Think Tank ...

"What challenges do optometric educators face when integrating low vision education with entry level competency and how can we overcome these challenges?"

A significant challenge is clinically educating students to the appropriate level of low vision care. It is rare to find an externship that truly does entry level low vision care; most "low vision" externships perform advanced low vision care. The new graduate then looks at low vision as an "all or none" practice pattern. She/he sees the ideal, advanced low vision clinic that includes a wealth of interprofessional providers, extensive (and expensive!) equipment and thinks, "I can't manage/afford to do that, especially in my entry level practice." The graduate then slowly becomes less comfortable in low vision, which perpetuates the polarization. The challenge for educators is to find clinical practices that perform entry level low vision, or to encourage practices to begin to include low vision and to have these sites specifically include this practice modality in their externship program.

Kierstyn Napier, OD, FAAO
Chief of Low Vision Rehabilitation
Western University of Health Sciences
College of Optometry

Low vision education is of major importance for our profession. As the population ages and life expectancy increases there is a huge need for more low vision specialists nationally and internationally. Low vision is one area in which optometrists often take the lead role.

Low vision education includes classroom instruction and clinical experience. When first encountering a patient with low vision needs, students typically become overwhelmed. The initial fear can be a barrier for teaching. However, it can be used as an opportunity to encourage students to learn more about the causes of a disease, the necessary testing, and the appropriate management. Delivering a high level of patient care and providing a good educational experience in a busy clinical setting is challenging. It may be necessary to bring the patient back at a later time. A follow-up visit provides an opportunity for students to learn more about the condition and its proper management. Clinical instructors who are not low vision specialists are also challenged to review the management possibilities for the patient and to consult with other instructors who are more knowledgeable about the subject. This, in turn, teaches the students the importance of seeking help and reviewing knowledge that may have been obtained in the past. It is in the instructors' hands to turn the students' feelings of fear into an exciting, challenging learning experience and to provide appropriate patient care.

Marcela Frazier, OD, MHP
Assistant Professor
University of Alabama at Birmingham
School of Optometry

My biggest challenge is convincing students that basic low vision care is part of primary care optometry in the broadest sense of the term. Students tend to believe that any low vision rehabilitation is "specialty work," best provided by those with advanced training. Just as prescribing vision correction, addressing accommodative disorders, fitting gas permeable contact lenses, and diagnosing and treating primary open-angle glaucoma all fall within the realm of the primary care optometrist, so too does providing some degree of low vision care.

Optometrists, by definition, are eye care generalists, and as such should demonstrate entry level competency in all aspects of optometric clinical care. Once I get my students to "buy into" the concept of full-scope optometry that includes some degree of low vision rehabilitation, it becomes a more meaningful experience for them.

Joseph J. Pizzimenti, OD, FAAO
Associate Professor
Nova Southeastern University College of Optometry

Even at the mention of the words "low vision," most students already have a negative connotation in their minds. Taking a closer look at why this might be and how educators can counteract these feelings is crucial to bringing low vision back to the primary care arena. Two areas need to be addressed to better allow students to feel more prepared to treat this patient population.

Taking a patient history is an art form. This is true in all aspects of vision care, but its importance in the area of low vision cannot be underestimated. Not only does the low vision history include visual and medical history, but it also is necessary to inquire about the patient's visual needs as well as his social history. The saying goes, "See one, do one, learn one." This should be the principle used in learning how to take a proper case history. This process should be implemented in the laboratory portion of a low vision course in the form of patient history demonstrations. Using fellow upper level students who are currently in the clinic, faculty members, or even hired actors to play the "patient" roles will allow real-life scenarios. These sessions can be taped and reviewed, either with each student or as a class, to complete the learning experience. This type of exercise can help guide students in determining the questions to ask and the types of devices that might benefit the patient. A role-playing exercise should also cue students to the need for specialty referrals, such as orientation and mobility training or psychological evaluation.

Another major issue is the disconnect between how low vision is taught in the classroom and how it is practiced. The disconnect is caused by a subject that makes students cringe, math. In the classroom, low vision is taught in a rigid manner. There are formulas for everything from calculating the power of the required magnification to determining the working distance for a certain power reader. Even though I was among the throngs of students who were turned off by having to memorize formulas after having left optics behind, this basic understanding of the math of low vision is the foundation for treating patients. First, there needs to be greater use of case presentations with real-life scenarios in the classroom to cement the need for understanding and using the math they have had to learn by rote. Second, in the clinic, we must get back to reinforcing the long-forgotten formulas and how to use classroom knowledge to offer the best treatment for patients.

Although many clinicians might argue that low vision is not primary care optometry, this could not be farther from the truth. Treating the many facets of vision is the foundation of the profession. As we cannot choose the patients who walk into our offices or clinics, we must be prepared to assist them with all of the tools at our disposal. The use of low vision devices can change the outcome of patients' lives, economically, academically, and socially. Optometric educators must do all they can to show students the power of this primary care aspect of the profession.

Marc B. Taub, OD, MS, FAAO, FCOVD
Chief of Vision Therapy and Rehabilitation
Residency Supervisor, Pediatric and Vision Therapy
Southern College of Optometry

New Optometric Education Diplomate Program

In May, the American Academy of Optometry Board of Directors approved the first Optometric Education Diplomate Program. This is an exciting opportunity for all optometric educators. The Diplomate status implies achieving a level of recognized competency and distinction in a particular area of study. Now optometric educators will have the opportunity to gain this recognition. Criteria for the Diplomate Program are posted on the Academy's website. Congratulations to the Optometric Education Section for this initiative.