EDITORIAL

FASTEN YOUR SEATBELTS

In October, 1993, the American Academy of Ophthalmology contracted with the RAND Corporation to conduct a study of the eye care workforce. RAND is a nonprofit institution that conducts health care policy research. The results of the study were reported at the Academy's recent meeting in San Francisco. I received several documents relating to the results, but I found the most meaningful to be the prepublication Executive Summary[1] and the American Academy of Ophthalmology's Preliminary Recommendations on RAND Eye Care Workforce Study.[2]

The goals of the study were:[2](p.1)

- To understand what the public need for eye care is now and what it is likely to be in the future
- To characterize eye care delivery: what services are being provided and who provides them
- To estimate current and future supply of eye care professionals, particularly ophthalmologists and optometrists
- To compare supply with requirements for eye care professionals and understand the implications for ophthalmology, eye care delivery and the public.

The RAND report makes it quite clear that it does not provide definitive answers regarding the supply questions because of a lack of reliable data ..."on the quality of care, patient outcomes, costs, and cost-effectiveness for comparable patients treated by different provider groups."[2](p.xvii) In spite of this, the report should not be taken lightly by optometrists; we are included in a study by RAND that was financially supported by ophthalmology.

It's a good guess that one of the reasons ophthalmology decided to take this initiative relates to recommendations by the Federal Government and the Council on Graduate Medical Education that the number of residency positions in medicine generally, and in the medical specialties more specifically, be reduced in the near future. I feel it's a good bet, too, that the degree to which optometry has successfully pursued an expanded scope of practice was a significant factor.

In any case, it's evident that the RAND study will serve as the impetus and basis for very significant long range planning for individual ophthalmologists and for ophthalmology itself. Indeed, in the preliminary recommendations document[2] some six recommendations are made, along with companion questions and discussion. While all of them have implications for optometry, two are particularly important.

The third recommendation states:

- The provision of **comprehensive eye care by ophthalmologists**—particularly primary eye care, vision care, preventive services and visual rehabilitation--should continue to be emphasized in both training and practice.[2](p.4)

Ophthalmology defines itself as a specialty with subspecialties in cataract, cornea, glaucoma, low vision, neuro-ophthalmology, pediatrics and strabismus, plastics and reconstructive, retina, and uveitis; virtually all of these have surgery as the centerpiece. It is consequently quite significant that it now calls for its members to become dispensers of comprehensive eye care. This constitutes a redirection of the profession. As a matter of fact, the things that are now to be stressed have increasingly been recognized by health care economists and policy makers as the rightful domain of optometry. Nowhere do any of the reports I've cited state how this redirection, which potentially fosters a duplication of services, will benefit the public in terms of the economics of eye and vision care. But the very interesting inclusion is preventive services and visual rehabilitation. While these terms are not clearly defined in the documents I've read, it's not a great stretch of the imagination to assume that they entail at least some of the things that behavioral optometrists have done and continue to do. Further, the provision of preventative and rehabilitative eye and vision services by optometry has received little support but rather a giant dose of skepticism from ophthalmology. Under the discussion of this recommendation it is stated:

> The RAND study indicates that the needs of the public for preventative care, primary eye care, medical treatment and rehabilitation are much greater quantitatively than the need for surgery.[2](p.13)

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This is something that optometry has always known and on which it has based its reason for being. It is something that ophthalmology apparently didn't know—it needed a study to become aware of it—and points out the dangers of overspecialization. I believe there's a lesson here for optometry; it is the potential risk of placing such emphasis on any relatively new area of care, however seductive, so that the more conventional areas—refraction, low vision, vision therapy and contact lenses—gradually become relegated to a secondary role. We need to keep this in mind as new residency programs are planned, and we need to reassess all of our clinical educational programs to guard against a creeping deemphasis on preventative and rehabilitative eye care. Here's a case where we can learn from ophthalmology and not take the same road they followed, but are now planning to leave.

The sixth recommendation states that there should be further study and discussion on:

- How can the delivery of eye care by different providers be better integrated and coordinated to meet the needs of the public?
- How could the education and credentialing of eye care providers be better integrated in order to enhance the provision of care to the public?[2](p.19)

The discussion under this recommendation points out the differences in education, modes of practice and interprofessional networking among the various disciplines engaged in ophthalmic practice. It points out that the lack of integration and coordination of training programs leads to a system of less than optimal patient care, with accompanying duplicative services and increased costs. An integrated educational system with a linked credentialing process is advocated.

Now, while these negatives are valid points, the proposed solution of a single, albeit integrated education system does raise some concerns. First, who would be the major planner and implementer of this system; who would be captain of the team? Further, would a single integrated educational system for opticians, optometric technicians and assistants, ophthalmic nurses, ophthalmologists and optometrists necessarily benefit the public? The argument can be made that nursing was previously dependent upon a similar system, but has found it necessary to increasingly distance itself from it. Further, a great benefit to the public has been two different systems of education between optometry and ophthalmology. It has provided a check and balance situation along with treatment options for patients that would probably be difficult to maintain under an integrated system. And, of course, there is the possibility that this is a velvet glove approach on the part of ophthalmology to establish a greater degree of control and limit the increasing independence of the other eye care professions.

Optometry has undergone profound changes in the past two decades. By contrast, ophthalmology has not. The RAND report signals the beginning of a metamorphosis. There are once again prevailing winds of change that will affect us. My advice to optometrists and optometry ... the price of independence is vigilance ... fasten your seat belts!

References

1. Lee PP, Jackson CA, Relles DA. Estimating eye care provider supply and workforce requirements. Executive Summary; MR-516-AAO Prepublication Copy. RAND, November, 1994.
2. Preliminary recommendations on RAND eye care workforce study. American Academy of Ophthalmology, San Francisco, 1994.