

thalmologists in diagnostic techniques will help achieve better control of sight-threatening diseases.

3 **Equipment.** All the necessary equipment must be in place and properly maintained. This is vital to the performance of the medical system and contributes significantly to better results. Eye-care equipment of acceptable standards is now available at reasonable prices, and this must be accompanied by appropriate maintenance systems.

4. **Use of Proper Instruments.** Good quality instruments are now available at lower costs. With the development of proper inventory control systems for a given operation, the costs can be lowered.

5. **Use of Appropriate Medications.** Access to low cost medicines is an absolute necessity for appropriate care.

6. **Use of Newer Technologies.** It is important to continually employ newer technologies that improve the quality

of care. Of course, this must be done with reference to cost-efficiencies.

Improvement of patient care is a dynamic process and should be uppermost in the minds of medical care personnel. Development and sustenance of a patient-sensitive system is most critical to achieving this objective. It is important to pay attention to quality in every aspect of patient care, both medical and non-medical.

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Review Article

The Patients View: How Can We Improve Patient Care?

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Introduction

The number of blind people in the world has reached over 50 million. For Vision 2020: The Right to Sight to succeed, there must be a significant increase in those receiving health education and also patients coming for surgery.

In his booklet, 'Breaking Down Barriers', Gert Vaneeste¹ outlines the barriers that patients can face when required to go to hospital and also practical ideas on how to overcome these barriers.

- But how do the patient and the community perceive the care that is offered to them?
- Do they want to receive the care that we feel they should receive?
- Is the care itself a barrier?
- Should we accept that some patients just want to remain as they are without our help?



Pre-operative eye clinic in Sudan

Photo: Ingrid Cox

An Example: Joseph Mwangi

"My backache is getting worse, my eyesight is not good, I find it difficult to help with the digging in the family vegetable plot, I can just about get to the toilet and back with a bit of assistance from my grandchild.

However I am lucky, my family is looking after me; they give me somewhere to sleep, a hot meal every day and in exchange I try to look after their young children by telling them stories. I never went to school so reading is not an issue. I feel secure and safe with my family around me.

The village 'doctor' is also my friend. He comes and sees me from time to time with his lotions and potions but they do not do much for me now, although I still live in hope and believe what he says.

After all, at least I am better off than my other friend who was blind and went to the hospital and returned blind and is now in pain. Noone can help him. Even the 'doctor' cannot stop his pain.

I am getting old. We have always known that we are going to get old, weak and blind and now I just enjoy each day as it comes. My parents worked hard to look after me. I did the same for my children. Now I just want to be left in peace, be cared for and relax in this quiet time I now have left."

This is the view of many of our patients who may have low vision or are blind . . .

The Ophthalmic Field Worker

The enthusiastic ophthalmic field worker who wishes to make an impact on the community and reduce the amount of avoidable blindness, may see Joseph Mwangi as a



A person with unilateral cataract in Cambodia

Photo: Ingrid Cox

blind cataract patient, not as an individual with rights and opinions. She can help to improve the quality of his remaining life by offering to him a 'quick' 30 minute operation which will restore his sight. Or perhaps her contribution is improving the sanitation in his village and reducing the amount of trachoma; then taking a few patients with end stage glaucoma for a second opinion to the large hospital a day's journey away, even though she knows not much can be done about their condition.

Our field worker is a carer who has been trained and wants to show that skills and knowledge can improve the lives of those in the community. However, often as field /health workers we impose our values, training and knowledge on our patients and forget that there may be some very good reasons why they do not want to come to the hospital. We find this difficult to accept.

The Blind Patient and Hospital

It is forgotten that for a blind patient to come to hospital is very difficult. Travelling to an unknown city, perhaps never even visited when sighted, is a terrifying experience and more daunting now that he or she is blind. The fears of the city, where to stay, what is going to happen



After eye surgery in Sudan

Photo: Ingrid Cox

when left alone in this hospital, possibly far outweigh the perceived advantages of restored sight.

The patient has heard that the operation is painful and that you have to suffer with the pain before you get better. They 'take out your eye and put it back in again', but some people never get their eyesight back. Why is that? Am I one of those patients? No one will be able to talk to me as I come from a different tribal region. How am I going to pay for food; where do I sleep or how can I go to the toilet if my grandchild is not there to take me. Will I get home?

Stories, Questions and Comments

Stories travel well in small communities, and are believed more than those of the health worker who proudly brings a person from another village after he had had his sight restored in the big city.

- For many patients the fear of the unknown cannot be overcome. It has been said that for every unsuccessful operation, five good operations have to be done to counter the effect in the community.

- How do you explain Joseph Mwangi's neighbour's trabeculectomy operation compared to Joseph's 'quick' cataract operation?
- It is often held as a guiding light that money is an obstacle to surgery. We know of patients who have walked for days in Southern Sudan to receive treatment at a free eye camp and are incredibly grateful for any care that they can get. But we also know of the patient who is blind and lives right behind the hospital and still does not come for treatment, whether free or not.
- Recently in Tanzania, a well-meaning citizen gave a blind patient money to come to the city for cataract surgery. The patient did indeed come to the city but spent the money on alcohol, returning to his home some weeks later, happy but still blind!

Our expectations and priorities may not be the same as our patients.

Even if Joseph Mwangi did come for surgery and then went home with his sight restored there are still decisions that he would have to make.

Will he put in his eye drops and return for his follow-up appointment? He can see and that is what was promised. What is the need to go through all that travelling, cost and upsetting the family routine again? Regarding spectacles, he cannot read anyway, and he reckons that at his age he is not going to start to learn.

Summary

The patient's view of eye care can be very different to the health worker's view. Neither view is right or wrong. We must recognise and be sensitive to traditional beliefs within communities in which we work and for which we have a genuine concern and sense of responsibility. As health workers we must try and accept that we are to offer the best care to all but also understand that there are sometimes situations when what we have been taught is neither acceptable nor wanted by Joseph Mwangi and others like him. As standards of eye care improve and the past misconceptions of poor eye care diminish, so too will the sharing of unhelpful beliefs and even untruths. This is what we should be working towards – improving and maintaining standards of eye care, and patient care, communicating clearly and effectively with those who look to us for help.

Reference

- 1 Vaneeste G. *Breaking Down Barriers*. Christoffel Blindenmission, 2001.



After eye surgery in Sudan

Photo: Ingrid Cox

Courses available at Pakistan Institute of Community Ophthalmology : 2002

MSc in Community Ophthalmology	One year
Ophthalmic Technicians' Course	One year
District Refractionist Course	One year
Ophthalmic Nursing Course	One year
Diploma in Clinical Ophthalmology	One year
Fellowship in Clinical Ophthalmology	Four years
Short Courses (Planning Eye Care; Management; Communication Skills)	One/two-weeks

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