

NOTHING MORE CAN BE DONE . . .

A Fable for Our Times

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Once upon a time, there was a trial lawyer who was also a juvenile diabetic. Despite taking reasonably good care of his diabetes, he developed peripheral vascular complications and gangrene of one foot. A below-knee amputation was required. The attorney was concerned that with the leg removed, he might not be able to return to his usual promenading around the courtroom and an otherwise active lifestyle.

"Not to worry," his orthopedic surgeon reassured him. "Even though it is necessary to remove your lower leg, we have learned many ways through the years to replace the function with one sort of prosthesis or another. With a little luck and some work on your part, we should be able to get you back to nearly normal function."

The rehabilitation process started soon after surgery. Initially, the patient used a wheel chair to provide some mobility. When the edema and reaction of the operation began to subside and the patient could tolerate having the leg dependent, he was referred to physical therapy for long-arm crutches. The therapist made sure that they were of the right length and gave him some instruction in their use. He soon learned that it was easier to use two crutches than one, for this allowed a swing-through gait, and that if only one crutch was used, it should be on the side opposite to the operated leg. These were minor points, but it made a big difference to the patient to have them explained.

After he was out of the hospital and back in his law office, he began to note that the long-arm crutches ruffled his suits and made his armpits sore. In addition, he was unable to carry papers very well. The physical therapist, who had stayed in touch with him during his rehabilitation process, suggested that he switch to the short Canadian crutches, which were much more convenient to use, left his hands free without setting the crutches aside, and made it easier for him to carry papers in a shoulder bag, which the physical therapist also suggested.

When the stump was finally healed, the orthopedic surgeon referred his patient to the prosthetist. When the artificial leg was ready, he returned to the physical therapist for gait training. Adjustments were needed to the socket, after which a final leg was made, complete with an articulating ankle and a flesh-colored "skin."

In the end, the attorney was delighted; the focus of his care had been not just fixing the leg, but fixing the patient. The plan for his rehabilitation had been outlined beforehand, had been started early, and had been adjusted to his particular needs along the way. He had received encouragement and emotional support. His disease had led to a disability, but, thanks to the care, very little ultimate handicap.

Time passed, and our attorney developed diabetic maculopathy. His ophthalmologist went right to work but despite the best that modern

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diabetic management, angiography, and laser treatment could offer, the patient ended up with 20/100 vision in his better eye and peripheral and central field defects to boot. The retinal specialist, who could no longer be bothered with such mundane things as refracting patients, announced in magisterial tones that the treatment was complete, and that "nothing more can be done." He gave the attorney an appointment for a 3-month follow-up examination, pupils to be dilated on arrival so the doctor could complete his fundus examination with a minimum of time.

Our attorney went into a profound funk. He could no longer read well enough to keep up his legal practice and so was faced with unemployment and loss of income. He had difficulty measuring his insulin dosages, trouble getting around in dim lighting, and was unsure of himself crossing the street. His fellow pedestrians seemed to resent his awkward mobility and gave him no quarter. Because our patient's vision was impaired, he had lost the prime means of gathering information that might have led him to some rehabilitative measures for his new handicap.

Fortunately, a relative came to his rescue. She read about an ophthalmologist who was actually interested in rehabilitating not only the eye, *but the whole patient!* The patient was kindly received at this doctor's office and was scheduled for a full 1½ hour examination. The ophthalmologist participated in the workup, but much of it was done by others who had been specifically trained in the rehabilitation of the visually impaired.

Our attorney was shown a range of optical aids such as high add bifocals, base-in prism reading half eyes, and a lighted pocket magnifier that once again allowed him to read the menu at business lunches in dimly lit restaurants. A theater buff, he was given a head-borne telescope that allowed him to follow the action on the stage.

Then he was introduced to a series of non-optical aids, such as a white support cane, which was valuable not so much for support, but because it announced to his fellow pedestrians that he had some visual difficulties, to which they might defer. He was shown devices for measuring his insulin dosage and was given absorptive lenses to help out with glare problems. He was surprised to learn how much yellow lenses could improve visibility under marginal conditions. A closed circuit (CCTV) also proved to be a big help for his legal work.

Finally, he was told about some *social service*

items that were available. For instance, although he was no longer able to see well enough to qualify for a driver's license, he was able to obtain the non-driver's card issued by many driver's license bureaus to serve as an identification document. He was introduced to a low vision support group, where similarly affected patients exchanged ideas on what had worked best for them and where they gained confidence and discharged some of their frustrations.

In the end, it turned out that there was indeed a great deal more that could be done, if not for the eye, at least *for the patient as a whole*. Our disabled attorney was rehabilitated to the point where he could resume his law practice on a satisfactory, if somewhat less intense, level.

His pleasure with the low vision rehabilitation services he had received, however, was balanced by his anger at the doctor who had treated only his eye and then dumped him back on the street. At his next follow-up visit, he confronted his surgeon with the contrast in rehabilitation care that he received from ophthalmology as compared with orthopedics. The ophthalmologist stammered a bit, saying something about being a highly trained specialist, about being very busy, that there was no money to be made in low vision rehabilitation work, and that ophthalmology was a fairly narrow field whose practitioners couldn't be expected to know very much about the whole patients in which the eye rides around.

The attorney took into account that the medical care had been first rate. He settled out of court for just his economic loss between the time his ophthalmic care was completed and when he finally found rehabilitation services on his own.

THE MORALS OF THE STORY

1. Even though it may be true that nothing more can be done for the *eye*, it is *almost never true* that nothing more can be done for the *patient*.
2. Providing rehabilitation services for their visually impaired patients is the medical and moral—and will likely soon become the legal—responsibility of all ophthalmologists. It is no more acceptable for an ophthalmologist to abandon a patient once the medical treatment is completed but before needed rehabilitation services have been provided, than it would be for

an orthopedic surgeon to abandon an amputee to hopping around on one leg. The difference is that common public knowledge would condemn an orthopedist who acted in this way, whereas a similar deficiency in the ophthalmic field is not yet so apparent to the layman. The ophthalmologist must *either provide these services or refer* the patient to someone who does.

3. Low vision rehabilitation services should start *early*, as soon as the patient's disease proves disabling, and long before a handicap is well established. The mild measures needed in the early stages of visual decline are often simple, inexpensive, and relatively easy to provide. They should be available as part of the routine care offered by every ophthalmologist.

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