OPTOMETRIC CARE

ITS CHANGING SCOPE

by

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Senior Studies

A review of the literature

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Displaying one of nature's most evident signs of good health, optometry is growing, expanding its borders. Education, new technology, and the use of mydriatics have combined to greatly improve diagnostic capabilities. Methods of treatment are also changing as state practice acts are amended to allow the use of therapeutic agents. Concomitant with these changes has been an evolution within our legal system by which the profession's standard of care has become increasingly indistinguishable from that held by ophthalmology.

Ironically, optometry initially sought and gained its professional identity through refracting opticians arguing that it was not a branch of medicine. Using this argument to place its proverbial foot in the door, optometry acquired separateness from medicine by legislatively fathering its own guidelines for licensure and regulation. Charles Prentice succinctly summed up optometry's original, purely functional responsibility, saying "an optometrist treats light."[1]

Two major components which added drive to an upswelling interest in ocular health were complications from contact lens wear, and glaucoma with its devastating endpoint and relatively high incidence. In January 1968, a group of influential figures met to informally discuss the future of optometry, led by Dr. Alden Haffner, then dean of the College of Optometry at SUNY, the group concluded that optometry should expand its scope to include the diagnosis and treatment of ocular disease.[2] They realized that education would have to change before legislators could be convinced to amend state practice acts.

Shortly thereafter these educational changes began with a few schools strengthening their courses in ocular anatomy, physiology, pharmacology and

pathology. Not far behind were legislative changes. Between 1971 and 1982 29 states amended their practice acts to include diagnostic pharmaceuticals. In 1976 West Virginia became the first state to allow both diagnostic and therapeutic agents. Currently all 50 states allow diagnostics and 25 allow therapeutics as well.

With the option of moving optical correction from the spectacle plane to the corneal plane came quite naturally an added interest in anterior segment pathology. Practitioners were drawn into knowing and understanding the anterior segment when the very device they dispensed could occasionally cause or enhance complications such as: bacterial keratoconjunctivitis, superior limbic keratoconjunctivitis, and corneal pathologies such as neovascularization, edema, abrasions, and ulcers. Corneal abrasions present as one of the most common problems and without proper treatment can potentially be the most devastating. Ulceration can progress so quickly that here common sense and the courts strongly agree that the medical standard for treatment must be followed and that referrals for such treatment must be made without delay.

A common cause for litigation in the past and still is yet today is failure to diagnose glaucoma. In 1971 a case decided by the Washington Supreme Court questioned the long-held standard that stated a practitioner must provide care with a degree of skill, care, and knowledge that a reasonable and prudent practitioner in good standing would provide in like circumstance. Here the court demanded strict liability and held the physician negligent regardless of his following the existing standard of routinely performing tonometry only on patients over 40 years of age. A long term contact lens patient was eventually tested at the age of 32 and was found to have glaucomatous fields of only 10°. The concept of strict liability was hotly debated and has yet to resurface in the

courts. The widely publicized case did leave its mark though as it is now standard for eye care providers to perform tonometry routinely on all those patients on whom it is possible.

The use of mydriatics is another plot of medical territory where optometry has joined with ophthalmology in occupation. Here as well, the courts are holding optometrists to the medical standard of care. Reasons for litigations which have appeared against optometrists include: misdiagnosis, negligence in failing to dilate or refer for dilation when signs or symptoms require it, and also failing to inform the patient of examination findings. The question of on whom, when, and how often should dilated fundus examinations be performed can be answered quite simply (legally, anyway) - follow the current ophthalmologic standard.

The areas discussed just begin to address the breadth of change that optometry has undergone from its beginning, purely functional role. Optometry originally gained its professional identity by claiming its separateness from medicine, and yet since thus getting its foot in the door, has slowly crossed the threshold and is progressing patiently along medicine's guarded halls. The addition of diagnosis and treatment of ocular diseases to the scope of optometric practice adds challenge and excitement while also increasing the quality of patient care. Such growth will keep the profession healthy.

NOTES

1. John G. Classe, O.D., J.D., "optometry: a legal history", Journal of the American Optometric Association, Aug. 1988, p. 644.

2. Milton J. Eger, O.D., "Our Optometric Heritage," Journal of the American Optometric Association, April 1989, p. 324