Is Visual Acuity the Ophthalmologist’s Barrier for Referral to Low Vision Rehabilitation?

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Introduction

Deciding about Visual Rehabilitation depends on at least two individuals: the ophthalmologist and the visually impaired person.

On the one hand, the ophthalmologist may constitute the first barrier on the road to Vision Rehabilitation by not referring eligible individuals to low vision clinics or full-service agencies. On the other hand, the patient, even if appropriately referred, may decide not to take advantage of available programs that could provide assistive devices and training.

The purpose of the “Barriers Study” is to examine the demographic and psychological patient characteristics that may influence this decision-making process.

Present Study

Visually impaired individuals (VA of 20/70 or worse in the better eye with best standard correction) are being recruited in three ophthalmology departments of university-affiliated hospitals in Montreal, Quebec, Canada. The study data are based on responses to a semi-structured interview, containing demographic as well as questionnaire components.

To date, 287 participants have been recruited. The semi-structured interview addresses patient characteristics such as age, gender, educational level, health status, living distance from the hospital, symptom duration, etc.

The central question in the interview concerns the person’s state of knowledge about, referral status to, and/or experience of Vision Rehabilitation Services. Participants were sorted according to three possible responses, as shown in the graphs. They are:

Did not Know = Unaware of Rehab Services / no referral (29%)
Know & Did not Go = Aware/referred but did not utilize Services (11%)
Know & Went = Referred and utilized Services (60%)

Results

Individuals with more recent onset of vision loss are less aware or less informed about Vision Rehabilitation Services.

Ophthalmologists seem to selectively refer visually impaired people for Rehabilitation Services depending on their level of visual acuity.

Individuals who are still part of the workforce were less aware of or informed about the possibility of Vision Rehabilitation.

Overall, men and women were referred equally, independent of their acuity status.

Additionally, age, educational level, living conditions, health status or living distance from the hospital did not seem to affect the referral pattern of ophthalmologists or the decision of the patient to seek services.

Conclusions

The data obtained during the first nine months of the study indicate that access to Vision Rehabilitation Services is related to a number demographic factors: Symptom Duration, Level of Impairment, and Employment Status.

Psychological variables, such as depression, coping skills, life satisfaction, and subjective evaluation of visual function are also examined in the context of this study. These data will be presented in the near future.

It remains to be investigated in more detail which of these factors influence the referral decisions of ophthalmologists and which form the largest obstacles for the patient. By understanding both the demographic and psychological profile of an individual who is eligible for Rehabilitation Services, it will be possible to counsel potential patients more effectively and provide them with optimal care.

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