Chapter 2

Communication skills

David B. Elliott

CHAPTER OUTLINE

2.1 Turning anxious patients into satisfied ones

2.1.1 Patient satisfaction is linked to good communication skills

The research literature consistently indicates that patient satisfaction is linked with clinicians having good communication skills: being able to explain diagnoses, prognoses, treatment, and prevention using clear, non-technical terms and being honest, empathic, and able to listen well and address patient concerns.[1] Good communicators are popular with their patients, and good communication skills lead to the majority of your patients returning for future appointments; those patients inform their friends and family so that your patient base increases and you are less likely to be involved in lawsuits.[1]

2.1.2 Why are some patients anxious?

Poor patient satisfaction is linked with preconsultation patient anxiety.[2] A significant number of patients are anxious about attending an optometric examination[3,4] and particularly fear receiving 'bad news' of one form or another.[4] Patients need not display obvious signs of anxiety, and it can be useful to assume all patients have some level of anxiety prior to the examination. Anxiety reduces patient–clinician communication and causes reduced attention, recall of information, and compliance with treatment.[4] This limits the usefulness of the examination because anxious patients are unlikely to provide a full case history and reveal all their visual problems, unlikely to attend appropriately to your instructions, could provide unreliable responses in the subjective refraction, and could easily misinterpret or forget what you said about their diagnoses and management plans. To be empathic, you need to be aware of possible reasons for patient anxiety and these include:

(a) Being told they need glasses.[3] This can be a worry for both prepresbyopic[5] and presbyopic patients[3] who are concerned about the effect on their appearance.[6,7] Some younger patients report bullying at school because of wearing glasses[6] and elderly patients worry that glasses will make them appear older and more frail.[7]

(b) Fear of vision loss. Particularly true of elderly patients where eye disease is a greater risk.[3,7] There may also be an associated fear of losing their driving licence because of poor vision.[7]

(c) Cost issues. Both young and old patients are worried about the potential cost of glasses and contact lenses.[3,6,7]

(d) Fear of making a mistake. Young and old patients report worrying about making mistakes during the subjective refraction part of the examination.[6–8] This may be because they believe that a mistake on their

part could lead to the provision of an incorrect refractive correction in their glasses[8] and/or are worried about feeling foolish if they make a mistake.[7]

(e) Fear of increased ametropia. Some patients worry that wearing glasses will make their eyesight worse[6] and that increasing ametropia will mean thicker and less attractive glasses.[9]

(f) Being told that they cannot wear contact lenses any more. Young contact lens wearers typically report a better vision-related quality of life than glasses wearers[9] and some may worry about being told that they cannot wear contact lenses any more.

(g) Adaptation problems. Many older patients report concerns about being able to adapt to their new glasses.[3]

(h) Fear of looking foolish. Some patients are very tentative about admitting some of their concerns about their vision in case they are made to look foolish by raising the issue. Concerns about vitreous floaters are a typical example of this.

(i) Fear of mental health problems. Charles Bonnet syndrome, in which patients suffer visual hallucinations, is not uncommon in patients with visual impairment, particularly if severe,[10] and patients are worried that they may be developing dementia or other mental health problems.

2.1.3 Building a rapport: relaxing the patient

The entire patient visit needs to be considered as otherwise the 'arrive–wait–prescreen–wait' process could add to patient anxiety prior to meeting the optometrist, particularly given the silence about data collected in prescreening. Good communication skills from reception staff and clinical assistants are hugely important to help relax the patient.

(a) Provide information about the eye examination (via websites, leaflets, pamphlets, and so forth) prior to the appointment because this can reduce anxiety and improve satisfaction with the consultation.[2]

(b) Provide a comfortable and welcoming setting in the practice waiting room. Comfortable chairs, a selection of magazines, some low level music, and so forth can all help to relax the patient. Framed copies of the qualifications of all staff, either in the waiting room or the examination room, can provide reassurance to some patients.

(c) Clinical assistants should fully explain the tests that they are performing and indicate that the test results will be discussed with them by the optometrist.

A good communicator will be able to relax an anxious patient and increase patient satisfaction with the eye examination.[1,2] There are many ways to relax a patient and build a rapport and these include:

(d) It would appear that formal attire is becoming less important than it once was. Research from medicine suggests that although some older patients prefer a formal, 'professional' appearance, there is a wide variation depending on country, setting, and context of care.[11]

(e) First impressions count and some clinicians like to greet patients by name and escort them to the examination room. Smile and make eye contact.[12]

(f) Change the chair height to ensure you are at the same eye level as the patient.[13]

(g) At the start of the case history, pay full attention to your patient and do not look at the screen (or put your pen down). Your posture and style should be relaxed but attentive.

(h) Some clinicians like to chat about non-clinical issues (e.g., weather, holidays, sports teams, parking) prior to the examination to help relax the patient. In this respect, it can be useful to make a note of any relevant information (e.g., a child's favourite sport, sports player, team, author; the patient's pets and their names, their children's successes) to allow you to start a conversation at subsequent visits.

(i) Maintain regular eye contact and use the patient's name at appropriate intervals during the eye examination. The preference for the use of the patient's first or family name can be linked with their age and it can be useful to ask which your patient prefers. Your tone of voice and intonation should match what you are saying.[12]

(j) An open question is typically used to start the case history (section 2.3.1, step 3) as this allows patients to tell you about any problems with their vision or glasses. A balance is required between allowing patients plenty of time to discuss their problems and not rushing them, but at the same time retaining control of the discussion. You need to ensure that patients feel that you have fully listened and understood their problems and you may even need to allow them to talk about information that you know is not necessary from a diagnostic viewpoint. However, you also need to develop the skill of being able to interrupt an overly talkative patient without appearing rude.

(k) Some patients are very shy, and an open question provides little information and may make the patient feel uncomfortable. Closed questions (i.e., that have a yes or no answer, such as "do you have any problems seeing the whiteboard at school?") can be useful at the beginning of the case history with such patients. An open question can be used later in the case history if the patient relaxes and conversation becomes easier.

(l) Listening is a hugely important communication skill. It is vital that you have fully listened to the patient and understood his or her problems.[2] There are a variety of cues to indicate to the patient that you are listening, and these include maintaining eye contact

and demonstrating attention by nodding and/or using affirmative comments such as "I see," "I understand," "OK," and "go on,".[12] Listening is also indicated by using follow-up questions to comments, such as asking about the location, onset, frequency, and so forth of headaches when the patient indicates suffering with them. Finally, summarising the patient's problems at the end of the case history (see section 2.3.1, step 10) is a useful way of indicating to patients that you have listened to what they have to say and fully understand what problems they are having, and it also provides the patient with an opportunity to inform you if you have missed anything.

(m) Provide a brief explanation to the patient of each test that you use during the eye examination. Patient knowledge about the contents of an eye examination is poor,[6,8] and patients indicate they want to be better informed.[8] Suggested information, in lay terms, is provided for each test described in later chapters.

2.1.4 How to improve your communication skills

All students should gain adequate communication skills via lectures, reading,[13] and clinic feedback. How do you become a better communicator? A helpful quality about communication skills is that you can learn them anywhere and from anybody. Obviously observing an optometrist or another health professional who is popular with patients could be particularly beneficial. You can also learn by experience so that any summer job that involves working with the general public can be valuable. Indeed, it is obvious from the level of communication skills shown in clinics, which students have had jobs that involved working with the general public and which ones have not. Finally, recording yourself performing a case history and/or eye examination can be a valuable tool and will particularly highlight your non-verbal communication skills. Review the recording with a colleague and critique your non-verbal communications skills. Try to avoid negative non-verbal communication cues such as a blank, unresponsive face, minimal eye contact, long silences, none or few affirmative gestures, inattentive or anxious gestures such as touching your face/hair or twirling a pen, leaning backwards, using a closed body position (arm across your body, legs crossed) or a dull, quiet tone of voice with no intonation.[12]

2.2 The importance of recording

It is essential that all test results (including the 'results' from case history-taking and the discussion of diagnoses and management plans) are recorded. If they are not recorded, subsequent legal analysis of the records will conclude that they were not performed.

2.2.1 Electronic health records

A large and increasing number of optometric records are now computer-based[14] and avoid the problem of illegible handwritten records and should reduce the likelihood of lost records (assuming appropriate backup arrangements), which were a significant problem with card-based systems.[15] Other advantages of electronic records over card-based systems include that information from a previous record can be uploaded and then amended with information from the current examination (this can also be done for the right and left eyes); they can be linked to digital ocular photographs, and referral letters are easier to produce and print.[14] Electronic health records vary widely and will continue to improve, but current disadvantages of many systems include the inability to sketch various features (e.g., cataract and fluorescein staining patterns) if digital photography of both the external and internal eye is not available; getting used to different systems can be difficult for locum optometrists; going to a complete computer system means that some companies scan old paper records which can become more illegible by that process; copying information from previous records or the other eye can lead to information overload and/or that you forget to put in details; drop-down lists can become very long and it can be difficult to get an overall picture of a patient because of the fragmented nature of the information. The latter can mean it is difficult to highlight important details as with a paper record card where you can write it in large capitals/highlighter on the front page.

2.3 Case history-taking

The case history is the cornerstone of an eye examination. It puts you in the position of detective: there are often problems to discover and you must use all your skills of observation, listening to what patients say and how they say it, and questioning to identify their problems as completely as possible. A summary is provided in Box 2.1. The case history is complicated and takes many years to learn well, so that the procedure described here begins with the simplest case of a patient without symptoms or glasses. It builds from that to a patient who wears glasses and contact lenses (CLs), but has no problems, then to a patient with oculo-visual problems, and finally discusses additional questions that should be asked of specific patients.

Box 2.1 Summary of case history procedure

1. Determine the chief complaint (CC). Use LOFTSEA or similar to collect all the appropriate information.
2. Refractive correction If not part of the CC, determine the type, number, and age of glasses and/or contact lenses worn, the quality of vision at distance and near with each, and the quality of vision without as appropriate.
3. Vision. If no Rx is worn, ask about the quality of vision at distance and near.
4. Symptoms. If not part of the CC, ask about symptoms of headaches, eyestrain, pain or discomfort, diplopia, and flashes and floaters.
5. Ocular history. Ask about the patient's ocular history, family ocular history, and LEE.
6. General health. Ask about the patient's general health, medications, allergies, family medical history, and LME.
7. Occupation, sports, hobbies, computer use, and driving.
8. Summarise the case history.
9. Remember that a case history continues throughout the examination.

2.3.1 The most basic case history

The case history of a patient who does not wear glasses or CLs and has no oculo-visual problems is described first because it is the simplest case history to perform. This section describes what questions you should ask (in lay terms), in what order and how to record the answers (an example of recording a basic case history is given in section 2.3.8a): It can be useful to master this case history first, before building on it with more complicated case histories described in subsequent sections.

1. Welcome the patient and introduce yourself.
2. Sit about 1 m from the patient at eye level. Your posture and style should be relaxed but attentive. Lean slightly forward toward the patient. Try to avoid long silences while writing notes and learn to type or write down answers in abbreviated form (Table 2.1) as the patient is talking, while retaining intermittent eye contact.
3. Chief complaint (CC) or reason for visit (RFV): Determine the CC by asking an open-ended question such as "Are you having any problems with your vision or your eyes?" In this example, the patient reports no vision or eye problems and has just attended for a routine eye examination.
4. Glasses/CLs. Ask "Do you wear glasses or contact lenses at all?" In this scenario, the answer is no, so ask whether the patient has ever worn glasses or CLs.
5. Last eye exam (LEE). Ask the patient when and where was their LEE. Ask if the optometrist reported any problems at that time.
6. Visual demands. Ask about the patient's distance and near vision and tailor the question to the patient's vocation and/or hobbies. For example, "How is your distance vision?" "What are the visual demands of your job?" "Can you see the white board at school?" "How about the TV?" "Do you drive?" "How is your vision for driving?"

   "How is your near vision?" "Is reading OK?" "Can you see your music sheets when playing the piano?" For presbyopic patients, you need to discover the distance used for computer use, reading, and other near tasks such as sewing, reading music, and so forth and the use of any additional reading lights (e.g., angle-poise or goose-neck lights; see section 3.2).

   It can be particularly useful to ask patients about contact sports (football, rugby, hockey), swimming, fishing, and racquet sports and whether ametropic patients wear their glasses or contact lenses for these sports and activities, so that they can be advised appropriately (see section 2.4.2).
7. Symptoms. Ask about the most prevalent oculo-visual symptoms. "Do you suffer from headaches?" "Any double vision?" "Any eyestrain?" "Any pain or discomfort in the eyes?" "Do you see flashing lights and floaters?"
8. Ocular history (OH), family ocular history (FOH):
   (a) OH: Ask an open question: "Have you ever had any problems with your eyes at all?" then more specifically: "Have you ever been to the doctor or hospital about your eyes?"
   (b) FOH: Ask an open question such as "Do any eye problems or eye diseases run in the family?" This can be clarified by providing examples of common hereditary conditions (in lay terminology) for their age, gender, and race, if pertinent. For example, for children and young adults ask "Any short-sightedness? . . Squint? . . . Lazy eyes? . . . any colour vision problems?"; for African American, African Caribbean patients over 30 years of age and all other patients over 40, ask about any family history of glaucoma; for patients over 60 ask about any family history of cataract, age-related maculopathy, and glaucoma. Do not ask about specific conditions (e.g., myopia) if you know the patient already has the condition.
   (c) If a patient reports that he or she is adopted, make sure you record this and do not ask about family history at future appointments.
9. General health information.
   (a) Ask "How is your general health?" and add a follow-up question such as "… any high blood pressure or diabetes?" If you receive a positive response, ask the patient how long he or she has had the condition because ocular effects of systemic diseases are more likely the longer the patient has had the condition. For example, the duration of diabetes is a major risk

Table 2.1 Abbreviations that could be used during the recording of a case history

Abbreviation	Stands for	Abbreviation	Stands for
CC (or PC or RFV)	Chief complaint or presenting complaint or reason for visit	Sxs	Symptoms
c/u (or C/U)	Check up	Px (or Pt)	Patient
F/U	Follow-up appointment	Hx	History
DV	Distance vision	LEE	Last eye examination
NV	Near vision	OH	Ocular history
OK	Okay	FOH	Family ocular history
↑	Increase	cat	Cataract
↓	Decrease	AMD/ARMD	Age-related macular degeneration
c̄ (or *c*)	With	POAG	Primary open-angle glaucoma
s̄ (or *s*)	Without	GH	General health
Rx	Prescription/glasses	FMH	Family medical history
CLs	Contact lenses	HBP	High blood pressure
RE (or OD)	Right eye	DM	Diabetes mellitus
LE (or OS)	Left eye	CVA	Cerebrovascular accident
B (or binoc)	Binocular	meds	Medication
BE (or OU)	Both eyes	Ung.	Ointment
1/7, 3/7	1 day, 3 days	o.d.	Once daily
1/52, 3/52	1 week, 3 weeks	b.i.d. (or b.d.)	Twice a day
1/12, 3/12	1 month, 3 months	t.i.d.	Three times a day
HA (or H/A)	Headaches	q.i.d.	Four times a day
Dip	Diplopia	p.r.n.	When needed
H	Horizontal	q.h.	Every hour
V	Vertical		
Fl & Fl	Flashes and floaters	LME	Last medical examination

A tick (✓) used to be used to indicate 'OK', 'good', or 'fine', but has been fallen out of favour owing to its misuse in other parts of the record card.

factor for vascular complications of diabetes, including diabetic retinopathy.[16] If the patient has diabetes or hypertension, ask how well the condition is controlled. The risk of diabetic retinopathy is greatly reduced with good glycaemic control in diabetic patients and by good blood pressure control in a patient with diabetes and hypertension.[16]

(b) Ask "Do you take any medications?" It is important to ask this even if patients say that their general health is good because some patients believe their general health is fine when it is controlled by medication. Patients may also be taking medications, but are unsure why because the medical diagnosis was not properly explained or was poorly understood. Note that some drugs can have adverse ocular effects, such as beta-blockers (dry eyes) and oral corticosteroids (posterior subcapsular cataracts). If you receive a positive response, ask the patient the number and dosage of the drug and how long the patient has been taking it because this will influence the likelihood of adverse effects. Note that patients may not consider 'over-the-counter' tablets (including travel

sickness pills, antihistamines, sleeping pills, and painkillers), inhalers, or eyedrops as medications, so it can be useful to ask about them specifically, particularly with patients with unexplained symptoms. Similarly, female patients may not consider birth control pills to be medication, yet the drugs in these pills can have adverse ocular effects.

(c) Ask whether the patient has any allergies.

(d) Family medical history (FMH): Ask an open question, clarified by examples, such as 'Has anybody in your family had any medical problem?' This can be clarified by providing examples of common hereditary conditions such as 'any diabetes or high blood pressure in the family?'

(e) Last medical examination (LME): Ask the patient when was your last visit to a physician and obtain the name of the physician.

10. Summary: Summarise the *pertinent* information from the case history and allow the patient to clarify any misunderstanding on your part or to add any additional information that has been missed.[17] For example, "So, Mr. Hazard, you are having no problems with your vision or your eyes and you are just here for a routine eye examination, is that correct? Are there any issues that I've missed?"

2.3.2 Case history for a patient with glasses and contact lenses but without visual problems

This builds upon the basic case history described in 2.3.1. However, at step 4, the patient indicates that they wear glasses and/or contact lenses. Step 4 is now as follows (an example of the recording is given in section 2.3.8b):

(4a) If the patient wears glasses (ask if you are unsure), you need a complete description of them.

(i) "When do you wear your glasses?"

(ii) "How is your distance vision in your glasses?" followed up by "Do you feel it is as good as it was when you first got them?" This can be adapted to suit the patient. For example, a student could be asked "Any problems reading from the whiteboard?" and "Is everything clear on the TV?"

(iii) "Any problems with reading with the glasses?"

(iv) "How is your distance/near vision without your glasses?"

(v) "How old are your glasses?"

(vi) "How many pairs of glasses do you have?"

(vii) "Where did you get these glasses?"

(viii) "How old were you when you first wore glasses?"

(ix) "Do you have prescription sunglasses?"

(4b) If you are unsure, ask if the patient wears contact lenses. If the patient does wear lenses, even if only occasionally, then you need a complete description of them.[17]

(i) "What type of lens are they?" (e.g., soft, gas-permeable, toric, multifocal, and brand if known)

(ii) If relevant (i.e., not single use lenses): "How old are your current lenses?" "How often do you replace your lenses?" and "What care solutions do you use?"

(iii) "How long do you usually wear the lenses each day?" and "How many days per week?" The first question can be confirmed by asking when the lenses are typically inserted and when they are removed, because average wearing times are typically underestimated.

(v) "How is your vision with contact lenses and how does it compare with the vision you get with your glasses?" If the patient wears both glasses and contact lenses, you will have to ask about visual symptoms (i.e., distance blur, near blur, headaches, eyestrain) for both forms of correction.

(vi) "Are you currently having any problems with your contact lenses?"

(vii) "When was your last contact lens aftercare and when is your next aftercare check scheduled?"

2.3.3 Case history for a patient who reports a chief complaint

This further builds upon the basic case history described in section 2.3.1. At step 3, the patient indicates that they have a chief complaint. Step 3 now needs to include a series of questions aimed at obtaining a full description of the chief complaint. An example of the recording is given in section 2.3.8c. Students can be guided to which questions to ask by the mnemonic **LOFTSEA** and examples of LOFTSEA-guided questions for CCs of blurred vision, headaches or diplopia include:

(3a) L - Location/laterality

- "Is it more blurred in one eye or is it the same in both?"
- "In which part of the head is the headache located?" *For a frontal headache, ask* "Is it above one eye more than the other?"
- "Is the double vision in all directions of gaze or just one?"

(3b) O - Onset

- "When did the blurred vision/headaches/double vision start?"

(3c) F - Frequency

- "How often do you get headaches?" Prompt if the patient is unsure: "Every day? Once a week? Once a month?" "Are they any better on weekends?" "Do they tend to occur at any particular time of day? Morning mainly or evening?"
- "How often do you get double vision?" "How long does it last?" "Does the double vision occur after a lot of reading or at any time?"

(3d) T - Type
- "Did the blurred vision start suddenly or gradually?" *If sudden vision loss, ask* "Was the vision loss partial or total?"
- "Is it a throbbing, sharp, or dull headache?"
- "Is the double vision one on top of the other or side by side?"

(3e) S - Self-treatment
- "How have you coped with the blurred vision?" (e.g., possibly by squinting, sitting at the front of the class, sitting close to the TV, using ready readers, borrowing a family member's glasses).
- "Does anything make the headaches go away?" "Do you take any painkillers for the headaches?"
- "Does the double vision disappear if you close one eye?"

(3f) E - Effect on the patient
- "How is your son's school work progressing?" "Does it affect your hobbies or sports?" "Is your poor vision affecting how well you can do your job?" "Have you restricted your driving?" "How well do you manage driving at night?"
- "How badly do the headaches affect you?" "Have you been to see your GP (general practitioner/physician) about the headaches?"

(3g) A - Associated factors
- "Are there any other symptoms associated with the problem?"

6-7. Depending on the patient's chief complaint, you will have asked some questions listed in section 2.3.1's steps 6–7 and whether these symptoms occurred with and without glasses/CLs. You now need to ask about visual issues in 2.3.1's steps 6-7 not yet discussed to 'fill in the gaps'. For example, if a patient has a chief complaint of headaches, once you have a complete description of the headaches and whether they are better with or without any glasses or contact lenses, you need to ask about the patient's distance vision, near vision, eyestrain, pain or discomfort and diplopia (with and without glasses as appropriate) and flashing lights, and floaters. If a positive response to any of these questions is obtained, you then need to obtain a complete description.

(See online video 2.1.)

2.3.4 Additional questions: birth history

Additional questions may be required, depending on the patient's age and/or other factors. With very young patients, you may need to ask your patient's parent/caregiver about the child's birth history because of the high prevalence of ocular abnormality (including retinopathy of prematurity, strabismus, and refractive error) in children born preterm, those with low birth weight or disorders of the central nervous system, and in children with significant birth complications (e.g., forceps delivery). Was the child a full-term baby or was the child born prematurely? What was the birth weight? (Less than 2000 g or 5 lbs is a significant risk factor for strabismus, in particular esotropia).[18] Were there significant complications at the child's birth? Is the child's current and past general health good? Since birth, has the child been investigated or received treatment for any medical condition?

2.3.5 Additional questions: patient at risk of falls

Falls are very common in the elderly, with about a third of people over 65 falling at least once per year, which can cause significant morbidity and mortality, with more than 80% of accidental deaths in this age group being caused by falls.[19] Patients with risk factors for falls should be asked: "Have you had any falls in the last year?" Risk factors include being over 75 years of age, using more than three medications (polypharmacy), antidepressant use, systemic conditions that reduce mobility, cardiac problems, diabetes, and inner ear problems. A history of falls is an important risk factor for subsequent falls and patients at high risk of falling need to be identified as they should have more regular eye examinations, earlier cataract surgery, and an altered glasses prescribing strategy (section 4.15.4).[19]

2.3.6 Additional questions: patients who smoke cigarettes

Cigarette smoking is a significant preventable risk factor for both age-related macular degeneration and cataract.[20] Patients report being comfortable being asked about cigarette smoking by their optometrist[21] and you should certainly ask patients with a family history or early signs of age-related cataract and macular degeneration: "Do you smoke?" If the patient appears uncomfortable with you asking this question (or you do), you can indicate the reason for asking: "Cigarette smoking is strongly linked with two major eye diseases" or similar. Follow-up questions of "For how long?" and "Typically how many per day?" can be used to determine whether the patient is a heavy or light smoker. These questions are probably best asked as part of the 'general health' section of the case history.

It can be very useful to ask patients who smoke whether they want to stop smoking and provide support for tobacco cessation.[21] The likelihood of optometrists asking these questions may vary across countries, and it seems likely that optometrists would be more involved in this process where there are national social marketing campaigns linking blindness and smoking. Australia became the first country to include a picture warning label on cigarettes to link blindness and smoking in 2007, and this has increased levels of awareness compared with other countries that have not yet

introduced these warning labels.[22] Optometrists are in an excellent position to help people to stop smoking because fear of blindness is a potentially important motivator.[21]

2.3.7 Additional tips

Once you become more experienced, you will start the differential diagnosis process even before you begin the case history.

1. Consider the patient's age (gender and ethnicity may also be important) because this can provide useful clues to what problems the patient may have, given the known epidemiology of certain ocular problems (e.g., presbyopia in a 47-year-old patient attending a first eye examination).
2. Observe the patient's stature, walking ability, and overall physical appearance. Pay particular attention to any head tilt or obvious abnormalities of the face, eyelids, and eyes that will require further investigation, such as facial asymmetry, lid lesions, ptosis, epiphora, entropion, ectropion, a red eye, or strabismus.

2.3.8 Recording

Both positive and negative patient responses must be recorded. Remember that from a legal viewpoint, if the response was not recorded the question was not asked. Abbreviations are essential to allow a sufficiently complete case history to be recorded, while retaining intermittent eye contact with the patient, which is required for good communication and building a rapport. Use standard abbreviations (see Table 2.1) and avoid personal ones. Using the patient's own words, recorded in quotation marks, can be useful. Here are some examples:

(a) Relevant to section 2.3.1: 10-year-old boy

RFV: Routine 2-year exam. No glasses/CLs. No problems. DV & NV good. No ha, eyestrain, pain, dip, Fl & Fl or other Sxs.

OH: No probs, never been to HES. LEE: 2 years, Dr. Salah, Liverpool; no issues. No FOH, no ambly, strab, myopia, or col def.

GH. Good, no meds, no allergies. FMH: None, no DM, no HBP. LME: 2/12, Dr. Firmino, Liverpool. Hobbies: Football and Video games.

(b) Relevant to section 2.3.2: 68-year-old Asian female (retired)

RFV: Routine 2-year exam. No probs. DV & NV good c̄ Rx. Bifs, worn all time. No ha, eyestrain, pain, dip, Fl & Fl or other Sxs.

OH: 1st wore bifs age 50, this Rx 2 years old. No other OH. Never worn CLs. LEE: 2 years, Dr. Aguero, Manchester. No FOH, no cat, AMD or glauc.

GH. Type II DM for 15 years, Metformin 500 mg bid, well controlled; high BP for 15 years, Propranolol 100 mg, bid, well controlled, CU every 6/12; high cholesterol last 2 years, "statins" 40 mg od now under control; aspirin od, last 3 years to "thin blood" & "help avoid heart attack," CU every 6/12; non-smoker and no history of falls.

LME: 2/12, Dr. Sterling, Manchester. No allergies, FMH: DM type II in family. Hobbies: Walking, watching TV. No PC use. Doesn't drive.

(c) Relevant to section 2.3.3: 25-year-old Px. Caucasian. Secretary

CC: DV ↓ for driving, c̄ CLs and > c̄ specs, esp. @ night last 2/12, RE blur>LE. Better c̄ squinting. NV c̄ Cls & specs OK. No HA, no dip, no eyestrain, no Fl & Fl, no discomfort. No other Sxs.

OH: Specs ~ 4 years old – not updated LEE 2 years ago. Worn soft CLs last 6 years: 6/7 & ~10/24. Comfortable for ~8/24 then sl. gritty. Monthlies brand X, multi sol'n brand Y. Fitted by Dr Son, London. Last AC 18/12 ago. Overdue a check. No probs c̄ CLs and no other OH. FOH: parents both myopic.

GH: OK, no meds. No allergies. Non-smoker. LME: 12/12, Dr. Kane, London. FMH: pat grandfather has heart disease.

Hobbies: Tennis, climbing. Uses PC ~ 5/24, 6/7.

2.3.9 Most common errors

1. Too much writing and long silences.
2. Asking questions in a random, unorganised manner (as you remember them).
3. Using leading questions. For example, "so you wear your glasses all the time?"; as the patient may assume that you expect the answer suggested and thus respond positively.
4. Not fully investigating the patient's chief complaint. Use LOFTSEA to remind you of what questions are needed.

2.4 The 5 Rs: providing diagnoses and management plan information

Patients expect you to provide information about the cause of their visual problems, the prognoses, and any management plans, all in a clear non-technical language.[1] (See online videos 2.2 to 2.4.) The 5 Rs can be used as a reminder of the five steps involved:

1. **Repeat/Remind:** patients of the symptoms they reported.
2. **Results:** describe your results and diagnosis that explains the symptoms in lay terms.
3. **Recommend:** the best available management plans that will solve the problem
4. **Recall:** indicate when you would like to see the patient again. Link this to the prognosis of the condition.

5. **Record:** your diagnoses and management plans
A sixth R, **Reassure**, can be used when appropriate.

2.4.1 *Remind* patients of their symptoms and link this to your *Results*

1. Indicate the eye examination has finished and you wish to discuss your findings. You may put down your pen and even turn off your chart. Make eye contact with the patient and make sure that the patient is comfortable and attentive.
2. ***Remind*** the patient of the patient's symptoms. Use the patient's own words here; this is why it is useful to record them.
3. Link them with your diagnosis (your ***Results***).
4. Explain what the ametropia or eye disease is in simple lay terms. Give the patient time to digest the information and encourage the patient to ask questions.
5. Use photographs to help your explanation (Fig. 2.1). Most computer-based programs also include diagrams to help you with this explanation.

2.4.2 *Recommend*. Explain the best available management plans

1. Present the various options available, with their advantages and disadvantages, and involve the patient in the decision of the most appropriate management.

Fig. 2.1 Fundus photograph of a high myope. The thin retina could be highlighted: visible choroidal vessels beneath the retina, retinal atrophic area, and peripapillary atrophy at the disc. This could lead to a discussion of the actions to be taken should the patient suffer symptoms of retinal detachment and the need to avoid activities such as boxing or bungee jumping.

2. Demonstrate any refractive correction changes to the patient. Computerised phoropters can swiftly move from the patient's habitual correction to the new prescription. A simple approach is to show the change in distance and/or near visual acuity with appropriate spherical trial case lenses over the top of their current glasses, given that cylindrical changes from one examination to the next tend to be minor.
3. Explain when the patient should wear glasses. Do not assume that the patient will understand when to wear them. For example, if a patient's CC was distance blur when driving, it may not be enough to indicate that he or she should wear the glasses for driving and assume that the patient understands that the glasses can be worn for any other distance vision task. Indicate that the glasses could be used for TV, cinema, and theatre, watching sports, and when walking about outside if the patient wants to wear them for those tasks. In this regard, it is very important to inform patients who drives without glasses whether they are legally allowed to do so.[23]
4. If appropriate explain that progression is expected and why. For example, young myopes can be informed that because a short-sighted eye is a big eye, the myopia will tend to increase as the eye grows with age. Similarly, it can be useful to explain to hyperopes and presbyopes that a gradual reduction in unaided vision is expected with age owing to the gradual loss of their focusing ability caused by the hardening of the eye lens owing to its continual growth. These explanations can be supported by simple explanations of long and short sightedness using cross sectional diagrams (Fig. 2.2).
5. Discuss possible adaptation problems (section 4.15). If making a relatively large change in refractive correction, particularly with older patients, warn them of possible adaptation problems. This is most important when making any cylinder changes, particularly with oblique cylinders. Take note of a patient's previous reaction to refractive correction change. It is better to overestimate rather than underestimate the time that adaptation will take.
6. Occupation, sports, and hobbies: Most clinicians tailor lens information to match the patient's requirements, based on the patient's occupation and hobbies.[3] Contact lens wearers are advised not to wear their lenses for swimming and to wear prescription swimming goggles, or to wear a single use lens with standard swimming goggles, and dispose of the lens immediately after swimming.[24] Ametropes who play contact sports benefit from using contact lenses as they usually do not wear their glasses while playing, although some football/soccer players do wear glasses and should be informed of protective eyewear.[25] Contact lenses will also have benefits for many other sports and leisure activities in that they can provide a wider field of view and they are

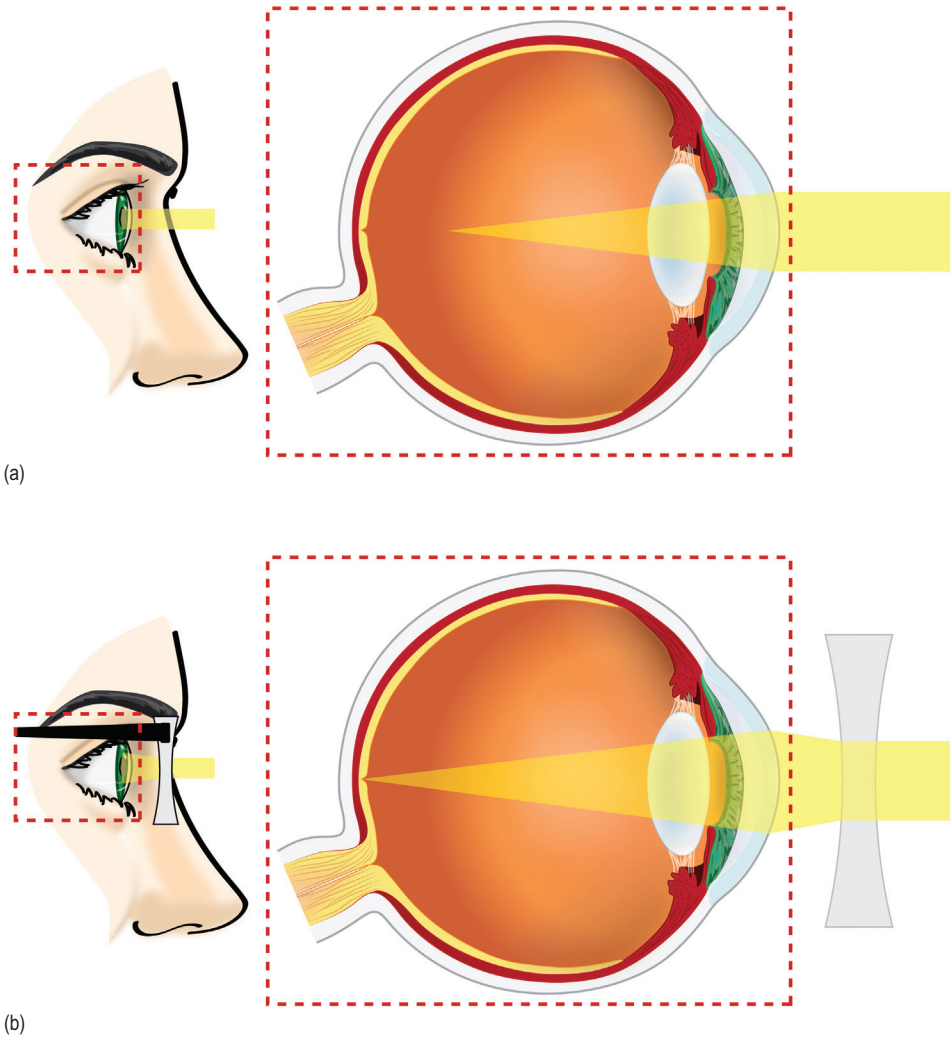

Fig. 2.2 Cross-sectional diagram showing light focusing in front of the retina in a 'large' myopic eye **(A)** and being focused onto the retina with concave lenses **(B)**. (Courtesy of Samantha Strong.)

not affected by fogging up or rain, for example. At the same time, contact lenses provide no eye protection, which can be important for sports that involve a high speed ball/puck and a stick, such as cricket, baseball, hockey (ice and field), lacrosse, and squash. [25] Finally, safety glasses may be needed for do-it-yourself (DIY) enthusiasts and keen gardeners and fishing is made easier and more comfortable with polarised sunglasses.

7. Patients increasingly obtain their health information from the internet,[26] but complementary therapies and treatments with a poor evidence base are often presented more positively than established, evidence-based treatments[26,27] so that it can be very useful to direct your patients to websites that you trust and that provide jargon-free clearly presented material.[28] The number of optometrists recommending websites to their patients appears low and well behind other medical professions[29] and this should be improved because there are very good websites that we can refer patients to, including patient-facing websites developed

by international optometry professional bodies.[30] These include:

(a) (UK) https://lookafteryoureyes.org
(b) (USA) https://www.allaboutvision.com
(c) (Australia) http://www.optometry.org.au/your-eyes.aspx
(d) The UK's National Health Service also provides a patient-friendly website (https://www.nhs.uk/conditions/) for a wide range of conditions with translations into 90 languages; the major support group agencies for eye conditions such as macular degeneration all have dedicated websites.

8. Instructions regarding contact lens care and maintenance and ocular disease management should be clear and unambiguous, with appropriate emphasis placed on the importance of procedures from a safety viewpoint.[17] Written instructions at an easy reading level (age ~8–12 years) are essential. Checking compliance, explaining the benefits of compliant behaviours, and repeating the instructions at follow-up visits can improve matters.

2.4.3 *Reassure* when appropriate

1. If the cause of the CC or other problem is not determined, then present your negative findings in a positive manner.[31] For example, nonocular headaches: "I do not believe that your headaches are caused by a problem with your eyes or vision, Mr. Aubameyang. Your eyesight is excellent and there is no need for glasses/change in glasses; your eye muscles and focusing muscles are all working normally and are working well together and there is no sign of eye disease from any of the tests that I have performed".
2. If the condition can be diagnosed, but no treatment is necessary, in addition to providing diagnosis and prognosis information in lay terms, reassure patients that they were correct in attending for examination.[31] An example would be pingueculae.
3. If a patient's attendance for an eye examination was because of increased risk of a certain condition, but you found no problems, reassure the patient that you have performed the necessary tests and confirm the reasons that the patient should regularly attend for examination. An example would be a patient with a family history of glaucoma that showed normal values for all assessments. In such a case, it can be useful to display the fundus photograph and visual field plots on your computer screen and explain what you found at and around the optic nerve head (Fig. 2.3) and what the field plot shows.
4. Reassuring patients with visual impairment and Charles Bonnet syndrome that the condition is benign and is a common response after vision loss and is not related to dementia or other mental health problems relieves concern among patients and their families.[10] Patients should be informed that, although visual hallucinations may persist for years in some cases, they usually resolve spontaneously. Provision of a leaflet or link to an appropriate website can be useful.

Fig. 2.3 This photograph of a British African-Caribbean fundus could be used to describe the healthy neural retinal rim on the disc and visible and healthy nerve fibre layers.

2.4.4 *Recall*

1. Finally, indicate to the patient when you would like to see him or her again. This should be linked to the likely prognosis of the patient's condition(s).
2. Always inform patients that if they have any problems with their vision or their eyes before that time, they should make an appointment to see you.

2.4.5 *Record* diagnoses and management plans

It is important legally to document all your diagnoses and management plans. Similarly, it provides valuable support when dealing with patients who return with complaints that you did not provide advice regarding the management of a certain condition.

1. List each separate diagnosis in a column. Do not list the individual symptoms and signs that allowed the diagnosis. Order diagnoses with the most important first.
2. For each diagnosis, outline a plan or a series of actions to be taken in an adjoining column. This should include any advice given and supporting information provided via website links or leaflets given.

not attempt to avoid difficult questions or even 'sugar the pill.'[32] Indicate that their central, detailed vision that allows them to drive, read, and see faces is likely to get worse. Blunt statements such as "I am afraid that there is nothing more that we can do" are not helpful. This may be correct for conventional treatment with glasses, but low vision aids may be helpful for a variety of tasks. Household modifications can be made (section 3.3.7) and smoking cessation can slow progression.[21,34]

6. Empathic statements such as "I know this is not what you wanted to hear. I wish the news were better" can be helpful.[33]
7. You need to be aware of the possible emotional responses to such news. Various models have been proposed, and a common model suggests stages of denial, anger, bargaining, depression, and acceptance. These stages are not universal and some patients skip stages whereas others get 'stuck' at a particular stage. In the denial stage, patients will often seek a second opinion. You should not see this as a slight on your ability as a clinician and you may even suggest it to patients who are openly in denial when you first tell them the news.
8. Explain the prevalence of the condition. This indicates that they are not alone. It can be very useful at this point to discuss support groups and local agencies. Support groups enable patients to meet other individuals suffering from a similar problem. They can discuss their experiences with each other, provide reassurance, and offer tips that have helped them cope.
9. Discuss the availability of low vision aids and what help they could provide. In this respect, remember the stages of response to vision loss. Patients are unlikely to have the motivation to use low vision aids successfully when depressed. Do not give up on these patients. As (and when) they overcome the depression and accept their vision loss, low vision aids may usefully be provided.[34]
10. Information leaflets and/or websites are particularly useful in these situations because the patient's shock at the initial news may mean that much of the remainder of your discussion is forgotten. Make sure the leaflets and websites include links to support groups.

2.6 What should a good referral letter include?

Letters of referral to medical personnel or specialist clinicians are required to provide information regarding the reason and urgency of referral. Reports may be required to a referring colleague, teacher, general physician, and so forth. The categories of patients who require a report may be covered by legal or contractual obligations.

2.6.1 Comparison of letter types

Structured referral forms have a standardised format and various boxes to complete. These can save time and, if well designed, may reduce the possibility of the omission of pertinent information. However, non-specific optometry referral forms can lead to the inclusion of irrelevant information and a lack of required details.[35] Referral forms specifically designed for commonly referred conditions, such as cataract, glaucoma, and macular disease, particularly when supported by referral guidelines for such conditions, are likely to improve referral quality,[35] and these can be easily provided within an electronic referral system.[36] Well-written referral letters are important to help develop a good relationship with secondary eye care personnel and increase the likelihood of feedback being obtained regarding referrals. The latter is essential to improve referral quality, especially for newly qualified optometrists.[37]

2.6.2 Procedure for producing a personalised referral letter

Because completing a structured referral sheet is somewhat self-explanatory, the procedure for producing an effective personalised referral letter is described.

1. Indicate to the patient that you will be sending a referral letter/report to another person or office. You should inform the patient of the reason for the referral or report.
2. Write the letter on headed notepaper that includes your practice address and contact information. The letter should ideally not be hand written, as this will make it less legible.
3. Include the date and the recipient's name and address at the top of the letter.
4. Begin the letter with the patient's name, address, date of birth (you may need to distinguish between several people with the same name and even between two people with the same name and address), appointment date, and file number (if applicable).
5. Remember that the person you are writing to is likely to be very busy and want to read only essential information.
6. A likely outline of a referral letter would be:
   - **(a)** Provide a diagnosis or tentative diagnosis if possible.
   - **(b)** Indicate the relevant symptoms (these are symptoms connected to the referral diagnosis, not those connected to any uncorrected ametropia or dry eye, for example).
   - **(c)** Include any relevant signs and provide an image if available.
   - **(d)** Indicate if there is any urgency in the referral.
   - **(e)** If appropriate, you might indicate what further investigations or treatment you believe to be necessary.