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Foreward

I have spent my lifetime listening to students.

Not merely to the words that drift across a seminar table, but to the hesitations, the half-formed questions, the sparks of outrage when old ideas no longer suffice. In those fragile moments of inquiry, education either opens outward—toward imagination and justice—or it retreats behind the walls of habit and hierarchy.

Dr. Bennett McAllister's Clinical Guide to Einsteinian Low Vision Rehabilitation chooses the open road. From its first pages, he invites readers to stand, as Bernard of Chartres once urged, "on the shoulders of giants," yet he refuses to leave the learner stranded atop that lonely perch. Instead, he constructs a scaffolding—LogMAR thinking, the Chain-of-Vision, Cause-Effect-Impact—so that each new generation of students may climb higher, see farther, and, most importantly, act with purpose.

Learning as an act of freedom

Traditional optometric education, like most professional schooling, too often resembles a procession of formulas to be memorized, rituals to be repeated, and authority to be obeyed. McAllister disrupts that procession. He tells his students—our future colleagues—"Look it up," not as a dismissal but as an emancipation. In doing so, he aligns himself with the pedagogy of freedom: knowledge is not a commodity handed down from the lectern; it is a common good, co-created through skeptical inquiry and collective problem-solving.

From a learning-psychology perspective, this is transformative. Research on self-regulated learning shows that students who generate their own questions, test their own hypotheses, and witness the immediate

relevance of theory to lived experience encode information more deeply and retrieve it more flexibly. By turning a visual acuity chart into a "slide-rule" for predictive analysis, McAllister converts abstract optics into an active laboratory of the mind. Cognitive load lightens, intrinsic motivation rises, and what might have been rote calculation becomes a much more powerful moment of discovery.

A curriculum of empathy

Howard Gardner reminds us that multiple intelligences—including linguistic, logical, spatial, and interpersonal—converge in any authentic act of care. McAllister's text honors that convergence. He insists that an optometrist is "a people doctor, not an eye doctor," and he trains students to see the patient's life world before they see the pathology. Contrast-sensitivity charts and functional-independence measures are not bureaucratic add-ons; they are windows into whether a grandmother will still read bedtime stories, whether a refugee physician will reclaim his vocation.

For learners, such contextualization nurtures what psychologists call situated cognition: knowledge tied to social purpose is remembered longer and acted upon more ethically. In a profession where reimbursement schedules and production quotas threaten to dull moral vision, this book restores clarity.

Punctuated equilibrium in the classroom

Borrowing from evolutionary biology, McAllister speaks of "re-punctuating" optometric education. The metaphor is apt. Paradigm shifts rarely arrive as gentle suggestions; they erupt, disrupt, and demand new alliances. By weaving narrative dialogues with students—Remi, Logan, Karen, and the mischievous "Einstein"—the author models a classroom where dissent is welcomed and where error becomes a portal to insight. Such dialogic teaching, long championed by critical pedagogy, cultivates resilience and civic courage: students learn not only how to think, but that they have a right, a duty, to think for themselves.

The ripple effect

What, then, is the potential impact of this book on optometry students? I offer three predictions:

1. Intellectual agency

Students will leave the clinic less as technicians of refraction and more as investigators who can

interrogate evidence, adapt protocols, and design solutions for conditions not yet named.

2. Solidarity with the marginalized

By foregrounding patients whose needs fall outside the comfort zone of conventional practice—the partially sighted child, the elder with macular degeneration—McAllister sensitizes future doctors to the structural inequities that shape health. This is history's lesson: when we center the voices at the edges, the circle of care expands for all.

3. A habit of constructive rebellion

Graduates steeped in "Einsteinian" low-vision rehabilitation will carry into every exam lane a quiet subversion: the willingness to ask, Why are we doing it this way? In an era when medical knowledge doubles at dizzying speed, that question is not insubordination; it is survival.

An invitation

I began by speaking of listening. Let me end with a call: listen to these pages. Hear the cadence of curiosity, the refusal to confuse tradition with truth, the faith that learning is most powerful when it is tethered to human need. If you are a student, take this guide as a license to challenge your mentors. If you are a teacher, receive it as a reminder that the classroom can still be a site of liberation. And if you are already in practice, may it re-ignite the radical hope that brought you to health care in the first place.

In the long arc of professional education, few texts bend the curve toward both scientific rigor and social justice. Dr. McAllister has written one. Our task now is to read it—not passively, but with the intention to act.

Mariam Hashmi, MS

Learning Psychologist

Preface

"Education is a progressive discovery of our own ignorance."

Will Durant

"Why?" I have been asked more than once, "Why a book on Low Vision Rehabilitation?" Especially one with such a presumptuous title invoking the greatest mind of the first half of the 20th century? I have asked myself that same question many times over the years as I mulled the idea of composing a Low Vision Rehabilitation work. It has taken me time to constellate the reasons and, though they are still incomplete, I finally did incline to see if I actually had something to contribute to what I see as this too-often-overlooked

field. Perhaps it is true what Daniel Boorstin, the Librarian of Congress, once said, "I write so I know what I think."

To my way of thinking, there is no other aspect of optometry that more encompasses the areas of optics, pathology, contact lenses, genetics, or serving people than low vision. Yet, in my forty-plus years of practicing, I have seen eager and bright students and doctors of optometry who initially embraced the rehabilitation field gradually drift away, eventually avoiding low vision entirely. As I have reflected on this perplexity, I queried a good number of the eye doctors who do not actively practice low vision. I got responses such as "it's boring", "makes me sad", and "takes too much time". There were others, of course, but they sounded to me more like excuses, rather than reasons. Upon years of reflection, I came to think that, just perhaps, the field is avoided by so many practitioners due to the way it is perceived traditionally in the classroom and clinic: that is, mechanical, step-by-step, with hours spent on each patient. While this classic method is certainly one way to approach practice and has been used for decades, I have another perspective, one that I wish to present here. It is not necessarily a substitute for the traditional methodology, but is rather a manner of thinking that can, in this author's opinion, enhance the delivery of low vision rehabilitative care by making it more rational and directed.¹

Permit a digression while I introduce a concept which might be illustrative. It is a concept well-established in other academic fields and drives my thesis. This would be the model of Punctuated Equilibrium, which was developed by evolutionary biologists Gould and Eldredge in the 1970s to explain gaps in the fossil record.² Previously, evolution was thought of as a gradual process, with numerous small changes leading to new species. Punctuated Equilibrium postulated that large, sudden changes occurred with long periods of stability between. This biological paradigm was subsequently borrowed by social scientists in the 1990s.³ It basically posits that social systems exist in a form of rough stasis for long, though variable, periods of time then are jarred or 'punctuated' by the introduction of a sudden change. This change, if powerful enough, at first dramatically disrupts the status quo before eventually creating a new stable system going forward. The same, I believe, can be extrapolated to and readily seen in health care. For example, cataract surgery underwent a profound punctuation when posterior chamber intra-ocular lenses were made practical in the 1980s. Suddenly, heavy, thick post-operative spectacles or high-plus

contact lenses that I grew up using in optometry school became as obsolete as buggy whips did when automobiles superseded horse-drawn carriages for transportation in the early 20th century. Another example of significant social disturbance comes from the 19th century during the Luddite phenomenon in England, when the introduction of sewing machines threw thousands of seamstresses out of work, causing widespread social upheaval that eventually led to labor unions and our system of labor management today.

In low vision rehabilitation, I note an incomplete disruption that might have revolutionized its practice but for some reason, did not. Looking back, I think that it was perhaps too disruptive for the field, with a paradigm shift too great for it to be fully embraced in all its power and advantages. It is hard to say with confidence, but in any case, I observe that the full thrust and power of the LogMAR 'punctuation' in the late 1970s was largely missed by the profession. At most, the field adopted only some elements of that potential 'punctuation', thereby missing out on the full possibilities of what I call 'LogMAR thinking.' As a U.C. Berkeley School of Optometry teaching assistant in low vision class in the late 1970s when the Bailey-Lovie chart introduced the LogMAR revolution, I had a front-row seat to what could be possible with LogMAR power. I incorporated that thinking process and was personally empowered without having to overcome the influence of the prior system of clinical low vision practice. I noted that few other practitioners followed, however, leading to a great deal of personal frustration as I watched bright, enthusiastic students and doctors continue to shun low vision practice. Even at the highest level of the profession, I encountered those who questioned the process of LogMAR thinking. More than once, following demonstrations of LogMAR thinking in streamlining exams, it was not uncommon for me to hear dismissive comments such as 'you are a really good guesser' and 'it's Voodoo,' which to me indicated too great a punctuation others would rather avoid in learning LogMAR paradigm.

So, back to the 'Why'. In large part, I am writing in an attempt to re-punctuate optometry and low vision practice out of their equilibrium and to reclaim the enthusiasm so many students evinced when they initially encountered this low vision rehabilitation field, where so much can be done to help the needy partially sighted patients. I believe that LogMAR thinking is a lost secret that has been hiding in plain sight and can overcome the perception that low vision practice is hard or time-consuming. If the power of LogMAR thinking is completely embraced and implemented,

then perhaps some of the original joy in helping the partially sighted patient with low vision clinical care can be re-discovered in practicing it fully.

In the Beginning

"Unless you try something beyond what you have already mastered, you will never grow."

Ralph Waldo Emerson

In the Preface to this writing, I addressed the 'Why' of its writing. Now, in this chapter, I would like to muse upon the 'How'. There are already books on low vision rehabilitation which address the totality of the classical approach and are comprehensive in that presentation of the orthodox scope. I used one of those books in my class and found it beneficial for teaching in the classical model. Having no desire to reinvent that wheel, however, I would return back to the 'Why' and observe that the current books may not 'punctuate', as I would like to really achieve a breakthrough of the resistance so many students and practitioners exhibit when they have completed traditional training in low vision. Therefore, it is not my goal to duplicate the work that has been done in other books and journals, but to augment and supplement them with a deep dive into LogMAR thinking and its application in clinic. This, then, will not be a comprehensive work, but one I hope will be essential to enhancing the approachability of low vision clinical practice applicable to most of the situations to most of the patients most of the time. As most visually impaired patients have central vision loss, most of them yearn to read printed text most of the time. LogMAR thinking is the tool I use to address the Most - Most - Most paradigm and one I believe is most efficacious.

I will be writing in a bit of a journey style, re-imagining conversations with students and doctors of different ilks and laying out the principles with, hopefully, flowing and revealing prose. In recognizing the current decline in reading full books among college students,⁴ the chapters will be short, yet, hopefully, accessible. In keeping with the accessibility goal, you will meet renamed students of mine who asked genuine questions on that journey to access the power of LogMAR thinking.

There are some students who complain of being bored with the classical approach to low vision care. Others hate memorizing formulae. Historical characters tell their story of developing the primary calculating device of the past few hundred years, the slide rule, and how that unlocked the modern industrial age with

application to LogMAR thinking. Another student who gets the LogMAR emerging epiphany quickly learns to implement it in patient care. Someone else clearly recognizes that the goal of care is not to improve vision but enhance patient quality of life, along with another who sees that improving sight alone isn't enough to fully help her patients. An optimistic student gives reign to her childlike wonder and awe to visualize success in her exam room. Still another is a focused student who initially doesn't care to know how LogMAR works, but just wants to memorize the minimum to pass exams and move on. There's one who knows all about optometry but less about people, which leads to learning better patient care. Howard Gardner is a real-life educator who shares his knowledge and concepts of what various intelligences are and how we and our patients can benefit from their concepts in clinic and life. A Marvel-ous visitor shows what super power matters in determining the proper low vision rehabilitation device powers. Others join us too, so read on to meet them.

Now that I have addressed the 'Why' and the 'How' of this book, it is time to move to what I call 'The Source', and may it always be with you!

May the Source Be With You

"Knowledge is just opinion that you trust enough to act upon."

Orson Scott Card

"Good day, class," Professor McIver opened the semester, "today we begin a journey in caring for our partially sighted patients, but it is my hope that you will be able to take the principles taught here and apply them to other facets and areas of optometry, and who knows, maybe even into aspects of your life outside. Tell me, who here got interested in becoming a Doctor of Optometry because they knew of someone who had lost some or all of their vision? And remember to begin with your name as there are a lot of you in the class whose names I need to learn."

"Hello, Professor McIver, my name is Remi, and while I don't usually speak out in class, I do have something to say on this topic. My grandmother gradually lost her ability to read as she got older, and the eye surgeons we took her to all said nothing more could be done. It wasn't until we took her to see a low vision optometrist that we found out there was hope to read again, and now she has special lenses and devices. Now, I want to do that and help as many people as I can so they are able to read again."

"I love that story, Remi." Professor McIver replied. "I must say, it is a strong motivation for a good number of young people who want to take this low vision rehabilitation path. Many times over the course of my career though, I have seen dedicated students with the same desire as you fall away as the old, classical mode of practice diverted them into other aspects of our profession. It makes me sad because I personally find this low vision field exhilarating and fulfilling and want them to see it that way as well."

"Oh, I don't think I could ever lose the feeling I felt when my grandma read for the first time after her low vision optometrist saw her." Remi insisted. "That is something that will always be with me."

"I love that childlike awe and wonder, Remi! So, let's get into some foundational things before we embark on our journey learning the art of low vision practice so you can become proficient at low vision while retaining your enthusiasm." Professor McIver said, wrapping up the introduction.

"Here we go now. Health care, whether it be medicine, dentistry, pharmacy, podiatry, nursing, or optometry, embraces what is now called evidence-based practice, and rightly so, as that mode gives us the highest level of confidence in diagnosing, treating, and managing the patient to the best possible level of care. Unfortunately, we often find the phrase "evidence-based" bandied about, especially when a speaker or author wishes to add gravitas to their presentation. However, unless they follow the delineated rules and framework of defined evidence-based procedures, they increase the risk of sully the concept and may confuse the audience from that which is actual evidence-based practice.⁵ As a long-term member of the American Optometric Association's Evidence-Based Optometry (EBO) committee, I have been schooled in the precise and proper use of the evidence-based schema. Confirming a predetermined answer is not the goal in evidence-based health care; the process is everything and, much like detectives on a case, the EBO committee follows the evidence wherever it leads. Let's get an overview of the true process for something to be called evidence-based."

"Do we have to go through the whole thing, Professor McIver?" came a voice from the class.

"First, always say your name when you begin to speak to me until I get to recognize you. Second, why do you not want to know how we should think as doctors?" Professor McIver corrected.

"Apologies, my name is Karen, and I think that there is so much to memorize in graduate school that I just want to know the answer and not waste time."

"Good to meet you, Karen." Professor McIver replied, turning to her. "Let me see if I can convince you why knowing the evidence-based process is so important. First, knowledge is not static, nor should it be considered absolute. It is therefore important to have a foundation in the process of what I call 'level of confidence', or how much do you trust the knowledge presented to you, and how much will you bet on it being correct. 'The Source' is a term I use for where the knowledge comes from and what level of confidence you can have in applying it. As class goes along, you will see The Source has some things very well sorted out and other things not so much."

"Well," Karen said surrendering, "I think I see what you mean. Please tell us about 'The Source' and how we use it."

"Very good." Professor McIver replied cheerfully, "Let's overview the EBO guidelines and what it actually means to be evidence-based. First, we have to define our terms to avoid confusion and misunderstanding. The American Optometric Association has those answers for us here on their website, so I would recommend bookmarking this in your browser and referring to it frequently."

To borrow a few lines, evidence-based practice is:

A process involving creating an answerable question based on a client or organizational need, locating the best available evidence to answer the question, evaluating the quality of the evidence as well as its applicability, applying the evidence, and evaluating the effectiveness and efficiency of the solution.



"That process involves 14 steps to develop an evidence-based clinical practice guideline. As part of those steps, studies and papers are pulled within the inclusion and exclusion criteria boundaries for the questions, and all are graded with A, B, C, D or discarded."

Here are their definitions

A-Level Evidence: This level includes randomized control trials, systematic reviews, meta-analyses, and high-level diagnostic studies.

B-Level Evidence: This involves weaker randomized control trials, cohort studies, either retrospective or prospective, and moderate-level designed diagnostic studies.

C-Level Evidence: This is populated by case-control and lower-level designed diagnostic studies.

D-Level Evidence: This is the repository of cross-sectional, case reports or series, expert opinion, reasoning from principles, reviews or position papers, chapters in textbooks, and consumer pieces."

"After the studies are graded, they are evaluated for issues that might be concerning enough to alter the grade, such as risk of bias, inconsistency, indirectness, imprecision, and publication bias."

"Once the grading of evidence is done, it is time for a practical clinical recommendation. They come in three levels, based on the evidence profile. These are:

Strong Recommendation: The practitioner should follow this unless a compelling alternate rationale is in play.

Recommendation: The practitioner should generally follow this recommendation but stay alert for new information.

Discretionary: The practitioner should be aware of the recommendation but be flexible in decision-making and be alert for new information."

"So, Professor McIver", Karen asked, "looking up some articles on-line that have solid evidence is insufficient to call something evidence-based?"

"Exactly!" Professor McIver exclaimed. "Do not fall into the trap of cherry-picking articles and passing them off as proper evidence-based practice. That is not to say something is wrong if it does not pass the strict criteria for evidence-based practice, but it should not be called such. There is much we do as doctors that has little or no supportive studies, but, until those studies come along, we do our best with the available evidence, our experience, and our judgment."

"You will find that in health care, as with much of life, if one follows the money, one finds where the most work is being done. In our vision care field, some of these areas include pharmacology, glaucoma, contact lenses, and diabetes research, where we see a large number of well-funded studies, which gives us a much better chance of establishing foundations for high-level evidence-based guidance. Sadly, in low vision rehabilitation, we find the quantity of such studies not infrequently lacking compared to those other areas mentioned above. Therefore, we are relegated to often using D level evidence with discretionary clinical recommendations in low vision rehabilitation. In this class, I will often present information that has stood

the test of time but has not met the highest levels of the evidence-based model since high-level studies are lacking. When that happens, you should recognize it and use it for what is worth while keeping alert for alternate information.”

“So, back to The Source.” Professor McIver segued. “It can be historical in the discovery of foundational knowledge or declarative information such as definitions of dioptric power, telescopic power, or certain human capabilities. It might be derived from established scientific laws and principles. It even could be generally validated, expert-based clinical practice and judgment. I will utilize studies also when they are applicable. In any case, our focus in this class will be on using the best information available from The Source to help our patients. That said, some information is declarative or factual and needs no exhaustive evidence-based process.”

“Well, that’s it for today’s introductory session. In closing, I’d like to just say that on your optometric journey: May The Source be with You!”

Three Primary Paradigms: The Black Box, Chain of Vision, and Case- Effect-Impact

“It must be remembered that there is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than the creation of a new system.”

Machiavelli

“Welcome, class!” Professor McIver began the semester. “I am pleased to welcome you to the topic that I like to think of as ‘optometry on steroids’; that is, low vision rehabilitation. This is the field in our profession where you will deal with the most unusual ocular and systemic pathology, advanced optics, unconventional refractions, interprofessional care, and interesting people. We are going to start with three new paradigms of care for you.”

“Excuse me, Professor McIver, but what is a paradigm?” came a voice from the new class.

“Please always start any communication with me using your name”, Professor McIver said, pausing.

“This is Karen again. Sorry about that. Will paradigm be on the tests?”

“Thank you, Karen, this is the second time you have told me your name, and I will endeavor to recall it going forward. A paradigm is a way of thinking about an issue. Consider it a model or viewpoint or set of theories to explain or consider how something could be understood. I chose that word specifically because

success in low vision rehabilitation is much easier if one has a mental framework or intellectual scaffold as an organizational structure on which to build further details. In my opinion, it beats the heck out of just trying to memorize what to do in every low vision rehabilitation situation. That can be boring and leads to exhaustion. A proper, organized, and rule-based paradigm also makes thinking about the complex more approachable and manageable. And to answer about will it be on tests; the answer is that the tests will be easier if you choose to use the paradigm(s) I am about to espouse. Does that make sense, Karen?”

“Yes, Professor McIver. I just want to know what to learn for the tests.”

“Well, Karen, I hope you will learn a lot more than that and use it as you develop your ‘doctor voice’; that is, how you present yourself and communicate with your future patients.” Professor McIver replied.

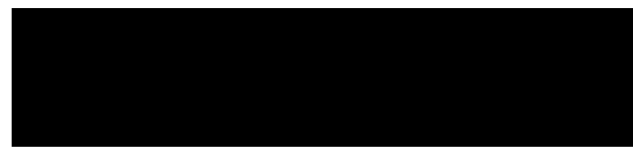
“Now, to the first paradigm. Who can tell me what this is?”

“Looks like a black box.” An anonymous voice from the back said.

“Exactly!” Professor McIver congratulated. “That Black Box can be thought of as the visual system of our patient.”

Karen piped up again and said, “What does that mean, Professor McIver?”

“Glad you asked, Karen. I chose it as we know about as much about what goes on inside the patient’s brain as we do what happens inside the Black Box. While we cannot see what is happening inside the visual system, what we can see is the visual stimulation and the



output response. From that, we can construct a model, or what was that word of the day?”

“Paradigm.” Several students said at once.

“Yes, paradigm. That helps us match what might be happening inside the brain with the visual stimulus and output response.” Professor McIver confirmed. “Now, imagine the Black Box with these two additions: stimulation on the left and output on the right.”

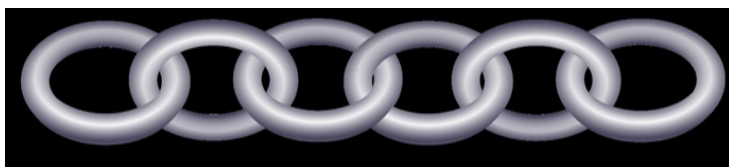
“Got it?” Professor McIver paused to survey the room and noted nodding heads. “Good, so always remember that we can only observe what the visual stimulus is and corresponding output based on patient behavior and responses, but not what goes on inside their mind. Now let’s put our second paradigm into

play; the Chain-of-Vision. You all should be familiar with the old saying that a chain is only as strong as its weakest link, right? This paradigm is conceived as a chain with six links, all of which must be fully functional for good vision.

Those links are (from left to right): (1) light, (2) media clarity, (3) focus, (4) retina, (5) nerve transmission, and (6) brain associations. If any one or more of those links is/are compromised, then the visual output arrow on the right will be negatively affected, and the patient will be visually impaired. These six links pretty much cover all ocular and systemic pathologies that can reduce visual input, processing, and output occurring in our Black Box."

"Professor Mclver, how does this help us?" Karen asked.

"Well, Karen, most low vision patients have a deeply ingrained cultural pre-conception that glasses



should make them see, and if they don't 'work', then stronger glasses will. This is so pervasive that you will not infrequently find referrals for low vision from eye surgeons that say something to the effect 'the patient needs stronger glasses'. Now, looking at the Chain-of-Vision, which link or links are amenable to the focus that glasses provide?"

"It looks like only link #3, the focus link, will be enhanced with glasses or other refractive interventions. But how does that help?" Karen again asked.

"Preconceptions are not easy to break down, but they can be used to redirect the patient's thinking by using other commonly understood cultural precepts like the Chain-of-Vision. If your explanation is too complicated, however correct, the patient will blank it out and revert to their original concept of just needing 'stronger glasses'. So using a six-link image puts it within the short-term memory's generally accepted limits of seven⁵ and brings to mind an approachable concept. Then, once they have a handle on it, you can walk them through the links, showing how each link operates. #1 means they need good lighting; #2 that their keratoconus or cataracts are the culprit; #3 proper refractive correction should help; #4 macular degeneration, diabetic macular edema, or retinal detachment must be addressed; #5 strokes, aneurysms, or trauma are the offender and must be ameliorated first; #6 is again, usually caused by strokes, aneurysms,

or trauma. If you can get the patient to understand this paradigm early, it can save much consternation down the road in the exam and more than pays back the short time expended explaining it in the beginning."

"But the Black Box and Chain-of-Vision are not just for the patient's understanding and acceptance of the change in their visual status; I find it is also helpful for myself to frame my own thinking and approach."

Karen mulled this a while, as did the whole class, then said, "I guess we all have those deeply imbued cultural preconceptions, Professor Mclver. Now I need to re-frame my own thinking to these new paradigms."

"It can take some time, Karen," Professor Mclver began, "but it is well worth it and makes low vision rehabilitation practice more productive, effective, and enjoyable."

"Now to introduce our third paradigm, which I believe should be a solid guide for you in your developing treatment and management plans. It has three parts, and while they will only be described cursorily here, they will be expanded upon later." Professor Mclver announced:

"The Cause is the deficit in visual abilities and their measures. The Effect is how a person functions given their Cause."

"Finally, we have The Impact, or how vision loss impacts quality of life and the amelioration of that Impact."

Remi piped up with, "That sounds a bit esoteric. Can you expand upon Cause–Effect–Impact a bit more so I can get a better handle on them?"

"Sure, Remi. Consider that in low vision, we need to approach the patient from a place somewhat different than we would a fully sighted patient. A perspective based upon Cause–Effect–Impact is a simple yet basically complete paradigm to do so. The Cause can be broken down to three areas: visual acuity, visual fields, and contrast sensitivity. Not just their measures, but how we can maximize performance with glasses, contact lenses, visual aids, and patient education; basically tools related to vision enhancement. History supplemented by functional independence measures comprises the Effect a particular vision loss has on patient abilities, while the Impact is found in our quality-of-life considerations and how we can improve them with interventions, both visual and non-visual. Keeping those in mind as we proceed through the journey of this class can help you build around the paradigm scaffoldings to a richer understanding of low vision rehabilitation practice. Welcome to my world!" Professor Mclver concluded.

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Petrosyan Workbooks

The 16 workbooks can help improve visual discrimination, form perception, form constancy, figure-ground, visual attention, visual memory, visual sequencing, visual-spatial, perceptual speed, and intersensory integration skills. They can also help increase the speed, accuracy, and automaticity of fixation and large and moderate angle saccades, as well as reading-related eye movements. They are designed to take the patient from large, simple, and uncrowded visual stimuli to tasks requiring accurate visual perception and speed and accuracy of reading-related eye movements.

