

STANDARD HEALTH CARE TERMINOLOGY: What Part of the Specialty Is Primary Care and What Part Is Secondary Care

For many years optometrists involved in the diagnosis, management and treatment of patients manifesting binocular vision and/or visual perceptual motor deficiencies have had what appears to be an identity crisis. They have used terminology such as behavioral optometry, functional optometry and developmental optometry to describe their area of interest. Although these terms may relate to the area's content, they do not relate to present day optometric terminology. I believe they create confusion within optometry and other professions with whom we interact. At present, these terms appear to have questionable value. Other terms such as primary care, secondary care and tertiary care are standard for health care providers, insurance companies and political bodies. It may be time for us to join mainstream health care. The term "primary care" is not new to optometry. Unfortunately, many practitioners, academic clinicians and optometric authors use this term to exclusively characterize the diagnosis, management and treatment of ocular disease.

I will raise two questions. First, what is primary care and how does it relate to the detection, diagnosis, management and treatment of binocular vision and visual perceptual motor deficiencies? Second, should the detection, diagnosis, management and treatment of these aspects of visual function be considered primary or secondary care either in part or completely?

Primary care is the entry point to the health care delivery system. The role of the primary care optometric practitioner

is to evaluate the visual system for the detection and diagnosis of refractive errors, systemic and ocular disease, binocular, accommodative, oculomotor, visual perceptual motor, low vision deficits and other conditions. These conditions will require management and treatment either by the examining optometrist, other optometrists or other health care providers. The optometric practitioner who does not detect and diagnose all of these conditions is not practicing primary care optometry. It should be apparent in this context that ocular disease is but a single, though certainly not insignificant, aspect of "primary care."

In the past, optometric referrals were mainly made to ophthalmologists, with occasional infrequent referrals to the patient's family physician. Today, depending on the specific needs of our patients, we find ourselves referring our patients to endocrinologists, cardiologists, pediatricians, neurologists and to other medical and health care practitioners. In fact, those patients requiring ophthalmological care are generally referred to retinal specialists, cataract specialists and anterior segment specialists for their specific expertise. In addition, primary care optometric practitioners should be referring patients requiring secondary level optometric services to those optometrists who have demonstrated appropriate interest and expertise. Unfortunately, this does not always occur.

Why is referral to the appropriate "expert" imperative? The answer is simple. Problems in all the areas of our responsibility may effect the patient's quality of life and, in some cases, life itself. A

practitioner who ignores the effect of a particular problem on the behavior and performance of his/her patient is effecting the quality of life of this patient and is potentially guilty of malpractice. He or she is certainly guilty of lack of concern.

This leads to an issue which must be addressed by those of us more interested and more expert in the "specialty" areas. As a result of the proliferation of literature and research in all areas of optometry, it has become virtually impossible to be expert in all aspects of the profession. Further, not all optometrists wish to provide secondary care in all areas of optometry, but all who practice primary care optometry must possess a basic level of competence in all areas. Consequently, it is incumbent upon those within the "specialty" areas of the profession to ascertain the degree to which each "specialty" area is included in primary care and define what constitutes secondary care.

Let's consider the "specialty" of binocular vision and visual perceptual motor development with all its related sub-areas. Should every optometrist be able to recognize the signs and symptoms and diagnose deficiencies in binocular vision, both strabismic and non-strabismic? Should they be able to recognize the signs and symptoms and diagnose deficiencies in accommodative posture, range and facility? Should they be able to recognize the signs and symptoms and diagnose oculomotor deficiencies, be they pursuits, saccades or the ability to maintain fixation?

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