# EDITORIAL

# STANDARD OF CARE

Behavioral optometrists have long been advocates for the functional and developmental concepts set forth, notably by the Optometric Extension Program Foundation and by the College of Optometrists in Vision Development. Other organizations such as the Australasian College of Behavioural Optometrists along the Pacific Rim and the British Association of Behavioural Optometrists in the United Kingdom have carried the message of functional optometric care around the world. The Mexican optometric community is very active. There is also increasing interest in behavioral optometry by practitioners in Asia, continental Europe, Central and South America. Times are truly exciting for the profession. But, with the geographic expansion and of the scope of practice of optometry we must not lose fact of our need to follow accepted guidelines. We need to insure that we are practicing by what is considered an ethical, legal and therefore appropriate standard of care for all our patients. The standard of care is ultimately governed by the scope of practice in ones particular state or nation.

It appears that the standard of care, in the United States, is encompassed by the American Optometric Association (AOA) Clinical Practice Guidelines. Indeed, those can be viewed as a minimal examination sequence or standard of care.[1] The adult optometric examination should include: a history of family, systemic, ocular health; a statement of the presenting problem; medications and vocational/recreational requirements. These minimal tests begin with far/near visual acuity and preliminary tests of near point of convergence, pupillary responses, ocular motilities, cover test, accommodative amplitude, stereopsis and color vision. Of course, refraction is performed. In addition, binocular vision and accommodative functions should be measured. Other supplemental testing should be considered and performed where indicated.

It is always necessary to assess the health of the eyes and perform a systemic health screening. An explanation of the examination process is, "Pharmacologic dilation of the pupil is generally required for thorough evaluation of the ocular media and posterior segment….initial examination may indicate the appropriate timing for subsequent pupillary dilation."[1(p7)] Further, the AOA recommends that adults up to age 40 need only to be examined every 2 to 3 years unless they are at risk. Over 40, the recommendations change for the nonrisk patient to every two years, until 60 years. The at-risk adult patient is however recommended to be seen every 1 to 2 years until 61. From 61 years upward, one should be evaluated annually.

The pediatric examination is much the same.[2] It is clear that the AOA considers the standard optometric examination to be a serious and comprehensive evaluation of the structure and function of the eye and the vision system. Anything less would appear not to be following the standard of care set forth by the AOA and dictated by the ethical standards of the profession.

Without following a minimal examination, it is impossible to adequately diagnose many of the conditions that are incumbent upon the optometrist to diagnose and treat. I suspect the optometrist or the ophthalmologist who states, "I just do not see that many convergence insufficiencies," may indeed not be performing the minimum number of tests to detect convergence insufficiency (CI) or other binocular conditions. If indeed, you find yourself in this situation of not diagnosing many binocular conditions, you may want to ask yourself if you are performing the minimum tests necessary for today's standard of care.

Recent papers[3,4] list a number of clinical findings that are necessary to rule out CI. These minimal procedures include a complete case history with a quality of life survey to document symptoms. In addition, a near point of convergence, distance and near phorias and near point vergences are necessary to adequately diagnose CI. This diagnosis is important for your patients, since it has been shown that these conditions are related inversely to one's quality of life and to ones academic achievement.[5-7]

If a diagnosis of CI has been made, then optometry's standard of care requires that the condition be addressed. For the asymptomatic CI, one may consider education of the patient/parent as to the signs and symptoms of the condition. Visual

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hygiene recommendations to negate the potential impact of CI on the patient's overall quality of life should also be considered. If, however, the symptoms are significant [16 and higher for the Convergence Insufficiency Treatment Trial (CITT) for children; or 20 and higher for the CITT in adults or 20, or higher for the College of Optometrists in Vision Development-Quality of Life (COVD-QOL)], then treatment should be offered as a minimal standard of care.

As shown by the CI Treatment Trial,[3,4] the most effective therapy for CI is in office optometric vision therapy (VT). VT was the only significantly effective therapy of those investigated in the study. If you do not offer VT in your clinic/office, then the reasonable course of action is to consult with or refer to an optometric colleague who does offer this service. This is the minimal standard of care demanded. If, however, you have considered VT in the past and for some reason have not followed through on this area of optometric care, may I encourage you to do consider offering VT in your office?

There are a number of good practice consultants who are available to assist you in beginning a VT practice, for example, Toni Bristol or Thomas LeCoq. There are also excellent postgraduate educational programs to assist you to reacquaint yourself to VT. With proper training of the optometric office in the use of staff and the effective delivery of VT, your office can begin to serve this largely neglected aspect of optometric practice. In offering VT in your office you will also be insuring that you are practicing the minimum standard of care.

## References


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