Low Vision Services in Quebec — A Working Model for the Rest of Canada

In mid-January of this year, C.A.O. sponsored a two-day study seminar to familiarize a group of optometrists with the structure and operation of the Low Vision services in the Province of Quebec. C.A.O. organized the meeting, which was held at a downtown Montreal hotel.

The meeting's first day included a visit to the Institut Nazareth et Louis Braille located in Longueuil, a south-shore municipality directly across the St. Lawrence River from Montreal.

That afternoon was also devoted to a visit to the Montreal Association for the Blind on Sherbrooke Street in Montreal. This Association is older than the C.N.I.B., which actually plays a very minor role in the overall provision of low vision services in the province.

The third major centre in the province, Institut Louis Hebert, located in Quebec City, was not visited by the group, but J-P Lachance, O.D., Director of the Low Vision Clinic, attended and presented a paper describing the services available in Quebec and some philosophical concepts guiding the provision of those services. Normand Giroux, Director of the Institut Louis Braille, in addressing the group, stressed that the over-riding concept guiding the operation is that of a team, consisting of several different disciplines and professions, including optometry.

The objective of low vision services is to optimize residual vision using visual aids or other techniques to make the subject as mobile and as independent as possible in daily activities, with due respect to age and health of the individual. In short, the low vision patient is treated as a whole person — there is no intention to treat just one element, specifically vision, and neglect the remaining aspects, like living habits, mobility and communication.

The Braille Institut and the Montreal Association were both originally founded to serve the totally blind and legally blind segment of the population. In the years since the Quebec government began providing services to the low vision person (20/70 to 20/200), some 40 - 60% of the clients are low vision subjects. It is estimated that there are 60,000 low vision subjects in the province.

Because LV services are not well-known, most subjects are referred by professionals (not necessarily an optometrist, physician or ophthalmologist) and service agencies, by the relative of a satisfied client, or by the clients themselves.

Most visual aids are supplied free for subjects under 36 years old, particularly for subjects whose rehabilitation will return them to gainful employment or permit them to return to a regular or vocational school. This includes all aids, whether they be typewriters, reading/talking books, or other devices such as closed circuit televisions and projectors or magnifiers.

The "team" concept is stressed as the fundamental key to success. The loss of vision is often a traumatic psychological event. Whether the patient will accept the handicap and be motivated to explore the possibility of rehabilitation is always the first question. He or she can just as easily sink into a deep depression, becoming an even greater burden to family and society.

The family physician, optometrist or local community agency may all be involved and referral to a low vision facility would be expected. If the patient accepts this suggestion, there is no problem. But if he/she refuses, a psychologist, social worker or clergyman may be called upon in order to convince the patient that it is in his or her best interest to seek the low vision services.

The first professional one meets at the facility will be the secretary, a social worker who receives the subject and records the history, i.e. the medical and social background. From this, a preliminary assessment of the patient's needs is made; e.g. is the basic need primarily a visual one, one of mobility or one of communication? Are the patient's desires to get around, to read and communicate? Do they include activities such as T.V., theatre, etc? What are the basic living needs — kitchen, care of self, clothes etc.? There are 1,000 behaviours listed.

In all facilities, the *vision* services are under the direction of an **optometrist**, who will determine the visual status (having on hand the ophthalmological report as to the nature of the pathology, the prognosis and any medical care indicated), and who will indicate the types of visual aids likely to best meet the patient's desires, e.g. to read bus numbers, street names; to read the newspaper; sew, crochet; to play cards or table games; other crafts. A basic message in the care of the low vision patient becomes clearer: we must distinguish *visual* needs from the patient's *desires*, and not try to impose criteria imposed with normally-sighted patients. For example, visually, two persons may have an identical condition, but one wishes to read the newspaper; the other wants to watch T.V. They cannot be handled in the same manner.

A **trained technician** will work with the patient to determine which visual aids, e.g. glasses, telescopes, microscopes, alone or in combination with non-visual aids, e.g. book stands, illuminators, magnifiers, will best satisfy the patient's requirements and desires. Upon approval by the optometrist, the technician will provide training in the use and care of the device or devices. It must be noted that prescribing a device is not necessarily a criterion of success. Not only must the patient know *how* to use it, he or she must actually make regular use of it.

There are several reasons which may explain why a well-prescribed aid is not used. It could be, for

example, a case of self-consciousness, the appearance of the device itself, pride or some other psychological or personality-motivated apprehension. Thus, the **psychologist** or **social worker** becomes involved in many cases.

Althouth the purpose of the total rehabilitation process is to make the patient as independent and as self-sufficient as possible, there are outside factors to consider as well. Will the patient's family accept a return to the home environment? Will the patient, for that matter, accept to go home, or opt to live alone in an apartment? Will the patient actually be self-menacing by choosing to live alone? Again, the social worker or psychologist may be called upon to help solve these problems.

The best rehabilitation of vision does not *ipso facto* make a person mobile. Field restrictions may require the use of a cane, a guide dog, or some form of electronic sensor. In such cases, the patient may require the service of an **orientation and mobility professional**, who will prepare a programme appropriate to the age, physical condition, general health and living conditions of the individual, tailored as much as possible to his/her expectations. A first step, for example, is to evaluate the degree of mobility the patient has acquired (or not acquired) prior to entering the low vision facility. The patient is encouraged to demonstrate his/her determination, and any allusions to helpful devices, canes, telescopes, etc., are avoided at this stage. The actual training will be undertaken later by O&M technicians and covers such aspects as the use of canes as feelers, mobility training in both dark and lighted environments, indoors and out; navigating stairs, corridors, doors; visits to supermarkets, making change, attending to personal care and dress, including basic kitchen functions.

The time spent in training the patient in orientation and mobility will vary with personality, motivation and, perhaps surprisingly, age of the patient. The initiative of the O&M technician comes greatly into play in creating activities which are stimulating enough to the patient to spur the desire to become more effective and self-confident.

But it is not only to optimize

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Fig. 1

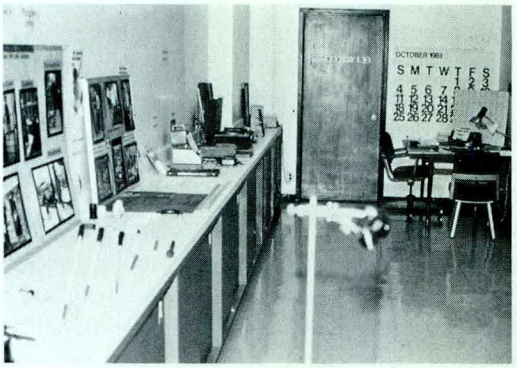

Fig. 2

Fig. 3

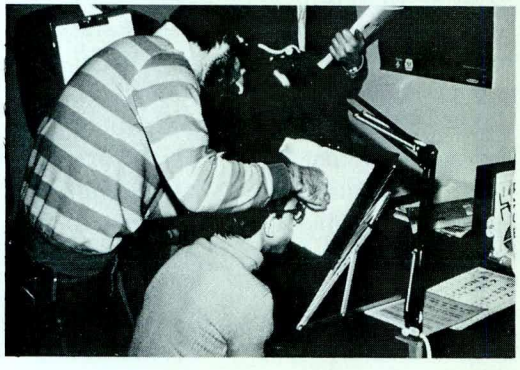

Fig. 4

Figures 1, 2, 3, 4: Photographs taken during the C.A.O. Low Vision Committee's January tour of the Institut Nazareth et Louis Braille and the Montreal Association for the Blind (see accompanying article). Vision services in all three major low vision centres in Quebec, the third being the Institut Louis Hebert in Quebec City, are directed by optometrists using a co-operative, professional team approach to total patient care.

among letters to the editor, had it not been for the contents of the Publisher's Page (editorial page) of the February 1 issue of the CMAJ. Willingly or unwillingly (we suspect the latter), the editor apologized to the C.O.S. for having accepted an optometric advertisement in a medical journal. What a terrible crime, particularly when the advertisement was an invitation to share knowledge. As the Lafontaine fable says, "Sa peccadille fut jugée un cas pendable"!

Unfortunately, this same editorial contained some blatant misstatements concerning the Optometry part of the Ontario Health Disciplines Act granting optometrists the right to "prescribe drugs" and not obliging them to refer patients suffering from conditions requiring medical attention.

Dr. Irving Baker, Registrar of the College of Optometrists of Ontario, responded quickly to correct these blatant errors but his letter, although published, was not given the same prominent attention such a major editorial lapse demanded. Dr. Roy Brown, Chairman of the Interprofessional Relations Committee of the C.A.O., also responded to both the letter from the President of C.O.S., and to the errors of the editorial page. It was not published, likely because to do so would have been an acknowledgement of the smallness of the individuals concerned.

Is it possible that the great medical profession as represented by the Canadian Medical Association and the Canadian Ophthalmological Society do not have the humility of an exalted discipline and choose to censor the knowledge available to its practitioners?

Is it possible there is a fear of exposing the family physician to optometric knowledge, lest he discover that ophthalmology does not have a monopoly on the care of human vision?

The advertisement itself is insignificant but the reaction to it revealed the fact that right or wrong, the medical fraternity is bigger and more important that the truth!

Truly, a sad day in the annals of medicine!

G.M.B.

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remaining vision or to teach patients to get around that these low vision programmes exist. Communications skills must also be attended to. There is always a desire to get back into the work force, to attend school, etc. and teaching a patient to read, to engage in crafts, even to play the piano are important factors in restoring the individual to a full and satisfying life. So enter the **occupational therapist**, the **reading teacher**, the **communications instructor**.

This latter person, particularly, will provide assistance in learning to write with, for example, felt pens, heavy lines on paper, typewriters, masks, increased illumination etc. For those with no central vision, or with vision which is not amenable to optical aids, there are talking calculators (desk and pocket size), talking watches and the *Optacon*, an electronic sensor which transforms print into electronic impulses to stimulate the finger tip. These impulses have the same shape as the print, and can be used for any print or language. Another device is the *Versa Braille* which can transform Braille to print or print to Braille. Also available are book tapes, reading machines, tape recorders, both regular and variable-speed 4-track, as well as closed-circuit T.V. units which can magnify as much as 60X.

Each of the facilities has a special section devoted to infant care. There is a pre-school day centre, which will accept infants as young as three months, even the multiply-handicapped child. (The mentally-handicapped cannot be diagnosed at this age.)

Parents are involved at this stage and are instructed in techniques of helping the child to be kept at home and to enter the mainstream environment. At a very young age, the detrimental effects of various handicaps on normal development are minimized. Enter the **child development specialist,** the **counsellor** to the parents, the **occupational and physical therapist**, not to omit the **teacher** for children of school age.

The Institut and the Association have facilities for school-aged children in 6-9, 9-12 age groups as outpatients, but they also have residences for those living too far to commute daily. Here again, all professionals are required to assist the teachers in providing education.

Throughout the months of training, consultations are maintained with the subject's physician or physician-specialist, such as the ophthalmologist.

Once the patient has been discharged, follow-up services are available. The social worker or the O&M professional will accompany the patient to his home environment to counsel both patient and family. Subsequent visits will be made as required to monitor progress or to remedy problems which may not have been foreseen, or new ones arising from changes in the home environment, the home itself, or family members caring for the patient.

Again and again the message emerges: low vision services *cannot* be effective if attention is paid *only* to the vision aspect. The whole team of professionals is essential to success. The contribution of optometrists, however, is vital. It cannot be overemphasized and appears to be the key to true success. This is evident from a comparison with services in the remainder of Canada to those in Quebec, where optometrists are part and parcel of the operation.

All other provinces would do well to copy the operation and structure of the Province of Quebec in the provision of its low vision services.

G.M. Belanger