EDITORIAL

ON OVERKILL

I recently purchased a new cordless telephone and notebook computer within the span of a single week. After the flush of having two new toys wore off, I got down to the business of operating these pieces of equipment. What became increasingly apparent was the number of options and features that each contained which I'll probably never use.

This is just another form of overkill that permeates our society. Our laws often overprotect the criminal but fail to provide the same degree of protection to the victim. In schools, it seems that there is frequently a bias to accommodate the disruptive child at the expense of the rest of the class. Our need for political correctness required that someone who is not computer literate to be described recently as "technologically challenged." Our obsession with personal health has led to an overkill in sports; people who should know better sustain knee and hip injuries by excessive running, and head and other bodily injuries from roller blading. Our overkill on eating the "right foods" has been quite confusing. Mayonnaise and margarine, which previous research indicated was bad for you, have been put in the "eat column" because they have been found to contain vitamin E.

I propose that American overkill is the excessive response to a particular event or phenomenon. It is a "knee jerk" reaction, sometimes to correct previous injustices, and sometimes brought about by the sound bites so commonly used on television and radio, or by incomplete reporting in the print media. The common result is that the public responds without fully understanding the underlying event or phenomenon, or the consequences of the newly condoned public reaction. This overkill, being a societal characteristic, produces a ripple effect. It has been particularly adopted by industry and higher education, as evidenced by current massive downsizing and cost containment. While there is good evidence that in both organizational structures some trimming of the fat was necessary, it is becoming increasingly evident that this overkill frequently occurs without adequate consideration of comparing the immediate gains against the long term consequences.

Which leads us to optometry. Now, I, with at least some of our readers, can remember the time when the most recognized meaning of the term "laser" was the butcher who wanted to marry Tevye's daughter in the play "Fiddler on the Roof." That this has changed drastically is evidenced by the fact that on the front page of the N.Y. Times on April 8, 1996 there appeared an article entitled "Optometrists Clash with M.D. Rivals Over Laser Process." Understand that this is the first time in my recollection that optometry has made the front page of this daily that is hated by some, loved by others, yet read by all.

The article, authored by Jonathan Rabinovitz, puts the recent legislative efforts of optometry, particularly in Connecticut, to gain the right to perform photorefractive keratectomy (PRK) in the context of a continually expanding scope of practice. However, Mr. Rabinovitz makes it clear that optometry's desire to enter this realm, and ophthalmology's desire to exclude optometry, are both motivated primarily by the "pot of gold shining in front of both groups" in a potential $10 billion dollar industry. This is not a trite consideration for both professions, as the article points out, in a time of reduced reimbursement from managed care.

It would appear from this article and by a relative lack of overt opposition, that optometry is solidly behind this move to use lasers. If this is the case, have we, as a profession, adequately engaged in long range and strategic planning; have we truly looked at all sides of the question? It is an important concept because this issue goes beyond the use of lasers; it goes to the more substantial issue of redefining the profession of optometry.

There can be little doubt that the age of lasers in eye care is here. The cogent question is the role that optometry takes; shall we strive to be allowed to push the pedal that ablates the cornea, or shall we opt for co-management with ophthalmology, as has been the case with cataract surgery? And if we are granted the right to actually perform the procedure, will this be enough? Is the next logical step laser treatment of diabetic and other retinopathies?

There are those who will say that the same questions could have been raised as we strove for the right to use diagnostic and therapeutic pharmaceutical agents (DPA and TPA). I propose that the laser playing field is quite different. In spite of the not insignificant legisla-

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tive opposition ophthalmology presented for the DPA and TPA battles, we weren't threatening their surgical raison d'être. Although optometric laser use is currently granted in two states, it is probable that ophthalmological opposition will be of a far greater magnitude in this arena than was evident for DPAs and TPAs. Do we have, and are we willing to expend the human and fiscal resources that this battle will require?

An optometric strength in the current climate of health care politics and economics is that we hold ourselves to be primary care providers of eye care. Is it possible that active optometric participation into what is apparently surgery can compromise our primary care status? Is this a risk worth taking? Further, an often heard complaint of health care providers is that in this era of managed care, the bosses are corporate and bean counter types. The industry of eye laser surgery is dominated perhaps even more by these types than the managed care industry. Do we wish to form still more alliances with these individuals?

There are ethical issues to be considered. Presently a number of optometrists hold high positions in companies that will perform PRK, and other optometrists are being recruited to not only become active referral sources to these companies, but are also encouraged to invest in them.[1] Do these relationships constitute, or can they be perceived to be a conflict of interest?

And finally, have we adequately considered the position of optometric education if we win the battle? This branch is still dealing with the demands placed on it as the states granted first DPA and then TPA privileges to the profession. Curricula that are said to be of a four-year duration are really longer by virtue of the requirement of practically every school and college of optometry for their students to complete summer clinical rotations. The envelope of optometric education has been stretched and is it possible that the instruction required for the use of lasers will provide the breaking point?

All of these questions are not easy to answer. They are certainly worthy of a wider forum than I perceive to have taken place. While the ability to use DPAs and TPAs have gradually changed the face of optometry, the granting of the use of lasers will undoubtedly change the body of the profession. Is this what we really want and is it in the best interest of the public?

The key issue is whether the impending battle to use lasers constitutes an overkill, or rather a requirement for optometry's future maintenance and prosperity. The model we can use is evident in "Fiddler:" for as Tevye, perhaps the prototype long range and strategic planner in the modern sense, often stated when coming to a difficult decision..."On the other hand...."

Reference

1. Scerra CA. Lasers and optometry: changing old lamps for new? Optom Econom, 1996 Winter: 10-16.