostly our seniors. Because my eye care population is primarily visually impaired patients and those with traumatic brain injury, as my practice gradually reopened, I continued to hear the ever-recurring question, "why was I told that my eyeglasses were as strong as could be made and that nothing

more could be done?" As I mentioned in a prior editorial, during this pandemic crisis the inability to see clearly, especially while being isolated, affected these individuals more than those with "normal sight."[2]

In a recent article it was stated that "despite the large number of patients who could benefit from LVS, [low vision services] rates of uptake are low, with only 5% to 10% of those with low vision enrolling in these services."[3(pe115)] Why is it that "the most common reasons for potential underutilization are related to lack of referral or miscommunication between patients and providers on the benefits of LVS?"[3(pe115)] With the emphasis on treating eye disease in our profession and the continued expansion of scope of practice laws, it is easy for an eye care practitioner (ECP) to not "see" or "hear" all the vision needs of a patient while trying to resolve the cause(s) of the decrease in vision. As a result, patients might not receive *all* possible eye care options.

Eye care practitioners (I use ECP because it is both optometry and ophthalmology who need to be aware of this) unquestionably need to make referrals for low vision optometric (or ophthalmologic) services if they are not going to provide it themselves. Interestingly, in another article it was stated that, "among optometrists who are not low vision rehabilitation practitioners, there is a significantly greater tendency for newer graduates within the past 5 to 10 years to never prescribe high adds of 4D or greater and/or to fail to make low vision rehabilitation (LVR) referrals for patients with mild vision loss."[4(p48)] Notably, low vision providers know that the earlier someone receives low vision services, the better off they are. So how can the underutilization of low vision services be rectified?

Any patient with reduced visual acuity that impairs or hinders activities of daily living such as reading, walking around, watching television, using smart phones, cooking, or being involved in recreational activities needs to have a low vision assessment. To consider this need, an ECP can include in the patient history an assessment of their patients' vision needs (work and play), and how well the patient can do these activities. Once the patient's problem is identified, the challenge of making a recommendation or referral for any service is to communicate in an understandable way how that problem can be mitigated. I will suggest a simplified approach using an analogy made to me by a pilot friend about learning to fly a plane. I was told that this is very simple: when in the pilot's seat and the plane is in the air, if you pull the yoke (steering mechanism) back, the nose of the aircraft points up and the houses below appear to get smaller, if you push the yoke forward the nose of the aircraft points down and the houses below appear to get larger. Obviously, learning to fly is far more complex than that, but the basic premise is

accurate. How the complexities of flying can be effectively taught requires someone who is certified to teach flying, with a receptive student practicing what has been taught.

For visually impaired patients, in order to see print which cannot be seen with conventional glasses or contact lenses, the print can be moved closer to the patient to appear to get larger or the print can be made physically larger at the patient's customary reading distance (both with the appropriate lens to focus the material). That is the basic premise behind being able to see print that is otherwise not legible. Each of us can demonstrate this concept quite easily in the exam lane by taking a +10.00 lens (for example), placing it over the best conventional refraction and holding the printed material at the (appropriate) 4 inch/10 cm working distance, showing the patient some improvement. Alternatively, with a black tipped marker, printing large letters of various sizes on a white piece of paper, and having the patient hold the material at the customary working distance (with the appropriate lenses), can demonstrate improvement. Either way, this should stimulate a discussion about referring for further evaluation by a low vision doctor to determine the appropriate lens power, explore equivalent powered systems, and effectively teach the proper use of suitable low vision options. Importantly, just as with really learning how to fly, really learning how to use a magnified image is far more complex than simply increasing the real or apparent size. Nevertheless, the simple activity of demonstrating magnification in the office should be enough to give the patient the opportunity to make a decision about whether or not pursuing LVR could be valuable in achieving their visual goal(s) (which often includes reading). This exercise takes no more time to demonstrate potential improvement that can be further explored in a formal low vision assessment than it would for someone to discuss how to make houses bigger or smaller with movement of the yoke, which could be further explored with flying lessons.

I, and many of my low vision eyecare colleagues, are often dismayed that some people must find low vision rehabilitation randomly. The simple activities described allow a visually impaired patient to be aware that options exist which can affect their quality of life. I would remind all my eyecare colleagues to take the time, when it is indicated, to do just that. And for those who say that once they refer the patient for additional medical or surgical treatment, the patient is often lost, might I suggest that in the letter describing the reason for referral, adding a simple sentence like, "Please refer for low vision rehabilitation services when appropriate." This should encourage the treating doctor to refer the patient on for appropriate services. By doing all of this, we will fulfill one of the duties of our

profession as described in the AOA Code of Ethics: "TO ADVISE [our] patients whenever consultation with, or referral to another optometrist or other health professional is appropriate."[5]

REFERENCES

1. Freeman P. Why don't more of us write scholarly papers?. *Optometric Clinical Practice*. 2020; 2(2):1. doi: 10.37685/uiwlibraries.2575-7717.2.2.1004.
2. Freeman PB. Optometry's contribution. *Optometric Clinical Practice*. 2020; 2(1). doi: 10.37685/uiwlibraries.2575-7717.2.1.1033.
3. Kaleem MA, West SK, Im LT, Swenor BK. Referral to low vision services for glaucoma patients: referral patterns and characteristics of those who refer. *J Glaucoma.* 2017;26(2):e115–e120. doi: 10.1097/IJG.0000000000000600
4. Malkin AG, Ross NC, Chan TL, Protosow K, Bittner KB. U.S. optometrists' reported practices and perceived barriers for low vision care for mild visual loss. *Optom Vis Sci*. 2020;97(1):45–514. doi:10.1097/OPX.0000000000001468
5. American Optometric Association, Ethics & Values. https://www.aoa.org/about-the-aoa/ethics-and-values?sso=y. Accessed February 16, 2022.