

Exploring the meaning of care among lived experiences of patients with blindness: an interpretive phenomenological study[†]



Original article

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Abstract: **Objective:** To explore the meaning of care experienced by people with blindness in hospitals.

Methods: Interpretive phenomenology along with the 6-step method of van Manen was used to conduct the study. Using purposeful sampling, 15 people with legal blindness were interviewed. Thematic analysis was used to isolate the meaning of care.

Results: Five themes emerged: (a) nurses in the eyes of patients with blindness; (b) negligence in the caring moments; (c) being cared for in ambiguity; (d) Uncoordinated care; and (e) Psychological discomfort. These sub-themes were condensed into an overarching theme titled as "marginalized patients inside the stereotypical healthcare system."

Conclusions: Lived experiences of patients with blindness revealed that hospitals provide stereotypic or inappropriate care for this minority group in society. Health professionals particularly nurses should be skilled to provide person-centered and coordinated care for patients with blindness.

Keywords: hospitalization • lived experience • meaning of care • people with blindness • phenomenology

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1. Introduction

Vision is the most dominant sense of human beings.¹ Our eyes are similar windows that connect the brain to the external world. Vision is more than just eyesight that is measured as visual acuity, but rather it is also an entry for cognitive processes in the mind.^{1,2} Indeed, vision plays a fundamental role in our daily life, and in the absence of eyesight, the affected person will experience life differently.¹ Blindness is a permanent or life-time condition that could be congenital or acquired.³

According to a global report in 2020, there were 258 million people with visual impairment worldwide, of whom 43.3 million people were blind, and 295 million people had moderate to severe visual impairment. Besides these, this review predicted that by the year 2050, 61 million people will be blind and 474 million will have moderate to severe visual impairment. Thus, despite many advances in ophthalmology, there is a global increasing trend in visual loss. Globally, the

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leading causes of vision impairment are uncorrected refractive errors, cataracts, age-related macular degeneration, glaucoma, diabetic retinopathy, corneal opacity, and trachoma.⁴

Daily life strongly relies on visual function.¹ When the eyesight of a person is impaired, it not only influences the daily life of the affected person but also affects the whole family, significant others, and society. Without eyesight, people may never drive a vehicle or they may never see how beautiful the flowers in the garden are.^{5,6} These are only some examples that express the vital role of vision in the daily life of human beings. Other than these, vision loss can impose major and long-term influences on all aspects of life, including mobility, everyday communication, social activity, maintenance of personal health, independence, learning, and the ability to access public services.^{7,8} Moreover, visual impairment is associated with risky events such as the risk of falls, injury, body limb fracture, and fatal events. A study concluded that psychological problems such as depression and anxiety are more common in visually impaired people.⁹ At all, the quality of life is affected by vision loss.¹⁰

Like the seeing people, individuals with blindness refer to health care centers to receive health care services, but with different conditions and abilities that are imposed by blindness. People with severe visual impairment need additional consideration by health care professionals and hospitals along with other healthcare centers should prepare appropriate care for visually impaired people.⁷ A retrospective study in the United States of America reported that hospital-based costs of patients with blindness are higher with poor clinical outcomes when compared with patients without severe vision loss. Therefore, it is necessary for hospital managers to explore and recognize this vulnerability and pay more attention to providing tailored care for this group of patients.¹¹

Traditionally, the nursing profession claims a holistic and personalized approach to the provision of care for everyone. Accordingly, nurses should prepare an appropriate caring environment for patients with blindness in healthcare settings, especially in hospitals. Nurses need to understand the difficulties and challenges of visually impaired people, recognize their abilities, and learn how to communicate and cooperate with them in caring contacts, especially in a hospital environment.¹² A previously published article showed that making effective nurse-patient communication has been challenging for both patients with blindness and nurses.¹³ A cross-sectional study reported that almost 34% of visually impaired people do not receive mental health services, while 57% of them stated to need these services.¹⁴ Additionally, lived experiences of a severely visually impaired patient in a hospital have shown some other drastic findings

including perceived misfortune of being admitted to the hospital, staff failure to understand their special needs, and challenges showing malpractices from health professionals in providing care for them.¹⁵ Another study revealed other healthcare-related experiences of visually impaired people including health professionals' poor awareness toward visually impaired people, limited access to information and healthcare services, isolation, lack of advocacy, and misunderstanding by others.¹² However, experiences of being a patient in a hospital can provide valuable knowledge to provide holistic and personally appropriate care for this group of patients.¹⁵ Therefore, this study aimed to explore the meaning of care in the lived experiences of patients with blindness in hospitals.

2. Methods

2.1. Study design

Hermeneutic phenomenology inspired the researchers to conduct this study. The focus of hermeneutic phenomenology is interpretive and the researcher tries to understand the meaning of lived experiences of one's being in the world¹⁶. Accordingly, we explored the meaning of perceived care experienced by patients with blindness. The method introduced by van Manen¹⁷ was used to perform the study. This method contains six active and cyclical activities.¹⁸ Table 1 presents this method and its application in the current study.

2.2. Participants

A list of people with blindness having a history of hospitalization during the last year was obtained from the Iranian Society for Visually Impaired (ISVI) as well as from the health information manager of hospitals, and then the eligible people were invited to participate in the study. Phone calls were made with 25 possible participants and 15 people agreed to participate in the interview (male = 9, female = 6).

The participants were Farsi or Azari language speakers and were living in Ardabil or Tehran provinces. Tehran is the capital of Iran and Ardabil is a province in the northwest of Iran. The main inclusion criteria were having total blindness confirmed by formal medical records; and a history of being admitted in hospital during the last year. The included participants were free of any disturbing psychiatric or other physical condition that could change their life experience. Participants' ages ranged from 20 years to 56 years ($M = 40.53$). People with only outpatient admissions were not included in the study. Participants were congenitally blind, or it had happened in early childhood. None of them could remember

seeing with their eyes. The demographic characteristics of the participants have been presented in Table 2.

2.3. Data collection

The study was explained to the participants on the first visit and activities such as recording the interview and obtaining the written consent were discussed with them, and the initial agreement was obtained. In the main interview sessions, semi-structured in-depth interviews were conducted to collect the data. Based on the participants' preference, the interviews were conducted in the hospital or at their home, in a comfortable and quiet room. Each interview began with general questions such as "tell me please about your life" and then progressed to less general questions such as "Please talk about your story when you were admitted in the hospital." The subsequent queries were more specific such as: "would you please talk about the challenges, worries and your communication with health staffs in

hospital." The interviews were recorded as audio files and immediately transcribed verbatim. Additionally, the interviewer took numerous field notes during the interviews which were analyzed along with the interview data. Transcripts were imported into the text analysis software, MAXQDA v10 (VERBI Software, Sozialforschung GmbH, Berlin, Germany). The duration of interviews lasted from 40 min to 120 min. Interviews were performed by the first author.

2.4. Data analysis

Data analysis was an inseparable activity throughout the study. Thematic analysis introduced by Max van Manen was used for data analysis. He suggested 3 techniques to draw out the meanings hidden inside a life story including a detailed line-by-line approach, a selective or marking approach, and holistic. In accordance with line-by-line and selective approach, the researchers carefully read and reflected on the words, phrases, and

Six methodical activities of van Manen	The researchers' activities in the current study
Turning to the nature of lived experience	Thinking and caring for patients with blindness, formulating the phenomenological question: how people with blindness experience healthcare?
Investigating experience as we live it	Prolonged engagement with clients with blindness, conducting in-depth interviews
Reflecting on essential themes	Listening to the audios, reading the transcripts, immersing in the data, conducting thematic analysis
Hermeneutic phenomenological writing	Writing the transcripts, writing about themes, writing to create a phenomenological text
Maintaining a strong and oriented relation to the phenomenon	Keeping thoughts and attention on participants' life stories, discussing the themes in relation to caring science
Balancing the research context by considering parts and whole	Moving between transcripts and themes, relating the findings to the literature

Table 1. van Manen's method and its use in the current study.

Participant	Age (years)	Sex	Marital status	Living with	Educational degree	Vocational status
P1	52	Male	Married	Spouse and children	Bachelor	Retired
P2	35	Male	Married	Spouse with blindness	Bachelor	Phone operator
P3	35	Male	Unmarried	Parents	Diploma	Part-time job
P4	56	Male	Married	Spouse	Diploma	Phone operator
P5	45	Female	Married	Spouse with blindness	Diploma	Housekeeper
P6	38	Male	Married	Spouse and children	Bachelor	Office employee
P7	39	Female	Unmarried	Parents	Illiterate	Unemployed
P8	35	Female	Unmarried	Parents	Bachelor	Unemployed
P9	53	Female	Married	Spouse and children	Diploma	Retired
P10	32	Female	Married	Parents	Guidance school	Unemployed
P11	43	Male	Married	Spouse and children	Diploma	Part-time job
P12	50	Male	Married	Spouse	Diploma	Retired
P13	40	Female	Unmarried	Parents	Bachelor	Knitter
P14	35	Male	Married	Spouse with blindness	Master degree	Teacher
P15	20	Male	Unmarried	Parents	Bachelor degree student	Student

Table 2. Sociodemographic characteristics of the participants.

sentences, and asked: "What does this term or phrase reveal about the lived stories of participants in the hospital?" Answers were the primary codes or thematic units which gradually progressed to subthemes, themes, and finally the main themes. Besides, Holistic thematic analysis helped us to reflect on a whole interview, interviews, or all extracted themes to capture a whole overarching theme which is representative of the lived care experiences of the participants with blindness in hospital.¹⁹

2.5. Trustworthiness

To improve the trustworthiness, possible activities were performed during the study. All the interviews were conducted by the first author. The researchers especially the first author attempted to gain proficiency in phenomenology as the research method. Prolonged engagement with participants was an important credibility measure, which was carried out during the study. In-depth interviewing, reflective reading of the stories, writing reflectively, turning to the research question at any point of the study, and attempting to generate a rich description of the phenomenon were other measures to improve the rigor of the study. Collaborative analysis was another strategy we used to ensure credibility and 2 authors independently analyzed the data.²⁰ Finally, the main theme and the sub-themes were explained to 4 participants, and their feedbacks were used to refine the themes.²¹

2.6. Ethics considerations

The Institutional Review Board of Ardabil University of Medical Sciences (ARUMS) approved the study project (code: 9319.1393-11-21). We were adherent to ethical codes as stated in the Declaration of Helsinki to ensure the confidentiality and anonymity of the participants throughout the study. Before data collection, participants were fully informed about the study, and verbal consents were given. In the data collection phase or interview sessions a written informed consent form in the Brail system was obtained from all participants. In the consent form, participants were assured that the study would not affect their future caring plan and they were free to omit their data before data analysis, as well. To ensure anonymity, cardinal numbers were used to refer to the participants in the reports and publications.

3. Findings and discussion

The experiences of the participants were condensed into the super-ordinate theme which is titled as "marginalized patients inside the stereotypical healthcare." This overarching theme was extracted from 5 sub-themes

consists of "nurses the eyes of clients with blindness," "negligence at the caring moments," "being cared in ambiguity," "undisciplined care for disciplined clients," and "emotional discomfort."

3.1. Theme 1: Nurses the eyes of patients with blindness

The lived stories of the participants discerned that nurses play an important role in caring for clients with blindness; as far as the participants recognized nurses as an alternative for their own eyesight. In this regard, participants have stated points that show the importance of nurses' existence in the caring environment. Participant 1 said: "*here [hospital] nurses really are my eyes. I am not worry because they can see.*"

Participants emphasized the need to receive full information about the physical environments. They prefer to receive a full description of the caring environment or clinical settings, and about the care they receive. Participant 5 expressed: "*I am very expectant of my caregivers especially the nurses in the ward. Thanks to my God, they [nurses] explain everything that I don't have information about them.*" Participants emphasized receiving information about drugs, procedures, manipulations, injections, etc. Participant 2 commented: "*I need full information about everything when I go to hospital. One day I asked him [nurse] to read the drug's instruction sheet but she answered: no need! If they know I am blind and if they understand we need to know about everything which we can not to see they may do not refuse our requests like this.*"

The first theme, "nurses the eyes of patients with blindness" suggests that nurses are the most important and key professionals for patients with blindness in the hospital where they have recognized nurses like their own eyes. This metaphor by patients about nurses primarily emphasizes on the fundamental role of nurses in helping and providing dependent care. In other words, in the absence of eyesight, people with blindness have to delegate some of the dependent care to be done by nurses. To meet this responsibility, nurses need to learn formal courses and practice the caring of visually impaired people.²² Looking at nurses as their eyes may partly be rooted in the educational and informative role of nurses and it can be more vital when there is a lack of educational content for visually impaired people.²³ In fact, the role of patient education is more important than its importance for the sighted clients. On top of that, proper access to information has been noted as the key factor in reducing health inequalities in providing appropriate health and social care for visually impaired people.²⁴ However, understanding visually impaired patients and providing individually appropriate care requires special

competencies that nurses should acquire during the academic courses and in the in-service education. A prior study too, emphasized staff's lack of skills as an important barrier for providing coordinated care for visually impaired people.¹³

3.2. Theme 2: Negligence at the caring moments

Participants talked about their interactions with health professionals, especially the clinical nurses. They pointed out that patients with blindness are ignored by the nurses and other health professionals in the caring environment in various fashions. Participant 3 while very complaining, expressed: *"my physician and the nurses think I am a disable person. When I came to the hospital the admitting nurse asked my health history from my sister while I was standing there alive!"*. Participant 7 expressed: *"I didn't know at what time my nurse comes to my room and at what time leaves. It is better they inform me of their presence and the leaves."* Patients as human beings need to be cared for with dignity and respect.²⁵ In fact, inattention to patients with blindness by the health professionals in the caring moments is in contrast with the human dignity and holistic approach to clinical care. Participants emphasized that the main cause of negligence originated from the staff's negative attitudes regarding people with vision loss. In addition, participants reported that health workers do not believe in the abilities of visually impaired people and may assume them as disabled persons. Consistently, in a prior study, blind patients expressed that they were viewed as disabled and incompetent persons.²⁵ In addition, there is a negative attitude toward disability among the general public, which can be the primary cause of the health staff's negligence toward patients with blindness.²⁶

3.3. Theme 3: Being cared in ambiguity

Being in ambiguity implies the experiences that mainly originate from the weak interaction of health professionals with the participants. First, participants stated difficulties about orientation and mobility that make them confused in the caring environment. Participant 11 who had diabetes mellitus, stated: *"when I go to diabetes clinic nobody tells me about the clinic's physical environment. I need to be familiar everywhere I go."* Participant 6 who was interviewed in the hospital, emphasized: *"this is my first time admission in this hospital, here is a new place for me and it is better a person show the critical locations, doors and entries for me!"*. Participant 7: *"I know here is hospital and I have come for the surgery but I don't know where the toilet is, and where is*

the nursing station." Participant 11 said: *"I admitted in a hospital, they fixed an I.V line on my arm but I didn't know more about the solution was dripping to my vein."* Participant 14 expressed: *"unfamiliar places are like a prison for me. I know I am in the hospital but it is only a name! Because I don't receive any descriptions about places in the ward."*

Because of vision loss, patients with blindness need to obtain essential information about the physical environment as well as about the received care. Narrates of the participants showed that they have received clinical care without any mobility and orientation tours. Helping patients to be oriented about the hospital settings is an important activity that brings out the patients with blindness from vagueness. Based on the lived experiences of the patients with blindness a formal or routine orientation program has not been received by them in the hospital settings. Although people with blindness are usually familiar with walking with a white cane, they need to receive instructions about the indoor environment, as well as other essential activities including movement from bed to floor, finding drawers, and addressing different objects in the patient room.²⁷ However, a mini orientation and mobility ward tour should be included as part of the nursing care plan, because the hospital environment is usually new and unfamiliar for patients, particularly for patients who are admitted to the hospital for the first time.²⁸

The admitted patient with blindness should be oriented in relation to the spatial space of the admission room, the ward's hall, the corridors, and other important locations such nursing station. In addition, the orientation needs to be ongoing and should be performed to notify the changes to approach the desired location safely.²⁹ However, the provision of orientation and mobility programs in the hospital acquires skilled personnel, particularly well-trained nurses. The findings of the current study showed no formal or informal orientation program for patients with blindness in which they described the caring environment with terms such as vague or ambiguous. Moreover, ambiguity about the hospital environment and treatment procedures can endanger the physical and psychological safety of patients with blindness.³⁰ However, a person-environment interaction assessment tool can help health professionals to better address the coping of visually impaired people in hospital environment.³¹

3.4. Theme 4: Undisciplined care for disciplined patients

Narrates of the patients with vision loss discerned that they adjust to and control their lives by making

an organized living environment and being disciplined in daily activities. Participants expressed that making an organized environment is a key self-care agent for being in the world. Alongside being disciplined and preferring to receive care in the disciplined hospital setting, the participants reported that they prefer to receive care from health professionals and nurses in an inappropriate and well-organized fashion. For example, participant 4 stated: *"here [hospital] I need a well-organized room like the home I am living with my family. Unfortunately, here [hospital] nurses and nurse assistants like to put my personal stuffs everywhere they like!"*. Participant 5 stated: *"everything in my room must be orderly arranged. Here I don't feel any order or arrangement."* Participant 6 has also expressed: *"this is the way I am exist [being disciplined]. I can't find everything by myself [by touching], so I expect from nurses and others to organize my room at least one time a day but this is only a wish!"* Participant 8 was complaining about the inappropriate caring behavior of health professionals: *"she [nurse assistant] usually comes to my room without knocking the door. Last night, I found a tray on the bedside table by my touch. I was alone and although I realized that it is a food tray with dishes inside but I did not eat it. The nurse, nurse assistant or anybody who come to my room, they should introduce themselves and their purpose for entering to my room. I don't like silent hospital workers!"*

Indeed, self-discipline is a fundamental coping mechanism or self-care agency in people with blindness in both daily life and unfamiliar environments such as hospital settings.⁷ Therefore, a well-organized patient room can improve blind patients' independence as well as their satisfaction. Despite the patients' emphasis on discipline and well arrangement of the patient room, they reported not enough orders in their room in the hospital. Hospital centers as well as health professionals need to make efforts to provide person-centered and coordinated care for patients with blindness.³²

3.5. Theme 5: Psychological discomfort

Exploring the lived stories of the participants showed that inappropriate care can cause psychological reactions in patients with blindness. Data analysis showed that negligence at the caring moments, care without information, and other difficulties of hospitalization can negatively influence people with blindness in the caring environment. Sorrow, anger, and anxiety were the main psychological reactions to the inequities and stereotypical care that they had to perceive as a patient in the hospital. For example, participant 2 stated: *"Really I am so angry today because they cannot to see me as a real patient."* Participant 13, a 40-year-old woman

expressed his emotions as: *"I am not comfort in this hospital; here I feel I am alone because the nurses only do their own tasks without speaking or interactions."* Participant 12 said: *"there [hospital] I really had emotional pain because personnel did not like to appreciate my needs and my special condition."* Participant 15: *"I had been depressed in the hospital; not for admission but for many free of respect behaviors. In their mind I was like a disable child who cannot care himself."*

While depression and anxiety have been reported as common psychological problems among visually impaired people, which needs special attention,³³ the current study discerned that inappropriate and stereotypical healthcare systems can cause additional psychological tensions that may disturb disease management and also worsen the clinical status of patients. Besides, vision loss has been reported as one of the most fearful health events, and a greater proportion of sighted people feel fearful when imagining blindness.^{34,35} Moreover, there are contextual limitations that can cause psychological distress in patients, including limited access to healthcare and information, poverty, pity behaviors, inequity, social stigma, and mobility challenges.^{7,12,35}

4. Conclusions

This phenomenological journey into the lived experiences of patients with blindness revealed that this group of clients faces stereotypical hospital care when they are admitted to Iranian hospitals. This study highlighted the central role of nurses in providing holistic care for patients with blindness because the participants, despite not receiving personalized care, described nurses as their own eyes. However, providing holistic and comprehensive care for people with blindness requires holistic attention for all needs of patients. Health professionals particularly nurses should increase their awareness and sensitivity about people with blindness through professional mechanisms such as empowering the basic nursing curriculums, continuing education, personnel development, and other periodic education. Further research on this subject can be focused on emancipatory interventions to change the healthcare system and establishment of infrastructures for personalized care and healthcare justice for people with visual impairment.

5. Implications for practice

In addition to the general readiness of hospitals for visually impaired people, hospital leadership needs to design and establish holistic and person-centered

clinical guidelines and standards for people with blindness to be used during admission, hospital stay, and follow-up. Moreover, nursing leadership can especially conduct curriculum-based and in-service courses to improve the nurses' skills for providing appropriate care for people with blindness.

Limitations

In qualitative studies, including phenomenology, the findings cannot be simply generalized to the entire population, and it is necessary to do this with consideration. This study was conducted with participants from Tehran, the capital of Iran, and from Ardabil, a city in north-west Iran, and recruitment of participants from other provinces was not possible. We could have enhanced the quality of the study by conducting interviews from diverse regions. In addition, almost 50% of the patients had been discharged from the hospital more than a month before the study which could affect the trustworthiness of the study. Some of the patients were congenitally blind and on the other hand in some of them, blindness occurred during childhood. Therefore, the experiences of acquired blindness may differ from congenital blindness. Further studies need to be conducted to improve the quality of clinical care and coordination of care for blind people.

References

1. Pow CP. "Sense and sensibility": social-spatial experiences of the visually-impaired in Singapore. *Singap J Trop Geogr*. 2000;21:166–182.
2. Fiorio G. The ontology of vision. The invisible, consciousness of living matter. Hypothesis and theory. *Front Psychol*. 2016;7:89.
3. Ardiel EL, Rankin CH. The importance of touch in development. *Paediatr Child Health*. 2010;15:153–156.
4. GBD 2019 Blindness and Vision Impairment Collaborators, Vision Loss Expert Group of the Global Burden of Disease Study. Trends in prevalence of blindness and distance and near vision impairment over 30 years: an analysis for the Global Burden of Disease Study. *Lancet Glob Health*. 2021;9:e130–e143.
5. Ernst MO, Bühlhoff HH. Merging the senses into a robust percept. *Trends Cogn Sci*. 2004;8:162–169.
6. Mclinden M, Mccall S. Learning Through Touch: Supporting Children with Visual Impairments and Additional Difficulties. New York: Taylor & Francis; 2016.
7. Shamshiri M, Mohammadi N, Cheraghi MA, Vehviläinen-Julkunen K, Sadeghi T. Disciplined care for disciplined patients: experience of hospitalized blind patients. *Holist Nurs Pract*. 2013;27:344–348.
8. Simeone S, Pucciarelli G, Perrone M, et al. Lived experience of patients with glaucoma glaucoma: a phenomenological study. *Prof Inferm*. 2017;70:178–186.
9. Evans JR, Fletcher AE, Wormald RPL. Depression and anxiety in visually impaired older people. *Ophthalmology*. 2007;114:283–288.
10. Lopez D, McCaul KA, Hankey GJ, et al. Falls, injuries from falls, health related quality of life and mortality in older adults with vision and hearing impairment – is there a gender difference? *Maturitas*. 2011;69:359–364.
11. Harris CM, Wright SM. Severe vision impairment and blindness in hospitalized patients: a retrospective nationwide study. *BMC Ophthalmol*. 2021;21:263.
12. Sharts-Hopko NC, Smeltzer S, Ott BB, Zimmerman V, Duffin J. Healthcare experiences of women

Authors contributions

M.S. (corresponding author) developed the study topic in addition to the main data analysis. M.H. carried out the second data analysis as part of ensuring rigor in qualitative studies. S.M. performed database searches and wrote the first draft of the manuscript. M.A.M. supervised the research project. All authors discussed the results and substantially contributed to the final manuscript.

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Ethical approval

This study was approved by the ethics committee of Ardabil University of Medical Sciences (IRB approval number: 9319.1393-11-21).

Conflict of interest

There is no competing or conflict of interest to declare.

- with visual impairment. *Clin Nurse Spec*. 2010;24:149–153.
13. Kopp K. Staff lack vital skills in caring for visually impaired people. *Nurs Times*. 2013;109:11.
 14. Van der Aa HPA, Hoeben M, Rainey L, van Rens GHMB, Vreeken HL, van Nispen RMA. Why visually impaired older adults often do not receive mental health services: the patient's perspective. *Qual Life Res*. 2015;24:969–978.
 15. Schneider K. Caring better for patients who are blind or visually impaired. *Am Fam Physician*. 2013;88:774.
 16. Bynum W, Varpio L. When I say ... hermeneutic phenomenology. *Med Educ*. 2018;52:252–253.
 17. van Manen M. *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*. New York: Taylor & Francis; 2016.
 18. van Manen M, van Manen M. Doing phenomenological research and writing. *Qual Health Res*. 2021;31:1069–1082.
 19. Heinonen K. van Manen's method and reduction in a phenomenological hermeneutic study. *Nurse Res*. 2015;22:35–41.
 20. Creswell JW, Creswell JD. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. California: SAGE Publications; 2017.
 21. McConnell-Henry T, Chapman Y, Francis K. Member checking and Heideggerian phenomenology: a redundant component. *Nurse Res*. 2011;18: 28–37.
 22. Stevens S. Assisting the blind and visually impaired: guidelines for eye health workers and other helpers. *Community Eye Health*. 2003;16:7–9.
 23. de Carvalho AT, da Silva ASR, Fenandes AFC, et al. Health education for the blind: evaluation of accessibility of an inclusive online course. *Creative Educ*. 2014;5:1559–1566.
 24. Beverley CA, Bath PA, Booth A. Health information needs of visually impaired people: a systematic review of the literature. *Health Soc Care Community*. 2004;12:1–24.
 25. Heydarian NM, Hughes AS, Morera OF, Bangert AS, Frederick AH. Perspectives of interactions with healthcare providers among patients who are blind. *J Blind Innov Res*. 2021;11:10.5241/11-206.
 26. Wang Z, Xu X, Han Q, Chen Y, Jiang J, Ni GX. Factors associated with public attitudes towards persons with disabilities: a systematic review. *BMC Public Health*. 2021;21:1058.
 27. Jeamwatthanachai W, Wald M, Wills G. Indoor navigation by blind people: behaviors and challenges in unfamiliar spaces and buildings. *Br J Vis Impair*. 2019;37:140–153.
 28. Plikynas D, Žvironas A, Budrionis A, Gudauskis M. Indoor navigation systems for visually impaired persons: mapping the features of existing technologies to user needs. *Sensors (Basel)*. 2020; 20:636.
 29. Virgili G, Rubin G. Orientation and mobility training for adults with low vision. *Cochrane Database Syst Rev*. 2010;2010:CD003925.
 30. Giles SJ, Panagioti M, Riste L, et al. Visual impairment and medication safety: a protocol for a scoping review. *Syst Rev*. 2021;10:248.
 31. Carignan M, Rousseau J, Gresset J, Couturier JA. Content validity of a home-based person-environment interaction assessment tool for visually impaired adults. *J Rehabil Res Dev*. 2008;45:1037–1051.
 32. Han CJ. A concept analysis of personalized health care in nursing. *Nurs Forum*. 2016;51:32–39.
 33. van der Aa HP, Comijs HC, Penninx BW, van Rens GH, van Nispen RM. Major depressive and anxiety disorders in visually impaired older adults. *Invest Ophthalmol Vis Sci*. 2015;56:849–854.
 34. Giridhar P, Dandona R, Prasad MN, Kovai V, Dandona L. Fear of blindness and perceptions about blind people. The Andhra Pradesh eye disease study. *Indian J Ophthalmol*. 2002;50:239–246.
 35. Demmin DL, Silverstein SM. Visual impairment and mental health: unmet needs and treatment options. *Clin Ophthalmol*. 2020;14:4229–4251.