EDITORIAL

APPLYING A DISEASE MODEL TO BEHAVIORAL OPTOMETRY

I am privileged to have observed the evolution of the treatment of eye disease by the profession of optometry. Over the last 40 years optometry has become a major player in that arena. The profession now treats many conditions, depending on state law, with topical, oral, and injectable medications. By and large this is true for the overwhelming number of optometrists whose practices are now termed "full scope." There are times, however, when the pathological condition is beyond the comfort level of the primary care optometrist. When this occurs, the generalist will enlist the assistance of a specialist. Of course, a network of referral/consultation has been in place with our medical colleagues in ophthalmology, neurology, pediatrics, family medicine, physiatry and others for years. However, an elaborate network of consultation and referral has been developed to assist the OD with these difficult pathology cases, *within optometry*.

I am surprised by how swiftly this optometry-optometry network has developed. It is unique in that the networking is specifically within the profession. Consultation and referral centers manned by optometrists are available for the primary care optometric practitioner. When it becomes clear that a presenting pathological condition is not responding to treatment, or the condition is something that the doctor does not feel comfortable treating, the referral center is called and a consultation is requested. The use of such services insures that the patient with an eye pathology is treated at an appropriate level and keeps the referring optometrist as an integral part of the treatment. At the same time, it helps ensure that the eye surgeon is working at his highest level of care, in the surgical suite. This model also ensures that the patient returns to the primary care optometrist for all future optometric care. This is a very efficient and cost sensitive way to deliver eye and vision care to the public. This system should be continued, encouraged and expanded.

This system is also applicable to behavioral optometry, most notably, vision therapy (VT). Unfortunately, at the moment it appears that the primary care optometrist does not offer VT, and many optometric students perceive VT as a specialty area within the profession. My firm contention is VT has a place in the primary care optometric office. The curricula in every school and college of optometry in the United States includes courses in the diagnosis and treatment of anomalies of binocular vision and impaired visual information processing. As such, VT is part and parcel of primary care optometry. Yet, if practicing optometrists were polled today, relatively few would report that they routinely provide in-office VT. This is because of the specialty status attributed to VT. Supporting this specialty model is the fact that for over 40 years the College of Optometrists in Vision Development (COVD) has been testing and certifying specialty status to those who have completed its fellowship process. Indeed, VT is both part of primary optometric care and a specialty area. Just as the primary care optometrist treats certain eye diseases, he/she should also treat vision conditions that require VT. And, just as the primary care optometrist will consult with specialty care when the condition is beyond his comfort level, as with pathology, so should the primary care optometrist consult with a specialist in VT when the condition is also beyond his or her comfort level.

The system that I have long advocated to my students is two tiered and mirrors the primary care, medical model. The primary care optometrist is responsible to identify and treat ALL eye and vision problems that present to that office. In the case where VT is indicated, treatment can entail all the armamentarium allowed by the particular state law. Lenses, prisms and other optical devices and yes, pharmaceuticals (e.g., atropine for amblyopia) are all tools for behavioral optometrists. Advice as to visual hygiene, the use of filters, occluders, magnifiers and lighting systems are also part of primary care. Optometry should also consider basic optometric VT as part of the primary care package. The basic diagnosis of symptoms and signs of ocular motor, binocular, accommodative and visual information processing deficits that are not alleviated by lenses and/or prisms should be treated with basic VT procedures. Furthermore, this should be accomplished in the primary care optometric office.

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accomplished in the primary care optometric office.

I would like to suggest the following protocol based on the primary care medical model of optometry. When a patient is diagnosed with a problem that requires treatment beyond lenses and prisms, a course of VT is offered by the primary care optometrist. The conversation with the patient/parent might go something like this:

> *Mr./Mrs. Jones, I have made a diagnosis of (fill in the blank-ocular motor, binocular, accommodative and/or perceptual dysfunction). This condition will require treatment more than lenses to solve this problem. It will require a specialized type of therapy that encourages the nervous system to learn to adequately control (fill in the blank-eye movements, eye teaming, focusing, information processing). My recommendation is that we institute such a program with you/your child. I will design the procedures and my staff will administer the therapy.*

Such a scenario is an example of verbage that might be used to talk to patients and initiate treatment of the condition at the primary care level. Of course the caveat is that the optometrist must believe that treatment is well within his or her competency. And, as is the case with ocular pathology, when this is not so, or the patient is not responding appropriately, a referral must be made. I suspect that if the primary care optometrist follows this plan, he would soon find an increased confidence in his ability to offer effective VT. The profession can feel comfortable that there are specialists to consult when the case is outside the doctors' comfort level. This two tiered delivery system should work as well for VT as it does for ocular pathology.