EDITORIAL

Growing Pains

The recent annual meeting of the College of Optometrists in Vision Development (COVD) highlighted two areas of clinical practice that are becoming more and more prominent; namely, the increasing liaison between optometry and occupational therapy (OT) and the care of the traumatic brain injured (TBI) patient. While behavioral optometrists have been the driving force behind the involvement in these endeavors, the implications for all optometrists are significant. In both instances, other professionals, particularly OTs and neuropsychologists, have been the catalysts. In essence, these other health care providers became aware that there were options for their patients that were not being offered by the existing health care delivery system available to them. What they've found to be particularly attractive is that not only could the optometrist address issues of ocular health, refractive, binocular, eye movement and perceptual status, but that the behavioral OD is prepared to use these areas as a basis to explain and enhance other aspects of human functioning. Thus, the interaction between the OT and OD offers an expanded understanding of the patient with a vestibular dysfunction, and the TBI patient with a visual field defect is not merely diagnosed by the neuropsychologist, but an array of optical and behavioral strategies become available as a result of optometric involvement. The application of yoked prism and binasal or bitemporal occlusion are examples of the more tangible use of some established vision therapy techniques that have positively impacted on the functional abilities of some of these patients.

Along more theoretical lines, the optometric application of the visual-motor hierarchy has significantly helped both OTs and neuropsychologists further understand the basis of and the potential for rehabilitation of some of their clients' disabilities.

These interactions have not been one-sided. Optometry has gained knowledge from these other fields. Clinical entities such as tactile defensiveness, and post rotary nystagmus[1] have found their way into optometric awareness; new methods of behaviorally specifying the qualitative and quantitative aspects of a compromised visual field have been offered to the profession.[2] Further, patients who would have ordinarily not been referred for optometric evaluation, are now routinely receiving this type of care.[3]

However, as with many things, expansion involves some growing pains. There are a number of issues that are surfacing and need to be addressed. I am convinced that the worst thing to do is to pretend that these concerns do not exist and hope that they go away.

I previously wrote about the uneasiness a number of optometrists have about the interactions with OTs.[4] Undoubtedly, a clear policy about the "give and take" of this relationship, particularly in terms of vision therapy, is needed. I've been informed that this was an agenda item of the Committee on Binocular Vision and Perception of the American Optometric Association (AOA) at a recent meeting. My information is that the Committee will seek input from its counterpart in occupational therapy. In order to maintain the growing and exciting liaison between these two professions, it is key that neither acts unilaterally in this instance.

It's becoming evident that OTs around the country are recommending the inclusion of ODs in their rehabilitation centers. While a number of ODs do serve as staff or consultants in these facilities, undoubtedly more are needed to round out the rehabilitation team. Hopefully, AOA will see fit to either include these centers as part of its effort to gain hospital privileges for ODs, or else commit resources to this end as a separate item.

Optometrists who care for TBI patients bring with them a special understanding and expertise. There is increasing communication between them, and in recognition of this, COVD has broadened the scope of its existing Rehabilitation Committee and the Optometric Extension Program Foundation (OEP) has added a speaker on this topic to its Regional Clinical Seminar program. The growth in this area has been impressive over the past several years. However, a number of colleagues expressed concern to me

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at the COVD meeting, about the term that some practitioners are using to describe this area of care; namely, "neuro-optometry." Interestingly, some nonbehavioral optometrists, who are members of organizations within the profession, have told me of their discomfort with this term. Both groups were unanimous in their opinion that "rehabilitative optometry" would be more appropriate and descriptive. I believe that this is an important issue and trust that this editorial will foster discussion.

As a profession we've experienced our share of growing pains as we've gone through the political and then educational process of having first diagnostic, and now therapeutic pharmaceutical agents added to our scope of practice. Perhaps it's more accurate to state that our recent involvement with OTs and TBI patients has caused more discomfort than pain. Nevertheless, it is in the best interest of the people we serve and the profession to recognize and intelligently deal with the issues that have been raised. All parties have much to gain--let's do this right.

References

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