Gerontology and low vision services provided by Australasian optometrists

Barbara Junghans[1], Anthea Cochrane[2], Peter Hendicott[3], Anna Palagyi[1], Robert Jacobs[4]

[1]Univ of New South Wales Australia; [2]Univ of Melbourne Australia; [3]Queensland Univ Technology Australia; [4]Univ of Auckland New Zealand

Background

Anecdotally, few optometrists specialize in the care of persons with permanent vision impairment to provide clinical assessments, rehab services or training in adaptive technologies.

Is this due to inadequate training or is there some other reason?

We investigated optometrists' practice preparedness and management patterns for the older patient and those with low vision (LV).

Fig 1. Institute awarding qualification

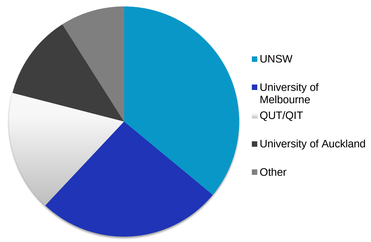

Table 1. Year of first registration

Year range	N (358)	%
Prior to 1960	3	1
1960 - 1969	10	3
1970 - 1979	52	15
1980 – 1989	93	26
1990 – 1999	94	26
2000 – 2009	106	30

Table 2. Primary mode of practice (N = 359)

	%
Sole practitioner	29
Associate/Partner	19
Franchisee	3
Employee of independent	24
Employee of corporate/franchise	17
University	3
Hospital	1
Non-Government Org.	1
Australian College Optometry	3

Methods

Cross-institutional ethics approval was gained in 2009 to survey all members of '*Optometry Australia'* and the '*New Zealand Association of Optometrists'*.

The survey covered 39 areas including demographics and practice management, range of visual aids prescribed and referral patterns to visual rehabilitation agencies.

Table 3. Reasons for not providing services to the elderly

Note: respondents could tick more than one item	% (of total responses)
Longer consultation times not appropriate to mode of practice	27
Cost of providing special services prohibitive	11
Space/access problems within practice	12
Limited numbers of these patients in catchment area	15
Not confident to provide care for older patients with particular needs	9
Do not have appropriate equipment to provide for this patient type	14
None of the above	12

Table 4. Reasons for referring LV patients

Note: respondents could tick more than one item	% (of total responses)
Happy to refer all low vision patients	27
Feel ill-equipped to provide low vision services	21
Not confident to provide low vision services	17
Few with LV in patient base/catchment area	17
Not appropriate to mode of practice	8
Cost of providing low vision services prohibitive	6
Space/access problems within practice	4
Unwilling to provide low vision services	0

Results

The distribution of the 359 responding optometrists reasonably represented the relative proportions graduating from the four schools of optometry in Aus/NZ (Fig 1), with 56% of respondents having graduated within the past 20 years (Table 1).

The practitioners:

•The 359 of 3,800 (9.4%) Aus/NZ optometrists came from a range of practice modalities (Table 2)

•54% self-employed, 46% employees

•74% located in capital cities, 26% rural

•44% male, 56% female

•1 in 4 said experiences during training influenced their desire, or not, to offer gerontology and LV service

•Passionate and empathetic teachers were a strong motivator.

Elderly patients:

•1 in 8 practitioners do not offer physical assistance, longer consultations or domiciliary visits. Older practitioners are more likely to so

•9% claimed 'lack of confidence' as the reason for not catering for the elderly, although were a wide range of reasons covering patient demographics, space, equipment, costs and patient flow (Table 3)

•Notably, there were no effects relating to place of training.

Low vision patients:

•58%, predominantly younger optometrists, essentially provide no LV services and refer all patients to a rehabilitation agency (Table 4)

•17% of those practitioners claim they lack confidence to manage LV patients and 17% feel they do not have the appropriate equipment

•Only 11% practitioners offer a wide range of LV services (Table 5), and even these practitioners refer 9% of patients for co-management

•13% of practitioners have an optometric assistant to help with low vision care

•Notably, there were no effects relating to place of training.

Discussion

Differences associated with where the optometrist was trained in Australia and New Zealand do not influence the manner of providing care for the elderly, particularly those with low vision.

Lack of experience with the elderly and LV patients appears to underpin the lack of confidence in many practitioners, particularly the younger optometrist.

Access to teachers who have a passion for gerontology and who demonstrate empathy when caring for low vision patients appears an important trigger in subsequent choice of patient clientele for graduands.

Table 5. LV aids and technologies prescribed for LV patients

Note: respondents could tick more than one item	% (of total responses)
High addition spectacle lenses	91
Hand magnifiers	75
Stand magnifiers	60
Head-mounted loupes	31
Telescopic devices	29
Closed circuit TV magnifiers	19
Electronic magnifiers other than CCTVs	11
Software solutions (eg screen reading software)	11
Field expanders / field displacement devices	9

Acknowledgements

This project was funded by the Australian Learning and Teaching Council. #DS8-628