EDITORIAL/ÉDITORIAL

Low Vision Care

Low Vision Care is based on the fundamental aspects of our training as Doctors of Optometry.

This writer can recall, during his undergraduate years at the College of Optometry of Ontario, that course content was a frequent subject of discussion among members of the student body.

There were the "pragmatists" who argued that a three-year course (as it was then) was too long, that it should be reduced, that only refraction, recognition of disease and practical optics (lenses and dispensing) should be taught.

Then there were the "visionaries" who, with the encouragement of the teaching faculty, maintained that the course was, in fact, too *short* to educate optometrists to care for all the public's vision and eye care needs.

In hindsight, even these thoughts fall short of where optometric education has evolved, but they did confirm a trend, already in its embryonic stages, which ultimately shaped Optometry's role as a primary health care discipline through the next several decades.

Perhaps the idea of a four year course had more to do with attaining a Doctorate degree than with health care *per se*, but it did imply that, the better the training, the more solid the recognition of the profession's services and, as a corollary, the stronger the integrity of its claims to becoming a true, primary health care profession.

We will not at this time even attempt to explain the rationale which caused the various modifications, deletions and additions to our educational programs, but will point out simply that, if any one aspect can be said to call upon the very fundamentals of all our training — it is Low Vision Care.

First, there is the recognition of pathology in either its covert or overt stages, to include subtle changes in colour vision and/or retinal dysfunction, whether detected by electrophysiological or other means.

Of course, one cannot omit the refractive and optical considerations in the form of regular spectacles, special lenses, prescribed optical vision aids and appliances.

But it is in the **human** aspects of Low Vision Care that the optometrist manifests understanding and sympathy, not to mention diplomacy. The fear of blindness or an impending vision impairment is one of the deepest and strongest emotions to which an individual can be subjected.

The psychological trauma which follows demands both comprehension and empathy.

The practitioner who deals with Low Vision patients must necessarily become no less scientific in the course of becoming more human.

There is no need to abandon one's knowledge of perception, vision and eyesight. One, however, must avoid overwhelming the patient with technical explanations. In essence, the practitioner's thinking must change from the concepts of blindness and impaired vision to the concept of Low Vision, which can be helped. The thinking must start from the scientific perspective and extend to the human level . . .

From Low Vision patient to low vision Patient.

Such an attitude demands that the practitioners realize that other health care workers have parts to play in the rehabilitation of the low vision Patient. One needs to understand the nature and the effects of the contributions of these personnel. Once again, the concept of co-operation comes to the forefront as a criterion for the most effective delivery of care to the low vision Patient.

Low Vision Care will become more important as the mean age of our population increases year by year. Optometry is the best trained discipline to care for the modality of human vision. The challenge is there and we *must* accept it as primary health care providers!

GMB

Acknowledgement/ Introduction

As is evident from a glance at the Table of Contents, this issue of the *CJO * RCO* is devoted to the field of Low Vision care.

The profession of Optometry and other ophthalmic disciplines are indebted to Professor George Woo who, last year, saw the realization of a worldwide International Symposium on Low Vision. Conceived and organized by Drs. Woo and Graham Strong of the University of Waterloo's Sight Enhancement Centre, the Symposium proved to be an outstanding success from both the technical and human perspective, reflecting a great interdisciplinary concern for patients with low vision problems.

The papers presented at the Symposium are being published *in toto* in a single volume which will be provided to all registrants who attended the full three days of the Symposium. For practitioners who were unable to attend, or able to attend only part of the program, a copy can be ordered directly from the publisher — a half-page advertisement elsewhere in this issue includes ordering information. The planners displayed great foresight by publishing these papers and making them available to interested individuals.

As the selected papers which appear in this special theme issue of the *CJO* RCO* reveal, concern for the Low Vision patient trancends professional boundaries. They also relate the opinion that Low Vision Services in Canada and, indeed, worldwide, are far from perfect.

Dr. Woo and his colleagues have taken a major step towards improving the lot of the Low Vision patient through this international Symposium and we thank all concerned for their part in this issue's advance look at the published proceedings.

Accompanying one of his early communications on the proposed papers which now appear in this issue, Dr. Woo included a summary of highlights of his own and the Centre for Sight Enhancement's activities at the School of Optometry, University of Waterloo in the area of Low Vision.

It is reprinted in this issue for the interest and information of our historically minded readers.