

LEARNING TO COPE WITH SIGHT LOSS

Six Weeks at a VA Blind Rehabilitation Center

William L. McGee
with Sandra McGee

Introduction

On the morning of August 13, 2003, my wife, Sandra, arrived home to find me sitting at my desk, staring off into space. “Sandra,” I said, “I have some bad news. I can’t see.”

That morning I had suffered a hemorrhage in my left eye—my last good eye as I called it—that would render me legally blind. Diagnosed with Age-Related Macular Degeneration (the loss of central focus vision), from that day on I would never drive again, never recognize faces again, never apply toothpaste directly to my toothbrush again, and on and on for a laundry list of other ordinary acts that I once took for granted. So, as I was closing in on my ninth decade, did I hear the worst news of my life: “Bill, you are legally blind.”

Then, in 2008, while attending a support group for men with vision loss at the LightHouse for the Blind, I learned about the powerful work being done at the VA Regional Blind Rehabilitation Centers located throughout the United States. As a World War II veteran, I was eligible even though my disability was not service connected. I could join a band of blinded brothers and sisters for six weeks of live-in training at a Blind Rehab Center near me. Together we would learn about low vision aids and techniques for coping with our sight loss.

Consider this: According to the Department of Veterans Affairs, 16.5 million Americans age 45 or older must adjust to vision loss challenges on their own. However, military veterans who have become visually impaired—whether service-connected or not—can get help with basic living skills at VA live-in programs located around the country. Having the opportunity to share experiences with other veterans is very important. Through participation in the VA program, most veterans feel their confidence, self-esteem, and attitudes toward their visual impairment improve as they regain independence, feel more in control of their lives, and more motivated to be active at home.

Sight loss can be a very stressful event in anyone’s life. I wrote this booklet—with considerable help from my beautiful wife and co-author, Sandra—to inform the thousands of legally blind or low vision veterans about the VA Blind Rehabilitation Centers. I hope my story will be helpful not only to fellow veterans, but to non-veterans alike, as well as their families and caregivers, in learning to cope with sight loss.

—William L. McGee

Copyright © 2010
by William L. McGee

All rights reserved.

Learning to Cope with Sight Loss: Six Weeks at a VA Blind Rehabilitation Center/
by William L. McGee with Sandra McGee
ISBN 978-0-9701678-2-8 (Booklet edition)

Library of Congress Control Number: 2009939502

1. McGee, William L.
2. Learning to Cope with Sight Loss
3. Retinal degeneration
4. Blindness
5. Vision loss
6. Veterans, U.S.A.

Available in three formats:

- Downloadable PDF document at no charge from www.BMCPublications.com
- Booklet: 36 pp, 4-color, 35 photographs, 8.5" x 11", ISBN 978-0-9701678-2-8, U.S. \$9.95
- Audio CD: ISBN 978-0-9701678-3-5, U.S. \$9.95

For more information, contact BMC Publications:

email: bmcpublications@aol.com
phone: 415-435-1883
web: www.BMCPublications.com

Printed in the United States of America
First Printing

Published by
BMC Publications
An imprint of BMC Communications
PO Box 1012, Tiburon, CA 94920
415-435-1883
bmcpublications@aol.com
www.BMCPublications.com

Contents

My Vision Loss History

VA Western Blind Rehabilitation Center

- Admission Requirements
- First Day
- Accommodations
- Food Service
- Nursing Staff

The Program

- Overview
- Visual Skills
- Orientation and Mobility
- Living Skills
- Manual Skills
- Computer Access Program
- The Stroke at Midnight
- Recreation Therapy
- Adjustment to Sight Loss
- Family Training
- Graduation
- Conclusion

Appendix

- Sight Loss Stories in the News
- VA Blind Rehabilitation Centers
- Resources for Blinded and Low Vision Non-Veterans and Veterans
- About the Authors
- Other Books from BMC Publications

“Best-written description of the VA’s Blind Rehabilitation Program that I’ve seen and an invaluable tool for those veterans considering participation in one of the Regional Centers.”

—Patrick J. Caskey, MD
North Bay Vitreoretinal Consultants

My Vision Loss History

In the mid-1990s while living in Santa Barbara, California, I had successful cataract surgery on both eyes which restored my vision to 20/20 without glasses. One morning in 1997, at age 72, I woke up with slightly blurred vision in my right eye and went immediately to my cataract surgeon thinking the small lens implant had moved only to have him tell me, “Bill, I’m sorry, but it’s not the implanted lens. You have a more serious eye problem and I want you to see Dr. Marc Lowe, a retinal specialist.” Dr. Lowe informed me that I had the wet form of Age-Related Macular Degeneration (AMD), a medical term I had never heard of. AMD, I learned, is a disease that blurs the sharp, central vision you need for “straight-ahead” activities such as reading, sewing, driving and seeing fine detail.

Dr. Lowe examined my eyes every six weeks and took fluorescein angiograms of the right eye to check for hemorrhaging.¹ The hemorrhaging continued on-and-off until finally Dr. Lowe performed laser surgery to stem the hemorrhaging. The downside from laser surgery was that I would be permanently blind in the central focus area of my right eye. Legally I could still drive, but I voluntarily stopped night driving when I believed it was no longer safe.

Sandra and I decided to get another opinion at the Jules Stein Eye Institute on the UCLA campus in Los Angeles. We met with Dr. Steven D. Schwartz, one of the foremost experts in the field of Diseases of the Retina and Vitreous. Dr. Schwartz confirmed the earlier diagnosis of wet AMD in the right eye and warned that the left eye was showing early signs of dry AMD. His prognosis: a 50-50 chance that I would end up with macular degeneration in both eyes. Dr. Schwartz referred me to Dr. Robert L. Avery, a renowned ophthalmologist and retinal specialist in Santa Barbara.

On August 13, 2003, Dr. Schwartz’s prognosis for the left eye came true. I woke up with very little vision in either eye. We went immediately to Dr. Avery’s office only to have one of his associates tell me, “Bill, I’m sorry, but you have hemorrhaged in your left eye and you are now legally blind.” It was a shock and a diagnosis I could not fully grasp, nor accept. What would I do if I couldn’t drive or read?

Sandra and I work together as writers and owners of a small publishing company. In August 2003, we were finishing the manuscript for *The Divorce Seekers*, a memoir of my cowboying days in Nevada. We tried to keep going, “business as usual,” as we had book signings, interviews and other promotional events lined up during the book’s release in spring 2004. However, the old ways of working together were not working. Two examples: I could no longer drive which meant more of Sandra’s time was taken up with errands and driving; I could no longer read unless it was with some form of image magnification making my share of the workload slow, tedious, and very frustrating.

¹ Fluorescein angiography is a diagnostic procedure which uses a special camera to take a series of photographs of the retina, the light sensitive tissue in the back of the eye. A water-soluble dye (fluorescein) is injected into a vein in the arm and travels through the veins and into the arteries which circulate throughout the body. As the dye passes through the blood vessels of the retina, a special camera flashes a blue light into the eye and takes multiple photographs of the retina. (Source: American Academy of Ophthalmology.)

Optical Coherence Tomography (OCT) is a non-invasive laser scanning technique that is often complementary to fluorescein angiography. OCT imaging is ideally suited for ophthalmology because it uses light and can be performed without physical contact to the eye, thereby minimizing patient discomfort during examination. OCT imaging can also achieve finer resolutions. (Source: *Optical Coherence Tomography of Ocular Diseases, Second Edition*.)

Seeking any sort of help or solutions to my dilemma, Dr. Avery presented photodynamic therapy (PDT) as something to consider.² PDT infrequently results in improved vision, but certain eyes treated with PDT lose less vision than eyes that do not have this treatment. I decided to try one PDT treatment which, at the time of my treatment, was not covered by Medicare nor my private supplemental insurer. The treatment cost \$2,000 out-of-pocket and was not successful in my case.

Another option, presented by the Braille Institute in Santa Barbara, was a desktop closed circuit television magnifier (CCTV). As it was the only way I could finish writing the new book, I purchased a CCTV which cost \$2,600 out-of-pocket and was not covered by Medicare nor my private supplemental insurance even though it was a health-related aid. At this point, I knew nothing about the VA Blind Rehabilitation Centers. (The last VA hospital I had been admitted to was in Reno, Nevada in 1947.) It would be five long years before I would learn about the VA Blind Centers.

Then I got the idea that if we moved to a smaller town where I could get around on foot and be more independent our lives might be easier. Sandra understood and graciously agreed to leave Santa Barbara where she had many friends and was entrenched in the ballet and music worlds. On January 31, 2004, we moved to the small town of Tiburon on the north shore of San Francisco Bay. Moving—lock, stock and barrel—while producing and marketing a new book, created enormous stress. Sandra and I accomplished what we needed to business-wise, but my patience and mental outlook were at wit's ends, and Sandra's health took a downward dip.

My new retinal specialist was now Dr. Patrick J. Caskey in Santa Rosa, an hour's drive north of Tiburon. Highly regarded in his field, Dr. Caskey possesses a caring manner and takes the time to listen, answer questions, and discuss the pros and cons of news clippings on AMD research. As new drugs were approved by the FDA, I got injections of Macugen in my left eye, followed by Avastin, and now Lucentis. The hoped for outcome of these injections was the preservation of my peripheral vision, as no one predicts a complete cure from these particular drugs.

As of this writing, I'm pleased to report that the frequency of these injections has decreased from every six weeks to about every three months. With the help of the CCTV, I can slowly read and write. My peripheral vision allows me to walk two or three miles a day, although I have lost some balance and must use a cane for support. Sandra and I have figured out new ways of working and living together. Finally, thanks to the VA's Blind Rehabilitation Center, I have acquired valuable new skills and greater independence in coping with blindness.

Legal blindness or low vision. The generally accepted definition of legal blindness is central visual acuity of 20/200 or less in the better eye with the use of corrective glasses. The definition of low vision used to generate estimates of veterans with low vision is central visual acuity equal to or less than 20/70 but greater than 20/200 in the better seeing eye with the use of corrective glasses. (Source: *Coordinated Services for Blinded Veterans*, Department of Veterans Affairs.)

² Photodynamic therapy (PDT) is a treatment that is helpful for some eyes with choroidal neovascularization (CNV) under the macular. PDT is a two-part process. First, a drug is injected into a vein in the arm and travels through the body and localizes in the CNV. Then a low energy laser is directed toward the CNV through a contact lens placed in front of the eye. The light activates the drug contained within the CNV resulting in closure of the abnormal blood vessels. Unfortunately, PDT usually does not permanently close the abnormal vessels.

VA Western Blind Rehabilitation Center

Admission Requirements

To participate, veterans must be legally blind which is defined as a central visual acuity of 20/200 or less in the better eye after correction (meaning they can see at 20 feet what someone with normal vision can see at 200 feet) or a visual field of 20 degrees or less in the better eye after correction.³ Legally blind people cannot drive, but chances are they can discern shadows and shapes, and can be taught to navigate around them. The key to adjusting is learning to trust the other senses, especially touch. The Center's Manual Skills program is specifically designed to help veterans maximize their sense of touch. (More on Manual Skills later.)

There are currently ten Regional VA Blind Rehabilitation Centers in the United States. The nearest location to me was the Western Blind Rehabilitation Center (WBRC) in Palo Alto, California. (See the Appendix for a list of VA Blind Rehabilitation Centers including the additional three being built and expected to become operational around 2011/2012, or visit www.va.gov/blindrehab.)

Application to the WBRC is made through the Visual Impairment Services Team (VIST), a component of the Veterans Health Administration's Blind Rehabilitation Service. VIST began shortly after World War II to provide services to war-injured legally blind veterans. There are currently 91 VIST programs throughout the VHA located at VA Medical Centers across the country.⁴

The San Francisco VIST Program is an outpatient service designed to identify legally blind veterans and provide them with comprehensive blind rehabilitation services. My first contact was with San Francisco VIST Assistant, Palma Sciuto. We completed and returned a Form 10-10EZ questionnaire. Several months later, I was scheduled for two days of appointments at the VA Medical Center in San Francisco. The first day, I received a complete physical examination from head-to-toe, moving from one department to the next with little or no waiting time to see the doctor or medical technician. The second day was devoted to a mental evaluation and to hear what my needs and expectations were from the WBRC program. We then met with Belinda-Bruce Hawkins, WBRC Regional Consultant. When she learned that Sandra and I were writers and publishers, she asked if the WBRC program would be work-related. I responded in the affirmative stating, "In fact, we plan to co-author an article on my experience in hopes it will reach many blind veterans."

First Day

On March 11, 2009, Sandra and I arrived at the WBRC at 3:30 p.m. The two-story building is situated on the edge of the sprawling VA Palo Alto Health Care System (VAPAHCS). The WBRC can accommodate 32 live-in veteran "students" (as we are called) with a constant turnover of one to six students "graduating" each week.

³ This legally blind requirement has been revised so that now a veteran or active duty service member is eligible for blind or vision rehabilitation services if s/he has "excess disability" or functional deficits related to vision loss, whether or not s/he is legally blind. Often people with less severe vision loss are seen at one of the 55 new low vision clinics, but if their needs are complex or extensive enough, they can be referred to a VA Blind Rehabilitation Center before they become legally blind. For more details, visit www.va.gov/blindrehab and look for the Continuum of Care link.

⁴ For the VIST location nearest you, visit www.va.gov/blindrehab.

I checked in at the nurses' station while Sandra and a nurse retrieved my bags from the car. A nurse gave us a tour of the ground floor, then led us to my living quarters for the next six weeks. Sandra left for home shortly after that.

The call for dinner came at 5:45 p.m. Most of my fellow veterans seemed to be of World War II-vintage. I was assigned to Table Four. One of my tablemates, Bill Light, the "student body president," asked me to introduce myself. I did and received a warm response. Following dinner, the tables were cleared for what was described as "sociable blackjack," but I opted to go to my room to unpack before lights out.

Accommodations

Each veteran has his or her own room and shares an adjoining bathroom. The rooms are furnished with a bed, desk, three chairs, and a four-drawer bureau. The bathrooms are fairly large with a stall shower, sink, and toilet as well as several well-positioned grab bars.

The dining room has six tables of six. The lounge area is an extension of the dining room with an accordion-like folding wall to separate the two areas when needed. The lounge has a large, flat screen TV with three rows of comfortable chairs as well as the all-important coffee bar. There is also a selection of videocassettes with movies scheduled one or two nights per week. The recreation room is at the far end of one of the corridors and has a pool table, stationary bike, treadmill, stair stepper, another flat screen TV, two CCTVs, and two desktop computers—all available on a first-come, first-served basis.

Food Service

Meals are provided by the main hospital kitchen and delivered to the WBRC on trays. Each tray is identified with the veteran's name and type of meal (regular, special diet, allergies, etc.). Breakfasts are pretty typical, ranging from juices and cereals to hot meals like scrambled eggs and bacon, French toast, or hot cakes. I won't detail the lunches or dinners, but they are very good. You can change your diet by meeting with the nutritionist who comes around weekly at mealtime.

Nursing Staff

The nurses' station consists of three small adjacent offices and is usually a very busy place. After a thorough question-and-answer session with Nancy Beach, one of the senior nurses, I was monitored weekly for temperature, pulse, and weight changes. A night nurse made the rounds between one and three in the morning. She would quietly open our doors and use a flashlight to make sure we were in our beds (and still breathing). A week or so later, I had another thorough interview with Registered Nurse Practitioner, Beverly Yee.

Facts About the Department of Veterans Affairs. In March 1989, the Veterans Administration was succeeded by the Department of Veterans Affairs. Perhaps the most visible of all VA benefits and services is health care. From 54 hospitals in 1930, the VA's health care system now includes 153 medical centers, with at least one in each state. VA operates more than 1,400 sites of care, including 909 ambulatory care and community-based outpatient clinics, 135 nursing homes, 47 residential rehabilitation treatment programs, 232 Veterans Centers and 108 comprehensive home-care programs. VA health care facilities provide a broad spectrum of medical, surgical and rehabilitative care. Special VA "centers of excellence" conduct leading-edge research in areas of prime importance to veterans, such as neurotrauma, prosthetics, spinal cord injury, hearing and vision loss. (Source: Facts About the Department of Veterans Affairs.)

The Program

Note: The following **boldface text**, excerpted with permission from the VA Palo Alto Health Care System booklet, *Western Blind Rehabilitation Center*, describes the various components of the treatment program. The author's personal account of his day-to-day experiences follows in two-column format.

Overview

While gaining information and skills needed to manage the effects of sight loss, veterans usually are able to form positive plans for the lives they will lead after they complete the program. Whenever possible, this planning involves family members. The focus of treatment is to enable veterans to understand and cope with sight loss and to provide rehabilitation to help them achieve the highest level of independence possible.

Each patient receives an individualized treatment program. The length of the average treatment program is six weeks. A full daily schedule of vision loss rehabilitation therapy is available Monday through Friday. Treatment areas include Visual Skills, Orientation and Mobility, Living Skills, Manual Skills, and Computer Access. Other services include psychological counseling, veterans' benefits counseling, social work services, recreation therapy, and interdisciplinary clinical consultations.

Visual Skills

Approximately 85% of the blind population has some useable vision. In Visual Skills, an optometrist and other staff evaluate useable vision. The optometrist examines the veteran and prescribes appropriate training and optical aids based on the veteran's goals. The veteran's identified needs may include: use of a handheld magnifier for reading labels and price tags; a closed circuit TV for prolonged reading; use of a monocular telescope for distance tasks such as reading street and store signs; and use of a spectacle mounted telescope for watching TV. The visual skills staff trains the veteran in the proper use of these special optical aids to make optimum use of any remaining vision.

The majority of my first day at the WBRC was spent in the Visual Skills and Optometry departments. From 8:15 a.m. to lunchtime, Dr. Ellen Chang, O.D., evaluated my vision loss in each eye. She used a variety of charts and graphs of all shapes and sizes, and with varying degrees of clarity—by far the most exhaustive eye examination I have experienced. Because I lost vision in my right eye in 1997 and then my left eye in 2003, she checked each eye separately. After Dr. Chang determined my useable vision in each eye, we tried a variety of optical aids ranging from handheld magnifiers to desktop CCTVs. I was very impressed with the entire Visual Skills Department staff, especially their patience and problem-solving approach.

At 3:15 p.m., Andrew Dadd knocked on my door for a get-acquainted meeting. Andrew would be my WBRC Coordinator and Visual Skills instructor for the next six weeks. He was one of the more senior instructors and recently transferred from Manual Skills where he had served for more than a decade.

It should be noted that the WBRC offers one-on-one training and most instructors have a Master's or Doctor's degree, many of them graduating from the same school, such as Michigan State, Cal State Los Angeles and Cal State San Francisco.

After spending some time getting acquainted, Andrew asked me to summarize my objectives for attending the WBRC. My answer: To learn everything I can in all areas of instruction with an emphasis on the Computer Access Program that I will use in my writing and publishing business. I explained to Andrew that I acquired my first computer in 1987 for my consulting company and understood the fundamentals, but wanted to be brought up to date on the latest software and technology, especially what was available for legally blind people.

Andrew gave me a large print ring binder filled with important information such as staff names, room numbers, phone extensions, and the main hospital number. He also gave me an audiocassette version.

My 40-minute Visual Skills sessions with Andrew took place Monday through Friday. After six weeks, I had received a total of 20 hours of individual Visual Skills training. Between my time in the Optometry Department with Dr. Chang and my Visual Skills sessions with Andrew, my goals as well as my limitations became crystal clear.

A partial list of optical aids considered for my low vision included several handheld magnifiers for reading labels and the contents of packaged goods, and three models of CCTV magnifiers. We settled on a pocket-size, electronic video magnifier and a Merlin CCTV with a 22" digital LCD Monitor. Another optical

aid was a monocular telescope, a small handheld device which helped in reading street and store signs. (More on this in Orientation & Mobility.) To my surprise, two weeks after my examination by Dr. Chang, I received a pair of reading glasses from her. After studying my low vision test results, she created a prescription just for me. While they don't help me read regular-size print, they do give me a very slight improvement in my reading ability with my CCTV—a genuine value considering I spend several hours a day reading archival material and/or copyediting manuscripts.

At the two-week mark, Andrew led a one-hour meeting with all of my instructors and Nancy Beach to discuss my progress. (My dining room tablemates jokingly referred to these meetings as "parole hearings.") I had expressed from the beginning that my focus in coming to the WBRC was for the Computer Training Program. This program was usually separate from the regular rehabilitation program and required different admission and application criteria. However, I was asked to attend all of the programs for the first two weeks and then an evaluation would be made as to my schedule for the remaining four weeks. Everyone at Andrew's meeting seemed satisfied with my progress and agreed that I was ready for a "dual-track" program, meaning that instruction time for Manual and Living Skills would be reduced in order to include the Computer Training Program.

"I live alone. I didn't know about the magnification devices before I came here, so you can imagine what a big difference the closed circuit TV for paying bills and writing notes will make in my life...also a device like the handheld magnifier for reading labels in the grocery store."

*—Joseph LoBue, Seal Beach, Calif., U.S. 20th Air Force, 1943-1945.
Vision problem: Macular Degeneration.*

Orientation and Mobility

The Orientation and Mobility (O&M) therapeutic program enables veterans who are blind or who have low vision to regain independent travel confidence and safety in all appropriate environments. Each veteran works one-to-one with an O&M therapist. The program is individually tailored based on personal travel goals stated by the veteran and results of a functional assessment.

Low vision veterans participate in a program that includes remedies for sensitivity to glare, efficient use of optical devices in the community, custom tailored long cane skills, and a functional vision rehabilitation program that helps many low vision veterans improve the distance from which they can see curbs, signs and other relevant pedestrian information.

Blind and low vision veterans participate in a success oriented program to develop orientation skills, long cane techniques, and community travel safety at curbs, stairs and street crossings. Upon completion of the program, most veterans experience a regained sense of independent travel confidence.

O&M may also include the development of independent travel skills using transportation options such as Para-transit, the city bus system, and rail systems. For some veterans, developing the ability to travel independently includes use of unique devices such as: Electronic Travel Devices for the blind; a four-wheel walker; or a motorized scooter or a power wheelchair.

My O&M instructor was Matthew Collins. My daily sessions with Matthew followed lunch and ran for 80 minutes excluding a 10-minute break. This was concentrated instruction totaling 40 hours for the 6 week period. It was my favorite program component because the majority of it was conducted in the outdoors.

At our first session, Matthew pointed out the fire and earthquake escape routes for the WBRC building. Then we moved outside where he proceeded to see how well I could follow his verbal directions. He called for me to lead him down a sidewalk, cross a street, make a couple turns, go into another building on the VPAHCS campus, and find the men's locker room, the Olympic-size pool, and the basketball court. Since I had never been to this building before, I had to listen very carefully to memorize his instructions. Matthew's early instruction also helped me find my assigned classrooms in the WBRC building.

The next day, we toured the entire VA hospital campus with Matthew giving me instructions as to where he wanted to go next, then having me lead which was quite challenging. We also visited the VA store and canteen in the Administration Building, as well as various medical offices throughout the building. The final test was a mock fire drill in which I had to find the way out of the building on my own. I accomplished this by asking for directions from several people I met in the hallways. We had to escape the building without the use of the elevators.

At another session, Matthew measured my eyesight by having me read words and numerals on a cardboard chart starting from about 50 feet away and moving in closer a half-step at a time until I could read the chart. Then we went outside so he could attach a chart to a lamppost; once again he was measuring the results at various distances only this time the chart was in bright sunlight. He then had me try different colored glasses to determine which color was best for me. I chose amber.

Matthew had me hold his upper arm while he led me by a half-step. As he walked, he was testing me on sighting various obstacles on the sidewalk ahead or perhaps sticking out from a tree at eye level. When I announced an obstacle, Matthew would stop me; while I waited, he would measure the distance between the obstacle and me. This instruction convinced me that I was not checking ahead for obstacles that might be in my path. Three weeks later, he conducted this test again and noted that I spotted obstacles much sooner than I had on the first go-round.

Approximately 60% of my time in O&M training was spent off-campus in Palo Alto's downtown and residential neighborhoods, learning many valuable tips on crossing busy intersections with and without stoplights, and using my long red-and-white cane. Suffice it to say, many of Matthew's tips would be obvious to most pedestrians, but the subtle techniques were far from obvious. For example, I've used a support cane for six years, but I knew nothing about the techniques for using a blind cane. These sessions on street crossings enhanced my ability to move around in any kind of traffic situation.

Another O&M instruction involved the use of a small monocular telescope which I received in Visual Skills. This optical aid enables one to read street and store signs from a distance of approximately 50 to 75 feet. Andrew Dadd gave me the initial instruction on how to hold and adjust the lens of the monocular for a specific distance. Matthew showed me how to read signs from across the street. However, as

with all things technical, I found there was a learning curve before I could fully utilize this vision tool. At first, it was stressful just to hold the little monocular up to my left eye and to keep my balance, while focusing for distance before trying to read a sign. As a no-nonsense instructor, Matthew picked the smaller signs for me to read, but the more I trained on the monocular, the more it became a useful tool.

During our many walking and street-crossing sessions, Matthew taught me orientation. For example, he seldom mentioned the location where he parked his VA van. He would then test my lay-of-the-land by asking me to lead him back to the car. I soon learned to get a fix on the sun's position in relation to where the car was parked.

During my six weeks at the WBRC, I appreciated being able to use Redi-Wheels, the San Mateo County paratransit service for the handicapped, to go home for the weekends. Redi-Wheels picked me up after my last class on Friday afternoons and drove me to a pre-arranged drop-off point in San Francisco, such as the Ferry Building. From there I caught the ferry to Tiburon, a 25-minute ride, then walked three blocks to my home. The Redi-Wheels fare was only three dollars from Palo Alto to San Francisco plus a tip. It should be noted that Sandra was perfectly willing to pick me up in Palo Alto or San Francisco, but an important part of the WBRC program is to teach independent travel skills and confidence. So it was with the WBRC's approval and blessing that I made this weekly trip on my own.

VA Palo Alto Health Care System. The VAPAHCS consists of three inpatient facilities (Palo Alto, Menlo Park, Livermore) and six outpatient clinics (San Jose, Capitola, Monterey, Stockton, Modesto, Sonora). These facilities provide some of the world's finest medical care and cutting-edge technology. VAPAHCS is a teaching hospital, providing a full range of patient care services, with state-of-the-art technology as well as education and research. VAPAHCS maintains one of the top three research programs in the VA. An affiliation with the Stanford University School of Medicine provides a rich academic environment including medical training for physicians in virtually all specialties and subspecialties.

Living Skills

The Living Skills program addresses skills needed to live safely and independently in the home. The program provides visually-impaired veterans with training and/or adaptive devices to assist with home management, meal preparation, and cleaning skills. Alternative methods for communication are addressed. These skills may include adaptive forms of handwriting, calculating, tape recording, and touch-typing, enabling veterans to efficiently manage tasks such as correspondence, check writing, storing and retrieving information, and labeling. Braille instruction may also be provided for such tasks.

Brandon Haile, my Living Skills instructor, was an amazing young man. He has far less vision than I do, but still manages to instruct blind or low vision veterans in Living Skills. Once he understood my keen desire to be in the Computer Access Program, he arranged for me to use one of his staff computers with Talking Typer™ software for practice in the evenings. I'm a hunt-and-peck typist, but was hoping to convert to touch-typing, although the jury is still out on this goal.

Brandon demonstrated an amazing digital recorder, smaller than a cigarette package, a Milestone 311 Daisy made in Switzerland. This device can record two hours of information; with the use of an optional memory card, like that of a digital camera, one can record much longer times. We agreed it would be very useful in my work as a writer and

Brandon assured me that I qualified for this piece of equipment from the VA at no charge.

Brandon also demonstrated a small Sony 4-track tape recorder/player and we agreed that this should be among my take-home aids because it played the Talking Books I receive from the California State Library in Sacramento.

On a personal note, in spite of Brandon's low vision, his interests are primarily outdoors. If he had his druthers, he would rather be teaching snow-boarding during the winter season at Telluride and be a Colorado River guide during the summer. He's already had experience in both fields, so his life story should be an inspiration to any young blind or low vision person. During my final session, Brandon presented me with a talking watch, a talking calculator, and a digital alarm clock—truly an amazing and bright young man.

"Before I came here, I was depressed. I sat on the couch. Going out to do things? I couldn't, I got frustrated. I found out about the VA Blind Rehabilitation Centers from my coordinator at the VA Hospital in Loma Linda. It took me two years before I called and said I'm ready to go. My second day at the WBRC, I wanted to go home, but my O&M instructor talked me through it and we went out for my first O&M session.

"In Manual Skills they taught me how to use my hands again and not get so frustrated trying to do things. I made a belt, did a copper tooling of the 'Last Supper,' and used a saw to make a frame for it. I did sanding, staining, oiling—all without being able to see what I was doing, just feeling my way. They gave me safety devices which I can take home to put on my own saw. The WBRC experience has been the best for me."

—John Spratley, Desert Hot Springs, Calif., U.S. Army, 1972-1974.

*Vision problem: A lack of blood supply to the optic nerves of the left and right eyes.
(Medical term: Anterior Ischemic Optic Neuropathy or "AION.")*

Manual Skills

The Manual Skills therapeutic program is dedicated to assisting veterans who are visually impaired to achieve their highest level of sensory awareness and personal independence. After evaluation, an individualized treatment program is developed based on the veteran's goals, assessed needs and interests. Activities are designed to challenge the veteran to use problem-solving skills and to introduce adapted tools and techniques for those who are visually impaired. Projects in leatherwork, copper tooling, ceramics, woodworking, and home mechanics are used to increase independence and confidence in achieving personal goals. After participating in the Manual Skills program, many veterans improve or regain the ability to perform tasks engaged in before sight loss, and have the confidence and skills to become involved in new activities.

My Manual Skills training was scheduled after breakfast between 8:00 and 9:30 a.m. "El" Grey, my instructor, was very dedicated, something her students seemed to appreciate. I explained to her that I hoped to be approved for the dual-track program and, after two weeks in the general program, hoped to reduce my time in Manual Skills in order to free up time for Computer Access Training. I further explained that Sandra and I were still writing and had little time leftover for hobbies.

My initial challenge in Manual Skills was to put together a leather belt made up of complicated multi-part links. It tried my patience to the max and I soon learned that it was what most veterans called the "dreaded belt assembly." The following day, El changed course on me to relieve my frustration and demonstrated a number of handyman tools for the blind—including several tape measures. The most interesting one for me was the "click ruler," consisting of a metal rod with a small knob every half-inch. For every sixteenth of an inch that the ruler is extended or retracted, it makes a distinct "click." Students count the knobs by feel to move the ruler to within a half-inch of their mark. Then they zero in by listening for the clicks. This, of course, takes away the need for marking the wood or for using a measuring tool that you cannot see. When a

student has lined up the cut, the instructor waits on the other end of the saw, as the student makes the cut using a push tool.

Most Manual Skills instruction is designed to help veterans get back in touch with what their other senses have to offer. Most veterans advance to operating power tools to make picture frames, wooden bowls, cutting boards and other items. As Andrew Dadd, a former Manual Skills instructor put it, "It's not so important what is made, it's more important how the veteran goes about making it. It's to use the experience to get them thinking about how they problem-solve differently. How does a person set up an accurate cut on a table saw, if they cannot use a traditional tape measure?" I should note that veterans do not have to learn how to use power tools. There are other options in Manual Skills, such as ceramics and copper tooling.

I had several more sessions in Manual Skills to hone my sense of feel and touch. One was feeling various shape and size holes while blindfolded. Another, also while blindfolded, was matching up a set of puzzle-like pieces assembled on a wooden board. It may sound easy, but when blindfolded it's a challenge, especially when "on the clock" competing with yourself.

Computer Access Program

The Computer Access Program assists veterans in using large print, speech- and Braille-access devices for computers. Veterans, who either own their own computers or are approved for issuance of prosthetics by Prosthetics and Sensory Aid Service, participate in this program. The computer program is separate from the regular rehabilitation program. Admission criteria differ and there is a separate application process. The average length of stay for the Computer Access Training Program is three weeks.

Two weeks into the general program, Lila Jaffray, Clinical Coordinator and Patient Advocate, informed me that I was approved for the dual-track program. Manual Skills would be replaced by Computer Access Training, Monday through Friday between 8:00 and 9:30 a.m. This would be followed by Living Skills, between 10:15 and 11:45 a.m., now largely devoted to touch-typing practice. My afternoon schedule would remain the same for the balance of my stay: O&M from 12:45 to 2:15 p.m.; free time from 2:30 to 3:05 p.m. (usually spent in the nurses' station, or in optometry for follow-up, or checking in with Sandra on her progress with our current book), and Visual Skills from 3:15 to 3:55 p.m.

My computer instructor was Miriam Emanuel. At our first session, I explained to her that I had some familiarity with computers. In 1987 I acquired my first computer for my consulting and publishing business, and used it for word-processing, desktop publishing, and online research. I also explained that in 2003 I was teaching myself to use voice recognition software just before I became legally blind. However, and perhaps out of frustration, I gave away my entire computer system when I thought I would no longer be able to use it. I explained to Miriam that I wanted to learn everything I could in three weeks to bring me up to date on the latest software and computer technology for my work as a writer and publisher. Miriam's enthusiastic response was, "No problem!" She then excused herself and headed for her supervisor's office to arrange for the delivery of my computer, printer and scanner, so we could set it up together the following morning.

The next morning, Miriam gave me some good news. Between Brandon Haile, Lila Jaffray, and Miriam, a small private office was arranged for me to use for the balance of my Living Skills and Computer Access Training. Miriam then unpacked and set up my new computer system. She also connected the computer to the VA's Internet system so Miriam could look at our web site and download a work-in-progress manuscript emailed from Sandra.

During one of our first sessions, Miriam asked me to type my goals for the Computer Access Program. I came up with the following: Learn to use the Internet for research; learn to touch-type and send or respond to emails; and learn to edit manuscripts—all in three weeks.

Miriam is very sharp and I had trouble keeping up with her instruction, so I asked and she granted me permission to tape-record our sessions. However, this did not work out because I was spending too much time listening to find an answer to something. Our solution: Boldface, large print "how-to" notes typed by Miriam. The end result: A half-inch ring binder of notes with a table of contents. This binder was created a page or two at a time, and was assembled when I completed my Computer Access Training.

By the end of the second week of computer training, I had added most of my Living Skills time to my Computer Access Training time. My computer time was now divided between touch-typing practice and manuscript editing using ZoomText™ audio and video in combination with a CCTV system.

§§§

The Stroke at Midnight

On Thursday, April 9, after one week of computer training, there was a slight interruption in my schedule. I was turning over in bed to get up to go to the bathroom, when I realized that my right leg below the knee was as limp as a noodle. At first I thought my leg was asleep, but when I sat up and tried to stand on it, it didn't respond as I expected it to. I made it to the bathroom by leaning on walls, but by the time I got back into bed I realized that the problem was more serious. I managed to get a little more sleep between midnight and early morning reveille. When I got up to shave and shower, I had a bit more feeling in my right leg, but from what I had learned over the years, my self-diagnosis told me I had probably experienced a mild stroke.

With the use of my support cane, I slowly made it to the dining hall for breakfast and then up to my computer room where I waited for my instructor, Miriam Emanuel, to arrive. In retrospect, I should have gone straight to the nurses' station. In any case, Miriam, after hearing me describe my leg condition, immediately called for a wheelchair and got me down to the nurses' station. After a consultation with the nurses, a volunteer arrived to wheel me to the main hospital, a distance of about three city blocks. I was admitted to the Emergency Room around nine o'clock and was given the first of many tests.

Sandra was called around noon, immediately packed an overnight bag, and drove to the hospital. Later that afternoon, we got the diagnosis: a mild stroke. Around six in the evening when a room became available, I was admitted to the main hospital. The Staff

Psychologist at the WBRC, Dr. Laura J. Peters, arranged for Sandra to spend the night in a "family training room" in the WBRC building, a thoughtful and much-appreciated gesture.

I remained in the hospital the next day and was literally tested from head-to-toe with a brain CAT scan, an EKG, an Echogram, and an MRI. I also had follow-up ultrasound scans of my legs to check for vascular problems. I had suffered a mild stroke on the left hind quarter of my brain, which is why I had the temporary paralysis in my right leg. Several of my fellow veteran students and instructors visited me. In the late afternoon, I was discharged and permitted to go home with instructions to take it very easy.

After a restful weekend, I returned to the WBRC and, after being thoroughly checked out, I was allowed to return to my classes.

I have nothing but high praise for the VA hospital staff. They were not only professional, they were like friends. The affiliation with the Stanford University School of Medicine meant I was seen and mostly evaluated by University residents and interns. All in all, I feel that I dodged a bullet, thanks to the excellent care I received. As I write this about four months later, both legs below the knees are a bit sluggish and my balance is less trustworthy than prior to the stroke, but I'm back to walking about two miles a day with the aid of my support cane. I guess it was a bit of the "luck of the Irish" to be enrolled in the WBRC program on the VA hospital campus when this happened.

§§§

Recreation Therapy

The role of Recreation Therapy is to facilitate community integration of the skills, techniques and philosophy of the WBRC. The rich offerings of the Bay Area make it possible for veterans to apply adaptive techniques, learned in their individualized program, which assist them to reintegrate into the community. Evening and weekend outings provide an opportunity to gain confidence, reclaim old interests and develop new ones. Leisure is at least one third of a healthy lifestyle; therefore it is critical for visually-impaired veterans to acknowledge a range of possibilities for their free time.

Kathy Kelley, Director of the Recreation Department, arranged for one of her therapists to give five of us new arrivals a tour of the recreational facilities in another building housing a full-size gym with a basketball court, an Olympic-size swimming pool, and many pieces of fitness equipment.

Organized social games scheduled after dinner ranged from a friendly game of blackjack to bingo. For bingo, all interested veterans walked as a group to the main hospital where we joined with other hospital patients, most in wheelchairs, for a joint bingo game in a large meeting room. Volunteer women from the local communities offered to “loan us their eyes” to be sure we marked our cards correctly. Prizes consisting of small coupon books valued at one dollar were good for purchases at the hospital canteen. The volunteers, ranging in age from their twenties to their sixties, were very nice and served us snacks and beverages. Without exception, the veterans thanked them profusely for their service.

On another evening, I mustered with about 20 other students for a bus trip to a bowling alley in Palo Alto. Lots of camaraderie and laughs, but no high scores as you can imagine. We did have one scare. One of our group fell into the next lane, but was able to get up with a little help and continued playing for the rest of the evening.

My favorite recreational outing fell on April Fool’s Day. Students had the day off while our instructors attended meetings and presentations designed to keep them up to speed

in their respective training specialties. Our outing was to a nice Italian restaurant in Palo Alto with eight bocce ball lanes: four indoor and four outdoor. We divided into two groups of twelve, with each group occupying a lane. Each group of twelve was further divided into two teams which competed with each other. There were very few high scores, but since we were all legally blind, getting that big ball somewhere close to that little ball was no easy challenge. However, we had lots of laughs, always a good thing, along with a delicious lunch.

The WBRC also organizes weekend outings around the Bay Area, such as a visit to the Monterey Bay Aquarium, a tour of a Silicon Valley high-tech giant, a San Francisco Bay cruise, a visit to Golden Gate Park, or a major sporting event. Because I went home every weekend to work on *Pacific Express*, I did not attend these outings. From what I heard from my tablemates, they were entertaining or educational, and some included a lunch stop along the way.

For my exercise, after dinner I sometimes walked around the perimeter of the hospital campus, a distance of 1.3 miles. I would alternate using my support cane and my longer white-and-red blind cane.

While all the students seemed to take the one-on-one skill instruction very seriously, the opportunities to connect with other veterans were very valuable as well. There were opportunities to connect with each other before and after “school” on weekdays, such as the early morning, pre-chow bull sessions in the

lounge over coffee, and the evening games of social blackjack, bingo and bowling. The popular weekend outings afforded veteran-to-veteran connection according to the feedback I got from my tablemates on Monday mornings.

Most vets I came to know felt they learned about as much from the other vets as they did from the WBRC staff.

“One morning 14 years ago, I woke up with macular degeneration in both eyes. It was quite a shock. I was a very active and ambitious person. I was selling insurance on the road, driving about a 1,000 miles a week. I was an avid golfer, traveling around the world to golf.

“It took three months to hit home that this had happened to me and I was legally blind. I went to an ophthalmologist first and he immediately sent me to a retinal specialist which I had never heard of before. The specialist took all these tests, then said very bluntly, ‘You have wet and dry macular degeneration.’ I remember laughing and saying, ‘Okay, I’ll take new eyes if that’s what you do here.’ He looked at me very seriously and said, ‘You cannot get any better. It’s impossible. But come back next year and maybe we’ll have something.’ I said, ‘No way,’ and went from one retinal specialist to another who, of course, all gave me the same diagnosis.

“I shall always remember the first time I came to the WBRC. I really wanted to die. I remember coming here very reluctantly, walking like I could barely move, holding both arms up, looking down at the ground, just not caring. They asked me if I had a cane and I said, ‘No, of course not.’ The instructor simply said, ‘Okay, we’ll use a cane.’ I said, ‘No way.’ The next thing I knew I had a cane in my hand and we were walking down the street.

“Eight or ten weeks later I left the WBRC with my head held high, a cane in my hand, and feeling like I could conquer the world. And since then, I have become very active with people with no vision at all. My spirits are now 100 percent.”

*—Shirlee Abrams, Laguna Woods Village, Calif., Coast Guard, SPAR, Yeoman, 1944-1945.
Vision problem: Macular Degeneration.*

Adjustment to Sight Loss

Sight loss can be a very stressful event in a veteran's life. Having the opportunity to share experiences with other veterans is very important. This can be done informally, and through the weekly Sight Loss Discussion Group, called the Forum, which is led by the WBRC Psychologist and Social Worker. Through participation in Blind Rehabilitation, most veterans feel their confidence, self-esteem, and attitudes toward their visual impairment improve as they regain independence. As veterans realize they can do more through rehabilitation, they feel more in control of their lives and more motivated to be active at home. The WBRC Psychologist meets at least once with each veteran who enters the Basic Rehabilitation Program. Issues related to coping with sight loss are addressed in these meetings. The Psychologist is also available to provide individual counseling for veterans who are experiencing stress in relation to their vision loss.

On my second day on campus, Melissa Snarski, Ph.D., a Psychology Postdoctoral Fellow, dropped by my room for a get-acquainted conversation and a brief interview. She explained, "Our objective is to get to know you, learn what your personal objectives are for the program, and to see if there is any way we can be of assistance."

I gave Dr. Snarski a brief resume of my background from childhood on. She had quite a few questions which I was happy to answer. Then we got into some simple test questions to check my memory and to do some basic math. For example, she asked me to subtract 7 from 93; then in increments of 7, to keep subtracting until I got to zero using mental arithmetic only. I accomplished that okay. Another example: Dr. Snarski gave me a word, asked me to spell it, then asked me to spell it backwards. Although this was fairly easy for me, as I work with words all the time, I'm sure it would be a different story for someone not used to writing on a daily basis.

The WBRC team of psychologists, led by Dr. Laura J. Peters, Staff Psychologist, along with Britney Blair, Psychology Practicum student, and Melissa Snarski, Postdoctoral Fellow, conduct a weekly Sight Loss Discussion Group, immediately following the Tuesday morning graduation ceremonies in the conference room. This forum has also been described as a communications workshop for veteran students with a fair amount of information exchange between students and psychologists.

I joined this group following the first graduation ceremony I attended. The discussion centered around assertive versus passive communication, with a lively dialogue between students and the professionals. I attended three or four more of these discussion groups and found them to be interesting and informative.

Family Training

The WBRC offers a Family Training Program, if appropriate, to a close family member or caregiver to come to the center for up to four days at government expense. The purpose of this program is to educate the family member on the implications of sight loss. The family member engages in direct and individual interactions with members of the veteran's treatment team. The two objectives of the program are to familiarize the family member with the veteran's capabilities and to provide education on specific supportive techniques. The family member can then share this information with others that interact with the veteran at home. The Family Training Program is not available to veterans that are solely enrolled in the Computer Access Program.

My instructors urged me to have Sandra attend the Family Training Program and, under normal circumstances, she would have gladly done so. However, the mid-April timing of my graduation was in direct conflict with our final preparations for getting the manuscript for *Pacific Express* ready for our printer. We made a commitment to launch *Pacific Express* in early May at a major Amphibious Forces reunion in

Portland, Oregon, so we had to have the finished books in our possession by May 4. Sandra and I both felt she needed to stay in the office in order to keep the project moving forward. As it turned out, we made our deadline with one day to spare; as an aside, our book launch was very successful and worth the stress involved.

"Before my husband went to the Blind Rehabilitation Center, I tended to hover, not wanting to let him out of my sight, not wanting to leave him home alone, for fear he would have need of some assistance or have an accident. Now I'm able to let go—a little—as he's learned from the best instructors how to safely get around and enjoy some more independence—very important for one's self-esteem."

—**Sandra McGee**, wife of WBRC graduate

"My vision problem comes from Agent Orange which caused my diabetes which caused my retina detachments. After being discharged from the Navy in 1965, doctors told me to stay off my feet because of collapsed bones in my feet, it's called Charcot foot. I put on weight; I developed diabetes; then detached retinas. I went into a deep depression for years. I didn't want to see anyone, talk to anyone, or do anything. Luckily my wife, Irma, ran into two ladies that told her about the Braille Institute. I joined Braille and I started coming out, playing golf with a bunch of blind guys. One guy said he got a hole-in-one, but he didn't have any witnesses!"

"He also learned how to use a computer at the WBRC in Palo Alto which is why I'm here. When I got the call to come, I had already had surgery to re-attach the retinas and my sight was a little better. I told Lila Jaffray [WBRC Clinical Coordinator and Patient Advocate] if there was someone worse off than me to let them come in my place. She said very firmly, 'No, you're up, you're on deck, and you have to salute the flag!' Since I've been here I've lost 33 pounds, thanks to the outstanding nurses who keep me and my diet on track, and my insulin intake has gone from 200 units a day to 48. Thanks to this program, I've come around 180 degrees."

—**Raul A. Rodriguez**, Cerritos, Calif., U.S. Navy, Machinist mate, 2/c. Vietnam, 1962 – 1965.
Vision problem: Tractional Retina Detachment caused by diabetes.

Graduation

Every Tuesday morning all students and the majority of staff instructors gathered to witness the ceremonies for graduating students. Timothy G. Langford, Acting Chief of the WBRC, introduced each student's coordinator who in turn introduced his or her student. The veteran student is obligated to say a few words. These were both fun and serious sessions which included a bit of joking as well as emotional moments between the students and instructors.

The coordinators presented their graduating students with a Certificate of Achievement.

On March 31, 2009, Bill Light, my tablemate and the departing "student body president," had the following to say at his graduation (see below). After the ceremony, Bill Light passed the "student body president torch" to John Spratley who, upon his graduation, passed it on to Shirlee Abrams.

"Buckle your seatbelts because I'm going to take you to 'Never, Never Land.' But first, as your student body president, I want to thank Mr. Langford and Ms. Jaffray for their open door policy which really helped me to achieve some of the things I wanted to get across. Then I want to introduce my son, Arnold, who is here for Family Training. [Applause and shouts of "Yea, Arnold!"] Okay, now off to 'Never, Never Land.'

"Thirty years ago I was diagnosed with macular degeneration. The word was common in the medical profession, but not to me. I started out with an ophthalmologist. He referred me to a retinal specialist who said, 'You have macular degeneration and there's no cure for it. You'll just have to keep checking back with me.' He gave me an Amsler grid. You may have seen one. It looks like a crossword puzzle with a dot in the center. You look at it everyday and if there is a change in what you see, wavy lines or a halo around the dot in the center, you call your doctor. Well, I went on and on. I never got any inspiration. It was always 'never, never, never.' That's why I said, 'Never, Never Land.' But I didn't accept that because I felt that there may be some help. What it took was a series of lucky events. I went to the Braille Institute for some help and the counselor there said, 'Have you heard of the Western Blind Rehabilitation Center in Palo Alto?' I said, 'No.' She said, 'Here's a name and phone number. Since you're a veteran, you can get some help.' I took her up on it and called the VIST coordinator at the Sepulveda VA facility where I go. She got the ball rolling and here I am at the WBRC.

"I came here without much vision. I could see some, but I really had no vision—I couldn't read; I couldn't write; I couldn't communicate. So I went into basic instruction and got the first thing—an exhaustive, extraordinary eye exam. The doctor measured me from every angle. Probably you veterans have been through that. When I came out, there was a baseline where I could see certain things which I never could see before. I'm wearing a pair of glasses now where before I was told glasses wouldn't be of any help. Of course, bifocals for reading, forget about them. This pair of glasses is for distance. I can see to the back of the room where I couldn't before I came to the WBRC.

"So never say never. There is always something there. Sometimes you have to seek it out on your own. I can now see more than I did when I came here. I can read with the visual aids. I can write. I can communicate with friends and family. The first thing I'm going to do when I get home is write a letter to my Representative to tell the Department of Veterans Affairs thanks for funding this particular program." [Applause]

—*Bill Light, Santa Clarita, Calif., U.S. Army, 1942-1945*
Vision problem: Macular Degeneration.

Conclusion

Although partial or total loss of vision can be overwhelming, the problem is not insurmountable. Rehabilitation can be the start of a new life. It is the beginning, the training ground, the base that prepares the blinded veteran to assume or continue a meaningful place in the family and in society. Rehabilitation assists the blinded veteran in building the strength, skills, and self-confidence to live a normal, happy, well-rounded life.

On April 21, 2009, I proudly accepted my Certificates of Achievement presented by representatives of the WBRC Basic Program and Computer Access Program.

I wish to thank the entire WBRC staff for the valuable training, the visual aids, and the

wonderful “back to school” experience they afforded me. I also want to thank my fellow “students” for sharing their very personal vision loss stories with me. Last but not least, I want to thank the members of Congress who continue to vote to fund this valuable program.

“The WBRC is wonderful and I wouldn’t change a thing about the program if they asked me.”

*—Robert L. Brewer, Hemet, Calif., Marines, 1st Engineers, Buck Sergeant,
Korean War, 1950-1951. Vision problem: Macular Degeneration.*

Appendix

Sight Loss Stories in the News

■ **“When the Vision Goes, the Hallucinations Begin.”** The Charles Bonnet Syndrome (pronounced: bon-NAY) is a strange but relatively common disorder in people who have serious vision problems. A Swiss philosopher, Charles Bonnet first described this condition in the 1760s. Sometimes called visual hallucinations, people with serious sight loss see all kinds of forms from simple patterns of straight lines to detailed pictures of people or buildings. Often whole scenes will appear and sometimes these complicated pictures can make it difficult to get around. For example, streets and rooms may have their shape changed and this can make it difficult to judge exactly where you are. (Source: www.nytimes.com, September 14, 2004, Susan Kruglinski.)

[*Author’s note:* In my case, I see a red brick building with green shutters off to the right side of the road when riding in the car with Sandra. Also it appears that the road is about to bend to the right when the car is actually going straight ahead. At these times, I’m convinced Sandra is not following the road, but of course she is. Unfortunately there is no known cure or treatment for CBS. I encourage readers with low vision to discuss this subject with their retinal specialist, as it’s a fascinating and puzzling phenomenon.]

■ **“Better Vision, with a Telescope Inside the Eye.”** A tiny glass telescope, the size of a pea, was successfully implanted in the eyes of people with AMD, helping them to read, watch television and better see familiar faces. The new device is for people with an irreversible, advanced form of AMD in which a blind spot develops in the central vision of both eyes... VisionCare Ophthalmic Technologies in Saratoga, Calif., the implant’s maker, says it expects the F.D.A. to give its O.K. later this year. The device has already been approved for use in Europe. (Source: www.nytimes.com, July 19, 2009, Anne Eisenberg.)

■ **“Study Suggests Gene Therapy May Enable Blind To See.”** Scientists believe the brain of a blind woman rewired itself and enabled her to see after partial vision was restored to sections of her retina through gene therapy. The finding surprised scientists at the University of Florida College of Medicine and the University of Pennsylvania, who two years ago began testing the safety of gene therapy in three patients born with Leber congenital amaurosis type 2, a rare blindness condition. The findings are contained in a study to be published in the *New England Journal of Medicine*. (Source: www.foxnews.com, August 12, 2009, Marrecca Fiore.)

VA Blind Rehabilitation Centers

VA Central Office (VACO)

Department of Veterans Affairs
Veterans Health Administration
Blind Rehabilitation Service (117B)
810 Vermont Ave. N.W.
Washington, D.C. 20420
(202) 273-8483
www.va.gov/blindrehab

Regional Centers

American Lake
Blind Rehabilitation Center
VA Puget Sound Health Care System
Tacoma, WA 98493
(253) 582-8440

Augusta Blind Rehabilitation Center
VA Medical Center
1 Freedom Way
Augusta, GA 30904
(706) 733-0188

Central Blind Rehabilitation Center
Edward Hines Jr.
VA Hospital
5th & Roosevelt Rd., PO Box 5000
Hines, IL 60141
(708) 202-8387

VA Connecticut Healthcare System
West Haven Campus
VA Medical Center
950 Campbell Avenue
West Haven, CT 06516
(203) 932-5711

Puerto Rico Blind Rehabilitation Center
VA Medical Center
10 Casis Street
San Juan, PR 00921
(787) 641-8325

Southeastern Blind Rehabilitation Center
VA Medical Center
700 South 19th Street
Birmingham, AL 35233
(205) 933-8101

Southwestern Blind Rehabilitation Center
Southern Arizona VA Health Care System
3601 South 6th Avenue
Tucson, AZ 85723
(520) 629-4643

Waco Blind Rehabilitation Center
VA Medical Center
4800 Memorial Drive
Waco, TX 76711
(254) 297-3755

Western Blind Rehabilitation Center
VA Palo Alto Health Care System
3801 Miranda Avenue
Palo Alto, CA 94304
(650) 493-5000

(Note: The WBRC facility is scheduled for demolition in 2010 with a new state-of-the-art building to be constructed in its place to house blind rehab and polytrauma services. Estimated operational date: 2012. During construction, the WBRC will temporarily operate in a nearby city.)

West Palm Beach
VA Medical Center
7305 N. Military Trail
West Palm Beach, FL 33410
(561) 422-8425

New Locations

Three new Regional VA Blind Rehabilitation Centers are planned for Cleveland, OH; Biloxi, MS; and Long Beach, CA. Estimated operational dates: 2011/2012.

VA Low Vision Clinics

There are currently 55 new Low Vision Clinics across the country whose services range from low vision and basic living skills through short term training in most areas of blind rehabilitation. Visit www.va.gov/blindrehab and look for the Continuum of Care link.

Resources for Blinded and Low Vision Non-Veterans and Veterans

American Council of the Blind
2200 Wilson Blvd., Suite 650
Arlington, VA 22201
(202) 467-5081
www.acb.org

American Foundation for the Blind (AFB)
11 Penn Plaza, Suite 300
New York, NY 10001
1-800-232-5463
(212) 502-7600
www.afb.org

Blinded Veterans Association (BVA)
477 H Street NW
Washington, DC 20001
(202) 371-8880
www.bva.org

Braille Institute of America
Serving Southern California with five regional
centers (Los Angeles, Santa Barbara, Rancho Mirage,
Orange County and San Diego) and more than 350
Community Outreach locations.
www.brailleinstitute.org

The Earle Baum Center of the Blind (EBC)
Serving Northern California from San Francisco's
Golden Gate Bridge to the Oregon border.
4539 Occidental Road
Santa Rosa, CA 95401
707-523-3222
www.earlebaum.org

LightHouse for the Blind and Visually Impaired
Serving Northern California.
LightHouse San Francisco: 415-431-1481

LightHouse of Marin: 415-258-8496
LightHouse of the North Coast: 707-268-5646
www.lighthouse-sf.org

Lighthouse International
111 East 59th Street
New York, NY 10022
1-800-829-0500
(212) 821-9200
www.lighthouse.org

National Association for Visually Handicapped
(NAVH)
22 West 21st Street, 6th Floor
New York, NY 10010
(212) 889-3141
www.navh.org

National Eye Institute, NIH
2020 Vision Place
Bethesda, MD 20892
(301) 496-5248
www.nei.nih.gov

National Federation of the Blind (NFB)
200 E. Wells Street
Baltimore, MD 21230
(410) 659-9314
www.nfb.org

VisionServe Alliance
(Previously known as: National Council of Private
Agencies for the Blind and Visually Impaired)
8760 Manchester Road
Saint Louis, MO 63144
(314) 961-8235
www.visionservealliance.org

About the Authors

William L. McGee was raised on a Montana ranch. At 17, he enlisted in the U.S. Navy and served in the Pacific Theater from 1942 to 1946. After the war, he returned to cowboying and worked as a dude wrangler on a Nevada divorce ranch south of Reno. In 1950, Mr. McGee made a successful transition into the radio and TV field where he enjoyed a 32-year career. In 1971, he launched BMC Communications, a consulting and publishing company, and wrote numerous guidebooks on broadcast advertising sales. After a brief retirement in 1985, McGee turned his interest to research and writing, producing four WWII military histories and a Nevada dude ranch history that have garnered critical praise from reviewers and readers alike. Mr. McGee is a member of Broadcast Legends and Western Writers of America.

Sandra McGee is a veteran publicist for the performing arts. She has co-authored two books and is a member of Western Writers of America.

Email your comments to bmcpublications@aol.com or visit www.BMCPublications.com.

Other Books from BMC Publications

Amphibious Operations in the South Pacific in World War II

A Trilogy by William L. McGee

Vol. I: *The Amphibians Are Coming!*
Emergence of the 'Gator Navy and its Revolutionary Landing Craft

Vol. II: *The Solomons Campaigns, 1942-1943*
From Guadalcanal to Bougainville, Pacific War Turning Point

Vol. III: *Pacific Express*
The Critical Role of Military Logistics in World War II
William L. McGee, Editor
with Sandra McGee

Also
Bluejacket Odyssey, 1942-1946
Guadalcanal to Bikini, Naval Armed Guard in the Pacific

The Divorce Seekers
A Photo Memoir of a Nevada Dude Wrangler
William L. McGee and Sandra McGee