# GUEST EDITORIAL

# IS THERE ROOM FOR "OLD-FASHIONED" CARE IN THIS ERA OF THE "NEW TECHNOLOGY" AND IS BEHAVIORAL OPTOMETRY "OLD-FASHIONED" CARE?

Clearly, a significant change has occurred in the health-care field and optometry is in the midst of it.

Legal responsibilities have increased and with them the demand for more detailed information. Insurance and prepaid programs have proliferated markedly. Competition has increased enormously. We are "bombarded" with the message: "You need more automated equipment and you need to delegate information gathering"--and the ultimate message is: "You Need to Become More EFFICIENT TO SURVIVE."

Automated equipment allows more detailed information but results in more costs. This must be met by either higher fees, which third parties discourage, or more patients per time, which requires more assistants and automated equipment.

In our opinion, it has resulted in a significant loss in direct contact between the practitioner and the patient. We find what has happened to be troublesome!

There are probably many optometrists who are professionally and personally content to practice in this manner, who see a value in their services, and who receive feedback from patients and their own colleagues that they are doing a "credible job."

However, for those of us who are beginning to understand the process/function of vision and its pervasive impact on behavior, it does not seem that the clinical information the "new technology" provides is enhancing that understanding. Is it possible to translate numbers and pictures into a true recognition of who the "see-er" is? After all, there is a "person" behind those eyeballs!

Can we help patients to expand their physiologic/perceptual processing while maintaining "minimal contact" with those patients (what is now referred to in management articles as "quality time")?[1]

An important aspect of the healing process has been an understanding of symptoms as an expression of the need for change. Developing that understanding takes time and is too difficult to do by oneself. It seems to us that the symptom- oriented clinical model, the companion to the new technology, reduces awareness and permits patients to function at less than desirable levels. It does not offer an opportunity for people to experience the relationship between those visual/ocular findings and their lives. They become, instead, the victims of their parts--that "rotten" left eye that is showing a higher refractive "error," that "miserable" accommodative-convergence mechanism which gives them a variety of asthenopic symptoms, etc. We are certain that you can recognize the equivalents in the other health-care fields.

We acknowledge that there is a "flip side" to our discussion. Some patients have had their sight, and even their lives, saved as a consequence of the information obtained through sophisticated (and expensive) equipment. To these people and those who care about them, everything else is secondary. However, is it proper that this technologic thrust continues to be the primary mode by which all patients are evaluated? Are the needs of all those other patients secondary? We believe not.

We feel that there is a need to recognize and acknowledge that a significant body of valuable clinical information about people is lost when data gathering is placed primarily in the hands of technicians who do not have to make judgments about, and recommendations to, the patients they service.

Without THAT information, how do we treat patients--as a whole person?[2] How can we, when our time and observations are limited, ascertain who that "whole person" is? How do behavioral optometrists continue to practice in a manner consistent with what they believe is necessary and meaningful in an era in which "time is money," "delegation = survival,"[3] and you are reminded that it will probably get worse? Is "holistic care" becoming too old-fashioned to exist and is behavioral optometry too "old- fashioned"?

## References


1. (Editorial) Better timing. Rev of Optom; Jan, 1991.
2. (Pamphlet #B-127) Optometric Extension Program. What is behavioral optometry? 1988.
3. Borish, IM. Delegation = survival. Optom Econ; Sept, 1992.



Guest Editors:
Abraham Shapiro, O.D.
21 Polly Dan Road
Burlington, CT 06013
Jack Esterson, Ph.D.
491 Griswold Street
Glastonbury, CT 06033


Date accepted for publication:
May 19, 1993