Austin Journal of Clinical Ophthalmology

Austin Publishing Group

Open Access Full Text Article

Editorial

For the Good of the Patient

Sarah Hinkley*

Michigan College of Optometry, Ferris State University, USA

***Corresponding author:** Sarah Hinkley, Department of Optometry, Ferris State University, USA

Received: December 03, 2013; Accepted: January 10, 2014; Published: February 14, 2014

"Why wasn't I told about this sooner?" That single question haunts me weekly. Patients sit in my exam chair, look at me with tears in their eyes and ask that question. Their frustration reverberates and causes me to shift on my exam stool. I am speaking of the patient with vision impairment from ocular or neurological disease who was told by their optometrist, ophthalmologist, retinologist, corneal specialist or a host of other wonderful doctors that "there is nothing more I can do for your vision." And although these doctors technically correct, they are under informed or perhaps too crunched for time to explain that there IS something more than can be done; vision rehabilitation. And their referral would connect the patient to a whole new world of options for maintaining function in daily life despite vision loss.

Vision rehabilitation is an important and yet underserved area in eye care. I have explored many areas of interest in optometry and have found none as rewarding and life changing as vision rehabilitation. The patient typically presents depressed, confused and sometimes angry and yet when they have reached the point in grieving their vision loss where they are ready for help, the results can be astounding. Providing patients with the pathway to compensating for a scotoma with eccentric viewing, mobility techniques to improve independence and reduce falls and home modifications that will allow them to live the semblance of a normal life is incredibly gratifying. I have experienced patient hugs, tears of joy and screams of "Halleluiah" that can be heard through the Eye Center. Every patient is an emotional experience. While this can be draining, the victory achieved when witnessing a patient achieve a goal makes this focus area completely worth it.

Vision rehabilitation is about more than magnifiers and lamps. Sure that is a piece of the puzzle but looking at the patient as a whole person, taking into account needs outside of vision and investigating all of the areas of their life that vision influences, will offer the most benefit. The examination begins with an extensive functional case history. After explaining the purpose of vision rehabilitation and how it differs from a traditional eye examination, the patient is asked the question that dictates the course of the entire rehabilitative process, "What is it that you cannot accomplish in your daily life or goals as a result of your vision loss?" Their answer becomes our first goal. Readiness for rehabilitation becomes apparent. Then my students and I explain how we and our team of professionals plan to get the patient to achieve the goal through vision rehabilitation.

The visual assessment, although collecting some traditional data such as visual fields, is driven by the need to assess function. Thus visual acuity is measured straight ahead and using eccentric viewing if the patient uses that technique to compensate. Contrast sensitivity, binocularity and scotoma mapping are performed routinely. Refraction is performed using out of phoropter techniques to maximize visual ability. After the functional data is collected, the struggles and goals of the patient determined and the patient is given a "pep talk" on being open minded and having patience, rehabilitation begins. Rehabilitation consists of numerous techniques, areas of training and optical and non optical device solutions. Techniques such as the sighted guide, eye tracking therapy and eccentric viewing training are commonly used. The patient is allowed to leave with the devices or equipment found to be beneficial during the examination on loan before purchasing anything. Using a device in the patient's actual living situation can produce completely different results than in the exam room. The patient is educated on the functional implications of the disease, provided with a vision rehabilitation manual summarizing all of the most important points that we discuss and listing additional sources of information and support. Home visit or in office follow up appointments are scheduled.

I cannot do all of this alone and am grateful for the excellent partnership we enjoy with a local nonprofit and state agency who provide many of these services collaboratively. And I make referrals, lots of them, to trusted colleagues who share my collaborative team philosophy. Referral letters and reports are generated. Every visit also generates a report to the referring provider, primary care physician and any other providers involved in the patient's care. The patient is included as a recipient of the letters as well so that they can remain informed about the communications between professionals and actively participate in the rehabilitative process.

As a believer in interprofessional collaboration and communication, I have found that the team approach to vision rehabilitation is the most successful and this is supported by solid research. Patients with vision impairment or blindness often need counseling, social work, occupational therapy or vision rehabilitation therapy, orientation and mobility training, driving rehabilitation, occupational rehabilitation and the list goes on. In addition to the care we provide as optometrists and ophthalmologists, patients need a team of professionals centering their efforts around the patient's goals. In vision rehabilitation, my role is more of a coach than a doctor. I must encourage, inspire, challenge and, at times, call out the patient when I am not getting the needed effort or motivation. I provide this role but it is ultimately up to the patient to make the most of their remaining visual function by pursuing the rehabilitative options that will be beneficial. The team collaborates and communicates for the benefit of the patient. Political differences and territorial battles are put aside, with each professional doing what he or she does best. I have witnessed this collaborative spirit and wonderful interprofessional relationships more in the field of vision rehabilitation than any other area of optometry or ophthalmology. I am revitalized and encouraged. There are struggles but the rewards are great.

It is my hope that the positive relationships I witness every day will spread to other areas of our professions. Because when the patient is at the heart of the way we work, amazing things happen.

Citation: Hinkley S. For the Good of the Patient. Austin J Clin Ophthalmol. 2014;1(1): 1004.