GUEST EDITORIAL

NO SURPRISE

ROCHELLE MOZLIN, O.D.

After graduating from optometry school, I completed a Residency in Vision Training at State University of New York State College of Optometry (SUNY), and then became a member of SUNY's faculty. I have viewed changes in optometric education from the perspective of a student and a resident, but primarily as a member of SUNY's clinical faculty. Over the last several years, three external forces have had a significant impact on both optometry and optometric education: the increasing scope of practice, the rise of managed care, and the cost of an optometric education. Taken together, these forces have created a challenging environment for all optometric educators, but especially for behaviorally-oriented clinicians.

A recent evaluation of the curricula of United States optometry schools listed classroom and clinical education hours devoted to each of eleven topic tracks.[1] From 1992 to 1996, an average of 200 hours was added to the optometric curriculum. These additional hours were almost exclusively devoted to clinical education. In the classroom, hours in the basic science tracks decreased 140 hours in order to increase hours in ocular disease by an equivalent amount. The average number of total curriculum hours devoted to ocular disease is more than twice that devoted to vision therapy (338 v. 146). *It is no surprise that as the average age of the optometrist practicing in the United States declines, so does the percentage practicing vision therapy.*[2]

The de-emphasis of behavioral vision care is not merely reflected in curriculum hours. Suchoff[3] proposes that a residency-trained primary care faculty is indoctrinating students with a clinical philosophy centered around the detection and treatment of ocular disease. If behaviorally-oriented faculty must wait until the students are assigned to specialty clinics in the fourth year, they are confronted by students with an "embedded" philosophy of patient care. Attempts at "disembedding" are often too little, too late. *It is no surprise that as the average age of the optometrist practicing in the United States declines, so does the percentage practicing vision therapy.*

The clinical experience that students receive in vision therapy and other behaviorally-oriented clinics is less than optimal. Students typically spend 10-12 weeks in the service as they rotate through all the specialty clinics. Factor in a high percentage of patients with poor compliance, low motivation, and multiple biosocial problems,[4] and the equation does not equal successful outcomes. Many students finish their clinical rotation with the concept that "vision therapy doesn't work." *It is no surprise that as the average age of the optometrist practicing in the United States declines, so does the percentage practicing vision therapy.*

Managed care has driven down optometric fees and forced optometrists to see more patients. The clinics at the colleges of optometry are no exception, and clinical faculty struggle to find the time to manage an expanding patient load. Behavioral vision care can be very time-intensive, as the doctor gathers information from other professionals and prepares lengthy reports, and most managed care plans exclude coverage for vision therapy services. The message conveyed to the student is "make a choice—managed care or vision therapy," and nobody wants to write those lengthy reports anyway. *It is no surprise that as the average age of the optometrist practicing in the United States declines, so does the percentage practicing vision therapy.*

My tuition bill for my last year of optometry school was $5300. I graduated from the New England College of Optometry in 1981 with student loans totaling $15,000. My monthly payments were $173. Today, the average tuition bill approaches $12,000/year.[5] Many graduates have student loans totalling as much as $140,000, and the average monthly payment on that debt is $1200. Some graduates are facing monthly payments as high as $1700. This financial burden makes commercial practice very alluring to graduates who seek positions with guaranteed incomes. They are not able to settle for less money today in order to build a future in a professional practice. Students seem to spend less time discussing practice opportunities and more time discussing jobs. *It is no surprise that as the average age of the*

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The response of many behaviorally-oriented optometric educators has been to learn to live with the JND (just noticeable difference). If one student in the graduating class is accepted into a vision therapy residency program or attends a behavioral optometric meeting, they rejoice. I have been less content to measure victory in single digits. I feel compelled not only to maximize but to create opportunities to teach my students "full-scope optometry" in both the clinic and the classroom. My greatest investment toward this goal has been as the instructor for a third-year course entitled "Vision and Learning." Every year I attempt to place more emphasis on adult learning principles and case presentations, and less on a structured lecture format with multiple choice exams. I have given my students more responsibility for learning by stressing creative, interactive and clinically-based activities. This year I required students to write a short "clinical question paper." They were allowed to select from a list of 22 clinical questions, and given the choice of either a traditional paper or multimedia format. I encouraged them to select the multimedia format by allowing them to work in pairs, but only 14 (out of 75) students selected this option. These students produced patient education brochures, electronic presentations, web sites, and a radio advertisement. The outstanding quality of the papers and projects was initially quite startling, but then served as a reaffirmation of my own concept of effective teaching. I afforded the students recognition for their efforts as well as an opportunity to learn from each other by showcasing selected papers and projects. I invited Service Chiefs, the Department Chair, the Assistant Dean and the Dean. The students appreciated a degree of support for this portion of the curriculum from the administration, and the administration was able to perceive the power of behavioral optometry in the minds and hands of the students.

It should come as no surprise to behavioral optometrists that creative, interactive and integrative activities result in learning. I will continue to use these basic principles to reach out to third-year students at SUNY and perhaps measure victory in double digits, but clearly that is not enough. The problem extends beyond the reach of optometric education. Every behavioral optometrist must develop creative, interactive and exciting opportunities to involve potential applicants, applicants, students and graduates in our brand of patient care. If we don't, then there will be no surprises in the next survey of practice patterns of optometrists in the United States.

References

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Corresponding author:
Rochelle Mozlin, O.D.
SUNY State College of Optometry
100 East 24th Street
New Youk, NY 10010

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