Editorial • Patients Can Be a Huge Part of our Life-long Learning: The Key is Listening

Marc B. Taub, OD, MS, EdD • Southern College of Optometry • Memphis, Tennessee

We start learning from an early age and hopefully continue to learn until the day we die. From an optometry standpoint, learning begins on the first day of optometry school and continues by way of continuing education courses like the OEPF Clinical Curriculum. Learning also comes through experience and practice. Think back to when you learned retinoscopy: how were you the first 100 times? Think back to the first time you tried to assess eccentric fixation or attempted to use vectograms for VT. I bet you have gotten better… through practice!

In thinking about how I learn and those ah ha! moments, sometimes they come via my patients. In my 22 years of practice, I have learned so much by working with and listening to my patients. I have learned not only things about being a better clinician but also things about myself.

Probably the most important lesson I continue to be reminded of on a daily basis is that less is more when it comes to prescribing. I was taught in school that if you find a certain prescription, you give it. It did not matter whether the prescription was being given for the first time or the 5th time. It did not matter whether the patient was hyperopic, myopic, astigmatic, or some combination. It did not matter whether they needed a tint or prism. You gave what you measured and called it a day. Over time, I have found that less is more 99% of the time; just because you measure it, that does not mean that the patient requires or tolerates or will thrive with that prescription. This can be an expensive lesson to learn if you own your own office, since remakes cost money!

I figured that I could not be alone in this pursuit, so I asked a small group of doctors about lessons they learned from their patients.

Justin Chelette, OD

Patients tell you what they need. Optometry school teaches you data analysis from a classical standpoint: when a finding falls outside of the normal ranges, you provide something to bring it back to "normal," and when a patient falls within normal ranges, you do not necessarily have to treat it as "the numbers look right." I have an adult patient who started off with 7 diopters of vertical strabismus due to a stroke, and through vision therapy, she was able to reduce the magnitude of her vertical strabismus to where she was comfortable with only 0.5pd vertical prism. Repeated progress evaluations showed "no problems" through the 0.5pd prism, yet she wanted an extra pair of glasses with 1pd, and then she wanted an extra 1pd Fresnel to help her when she got tired in the evenings. She was very explicit in saying that she felt she needed more prism, even though I saw balanced ranges and good stereopsis and fusion with the 0.5pd, so I wrote her the prescription and sold her the Fresnel. My exam is just a snapshot in time, whereas her comments are her daily lived experiences, so even though I didn't clinically find data supporting the "need" for more vertical prism, her observations and symptoms supported it.

What is a problem to a patient may not be a problem to you, and vice versa. I saw a child for a second opinion concerning an intermittent exotropia, and he was an unembedded, uncompensated 3 diopter myope; his accommodative-vergence findings were highly variable, and he also had never worn any glasses before. I reported to the mother that allowing him to wear glasses should normalize his accommodative-vergence findings (as lenses are the primary way that unembedded cases are managed) and that if any problems persisted, we could perform vision therapy later. He returned for follow-up, and through his -3.00D OU glasses, he had excellent alignment, stereo, oculomotility, accommodation, etc. I told his mom how great he was doing and that I did not see any of the concerns that she had originally presented with. She wasn't as thrilled, stating that when he wasn't wearing his glasses, she noticed an intermittent exotropia. She signed up for therapy because she did not want to see her child's eyes drift when he was not wearing the glasses. From my perspective, the child's visual skills normalized through wearing the glasses, there were no school concerns, and he enjoyed playing basketball. From the mother's perspective, there was a cosmetic issue. Regardless, we did not arrive at the same conclusions; presenting her the treatment options allowed her the autonomy of deciding how she would deal with a problem.

Sarah Sweeny, OD

There are so many patients who teach us how to be better clinicians, as well as better communicators, regardless of the relationship. One patient in particular was a current first grader who was at risk for not moving

on to second grade because of their lack of accuracy and confidence with laterality and directionality. She was struggling with letter and number identification, and while she had an optimistic attitude, she was starting to realize she was different, and the adults in her life were concerned and telling her maybe too much. She started asking more questions during therapy sessions. One day, when we introduced an early Theraball activity, her grandmother (and legal guardian) asked why we were calling each symbol "side" instead of "right" or "left." After a short but complete answer, we tried again, then the patient asked, "Why is this side right?" and she held up her right hand. To keep things moving, I said, "That's just what we call it, but we don't have to call it that today." Then she asked, "But I write with this hand." It took me a second to realize she wasn't aware of homonyms "right" and "write." I did my best to explain and wrote out the words so she could see the difference. She seemed happily surprised that there could be two words that sound exactly the same but are spelled differently and have different meanings. It seemed likely that she had been taught that her right side was the side she "writes with," and that perhaps contributed to the confusion. The lesson taken from this encounter centers on not assuming that patients are familiar with or understand what we know, or what everyone else knows, or what you THINK they should know. Phrasing responses and explanations to help patients feel comfortable in a learning environment is important to maintain respect and integrity and goes a long way with developing a trusting and long-lasting patient rapport.

Eric Hussey, OD

There was the young woman with whom I was using the bisected diamond. I had read about someone testing for suppression by using vergences with the Bernell near acuity target with alternating lines of letters. I thought I could do that with my Borish card that I'd purchased in school. So, I attached polarized plastic to the diamond target and sort of followed what the other guys had done. During the vergence testing, I asked her to "let me know if one side of the diamond goes black, and let me know which side goes black and if it clears up again. Then let me know if the diamond comes apart into two, then when it comes back into one, then if one side goes black again." With that instruction set, I got silence. So, after doing that on this woman, I pulled the prisms away, and she said, "oh, now it's black. Now it's clear. Now the other side is black…" Ta dah. I discovered a new way of testing. Well, she did.

Virginia Donati, OD

A 14-year-old male presented for his first eye exam. His symptoms were numerous (asthenopia, headaches, double vision at near, short near-point endurance), and the exam findings were pretty classic (large exophoria at near, remote NPC, tiny base-out breaks, low stereo). He was an excellent VT candidate, and his parents were thrilled that his questionable grades could be blamed on something. He was one of my first VT patients.

The problem was his attitude and his motivation. He had no desire to do anything: no home activities, and he would hardly participate in sessions. At his first progress check, he had hardly made any progress.

It was my first experience with disappointment in VT. I learned that it doesn't matter how much I want to help him, or how much his parents want him "fixed;" you can't do vision therapy TO someone.

I had a conversation with him with his parents in the room to review his goals. They were very vague: to stop seeing double and to get better marks in school. When he was prompted to consider how to achieve those goals, it became clear that he was waiting to be fixed, and, according to him, his therapist wasn't doing a good job.

I told the family that he needed a vacation from VT, and that although we were his guides to learning, the changes, and the will to make those changes, had to come from him. We were here when he was ready. He did not return to VT.

I am much more thoughtful with goal-setting now and a lot quicker to have this conversation if the patient seems to be needing to be dragged through sessions. Lessons learned.

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My hope is that by seeing some of the lessons we have learned, perhaps it will save you the time of having to learn them yourselves!