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Editorials

Low vision: a parochial view

Evaluation of success is a relatively recent development in health care delivery, although in the prescribing of low vision aids (LVAs) it has been common for many years. Surveys which showed that 60–80% of unselected patients could be helped with LVAs^{1–3} tried to convince professionals that this ‘Cinderella’ of ophthalmic and optometric services was worthy of their attention. It was accepted that some patients would not benefit, and explanations included poor general health, too poor acuity, senile dementia, lack of motivation for the tasks that LVAs can be applied to, or not having reached the required psychological state of realistic acceptance of the acquired loss. Such an analysis is reinforced by studies of well motivated young patients with stable pathology of congenital origin where 100% success can be achieved.⁴ It is now recognised that these short term, clinic based perspectives on successful prescribing are too simplistic: reaching a threshold performance for letters of newsprint size, for example, does not guarantee efficient reading by the individual with low vision.⁵ In a survey by Leat *et al.*,⁶ 75% of patients could read newsprint equivalent in the clinic, but only 35% admitted to reading normal print at home.

A major reason for this discrepancy is the lack of ‘training’; that process by which a patient (or client in this rehabilitation context) is restored to normal *function*, despite the continuing impairment. Mehr and Freid summarised the problem some 20 years ago, saying ‘even those applications of aids and procedures that seem fundamental and natural to the practitioner are, in fact, in many cases highly technical and complex to the patient. New sensorimotor coordination patterns of eye, head, hand and body movements must be developed’,⁷ but recognition of this has been slow in the UK. The traditional UK Hospital Eye Service (HES) provision (there is no official supply route through the General Ophthalmic Services (GOS)) is typically of complex aids in a single visit to an outpatient clinic,⁸ and has been criticised since the patients are then often left to their own devices to learn to use the appliance.⁹ That many patients do not achieve this has been shown by surveys suggesting that considerable numbers of LVAs are used irregularly, or not at all.^{8 10 11}

From countries with a longer history in this field, early anecdotal reports and qualitative support for formalised training^{12 13} are now beginning to give way to quantitative surveys,^{14–16} although scientific methodology and statistical analysis are still sadly lacking. Despite one dissenting voice,¹⁷ there is widespread acceptance of the concept, with training forming a major part of comprehensive

rehabilitation models which consider the individual’s needs (vocational, educational, social, psychological, financial, optometric, and medical) and encourage the optimal use of residual vision.¹⁸ While concentrating on the range of care which must be provided by such a service, and deliberately avoiding dictating which professionals should be responsible for that care, it seems axiomatic that this range of expertise cannot be found in a single professional group. Yet while much is made of the range of professionals involved^{19–21} in the models currently operating – an educationalist, employment specialist, physiotherapist, occupational therapist, social worker, lighting engineer, orthoptist, psychologist, and audiologist, among others, may be called into the team for particular clients – it is more usual to concentrate on a core of ophthalmologist, optometrist (carrying out refraction and prescribing), ‘low vision trainer’, and social worker. Interest in such low vision rehabilitation is enormous at present, particularly in mainland Europe. An international workshop is scheduled for September 1995 where it is intended that practitioners of this developing science (tentatively termed *videology* by the organisers) can exchange ideas, and disseminate worldwide models of good practice. It is hoped that several models applicable in the UK situation will come forth, since no one solution will be appropriate in all cases: the scope of services provided by a given profession will vary between individual practitioners, depending on the individual’s experiences, geographical location, and local resources. The UK is unlikely to be setting the trend, being closer to the guard’s van than the vanguard in the development of such clinics. Some multidisciplinary clinics apparently exist,^{22–24} although reports of their working methods are anecdotal so far and seem to indicate a stage of development reached in the USA and Australia some 15–20 years ago.^{25 26} No results have been reported to date. Success is difficult to define and statistics have to be interpreted carefully, but such reports are essential. They will act to encourage the spread of optimal patient care and, when the results pass into the wider community, will prevent each clinic from having to ‘re-invent the wheel’. Reports need to include controlled, scientific analyses of how well the clinic achieves its aims so that interested parties can decide which model is best suited to their situation. The study by Shuttleworth *et al* in this issue (p 719) is therefore extremely significant in the context of the future development of low vision services in the UK. It describes the effectiveness of one practical model of ‘integrated’ service (although unfortunately not truly

'multidisciplinary'), and offers the promise that such a service can be both cost effective and high in patient satisfaction. While the study addresses simple and straightforward questions, it does so in an objective and repeatable way, and it is to be hoped that it will be significant in forming future health policy. This is not to say that this is the only way in which low vision services can be provided satisfactorily. In this context it is totally inappropriate to be arguing that only one model is 'best' since any service which is 'successful' and 'cost effective' has a role to play. Both these measurement variables need careful definition, but if a service is found to be less successful and more expensive than the alternatives, then common sense dictates that a change is necessary; it appears that the 'traditional' HES low vision clinic currently finds itself in this position.

While it is laudable to gather evidence in favour of a major reorganisation of service delivery in the UK, it is difficult to see how the current fragmented and patchy infrastructure can be turned into multidisciplinary cooperation on a large scale. A survey by the Royal National Institute for the Blind (RNIB) not only exposed the fact that there were three times as many people in the UK who were blind and partially sighted than registration figures indicate, but also revealed that nearly half those registered as visually impaired wait over a year for their first visit from a social worker – or never receive such a visit.¹¹ Even ignoring questions about its effectiveness, the annual capacity of the HES to carry out low vision assessments has been estimated at only 60 000²⁷ for a visually impaired population nearing one million. In the moves towards 'shared care' – the integration of primary and secondary ophthalmic health care, with increasing cooperation between optometrists and ophthalmologists – low vision seems to be an obvious candidate for initiative. A national working party was considering ways in which practical schemes could be administered, and it appeared that the Department of Health was ready to fund a study to compare LVA prescribing by hospital outpatient clinics, optometrists working in high street practice, and some form of 'integrated' approach including training. This has now been shelved owing to lack of funding. This perhaps gives an opportunity for reappraisal, since the scope of the study seems sadly limited. There was too much concentration on who and where, rather than what was being done – there is no reason why a multidisciplinary model cannot be placed in an HES clinic if required. Despite the lack of a national move forward in shared care, many local schemes have been set up, but these are far more likely to relate to diabetes or glaucoma than to low vision. Some family health services authorities (who fund the GOS) are willing to allow spectacle vouchers to be used to purchase LVAs, although others steadfastly refuse to do so. None the less, it is astonishing that low vision – a condition affecting one in 60 of the general population – has led to only one out of a total of 65 schemes,²⁸ and only three UK optometrists

have taken the higher fellowship qualification in partial sight of the British College of Optometrists. Although it will be interesting to watch this field of vision care grow (as it must), its unstructured growth could lead to intraprofessional competition and a severe weakening of service provision. A model of staffing and funding must be developed for the UK, not necessarily prescriptive, but with clearly defined goals. Allocating the resources, however well intentioned, is only half the story,²⁹ and such a project is incomplete without scientific methods of assessing whether worthwhile results have been achieved.

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