REFLECTIONS ON OPTOMETRIC SCOPE OF PRACTICE WITNESSED OVER ONE CLINICAL EDUCATOR'S CAREER

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10.14434/hindsight.v55i1.40254

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ABSTRACT

An optometric educator offers observations on the profession's scope expansion starting from his entry into optometry school in 1975 to the present.

KEYWORDS

Optometric education, optometric procedures, optometric scope of practice, optometry history

For any piece entitled "reflections," two thoughts immediately come to mind. First, the only persons asked to produce this are assumed to fall into the "old" category. Second, it seems fairly egotistical to assume anyone might be interested in reading it. I have, however, had the good fortune to have enjoyed a number of unique opportunities and experiences. Hopefully, these reflections may offer some insight into the many scope changes our profession has seen over the past 50 years.

Some hint of the changes that would be witnessed may have been evident from the very first day of optometry school. My classmates and I entered Indiana University (IU) in the fall of 1975 as members of the first entering class into the "School of Optometry." Prior to that, it had been the "Division of Optometry." It also marked the first year IU established external rotation sites. The breadth of experiences available at external sites such as these played a significant role in supporting and accelerating scope expansion in optometry.

In terms of optometric clinical practice, this was a time when states were beginning to amend their laws to allow the use of diagnostic pharmaceutical agents (DPAs). Rhode Island had been the first state to specifically authorize DPAs in 1971. We need to qualify it as "specifically authorize" due to a very fortunate optometry practice act passed in Indiana in 1935. A short explanation of that act is warranted, as it had a large impact on optometric clinical education and practice in Indiana.

Indiana rules of practice allow procedures "taught in accredited schools and colleges of optometry" (Rule 3; sec.1.A of the Indiana Practice Act). Further, it allows the "employment of any means, for the purpose of detecting any … condition of the eye" (Sec.4.a), and/or "the furnishing or providing of any prosthetic or therapeutic devices". (Sec.4.b) "Any means" is further described as any physical, mechanical, optical, physiological or psychological therapy. The language of this act therefore allows a wide scope of practice for optometry in Indiana, as long as it is taught in optometry schools. This also meant DPAs were being legally used in Indiana prior to the 1971 Rhode Island law, as their use was being taught in a number of optometry schools and colleges.

During my third year of optometry school (1977-78), DPAs were used in the on-campus optometry clinic, though not extensively. Topical anesthetics were common, with mydriatics less so. In fact, mydriatic drops were kept in a locked cabinet that only consulting doctors could access, and their use was limited. In the summer between my third and fourth years (yes, we had the entire summer off in those days), I volunteered in IU's Illinois Street Clinic in downtown Indianapolis, which had been opened the previous year. Under the direction of Jim Hunter, we practiced full-scope optometry. All patients were dilated, and ocular conditions such as external and corneal disease, iritis and glaucoma were treated by optometry. This had to be a unique and rare experience for an optometry student at that time.

Upon returning to the Bloomington campus clinic in the fall, I "inadvertently" had kept a bottle of tropicamide in my clinic coat pocket. I also purchased a binocular indirect ophthalmoscope (there were only several available to check out) and began to routinely dilate all patients. IU had just established an external rotation in Huntington, West Virginia, and I spent the spring semester of my fourth year at the Huntington VA under the supervision of Jack Terry. West Virginia had passed the first law specifically permitting the use of therapeutic pharmaceutical agents (TPAs) by optometrists in 1976. By 1977, West Virginia, North Carolina and Indiana were the only states using TPAs. Having an external rotation in a TPA state and at a VA that did not have ophthalmology, only optometry, allowed for an outstanding and unique educational opportunity taking care of all eye care needs. In fact, while at this rotation, I performed what we were told was the first fluorescein angiography procedure in the VA system done by optometry.

Due to these exceptional educational experiences practicing broad-scope optometry, I was asked by Irvin Borish to join the faculty and help bring more advanced care into the Indiana University School of Optometry (IUSO) campus clinic. (As an aside: to cite another instance of unique opportunities, how many people can say they fit Irv Borish with bifocal contact lenses—twice?) To paraphrase what I heard Dr. Borish state on several occasions, he wanted optometrists to be loyal and passionate about their profession, but also to be a little dissatisfied. It was this dissatisfaction that would push the profession forward. I believe this is what happened at IUSO and at many other optometry school clinics, where new graduates who had benefitted from the advanced training introduced expanded scope into the campus optometry clinics. Starting in the fall of 1979, routine dilation and treatment of anterior segment disorders was encouraged, and in a few years glaucoma treatment was added in the campus clinic.

The goal of teaching programs is to prepare their graduates to be able to be licensed in any state they might choose. During the time when the passage of DPA and then TPA laws was sweeping the country, it became challenging to have teaching clinics stay at the forefront of the field. If located in a state yet to pass such laws, this experience might have been achieved by utilizing ophthalmology in its programs and clinics. This was also a place where the external rotation sites played a big role in providing this more advanced education. As more and more graduates expressed their dissatisfaction of not being able to utilize the fullest extent of their training, they helped university clinics expand their scope as well as helped states amend their laws.

The next significant event concerning the scope of optometric clinical education occurred in 1981, when Medicare began to allow optometric participation in cataract post-operative care. Prior to this we may have seen these post-op patients for refractive services, but optometry was not participating in their medical post-op care. In 1986, Medicare allowed optometry parity for ocular health-related services for all Medicare patients, not just post-operative patients. This significantly expanded the patient base and the learning opportunities from treating many more patients in campus clinics and at many external rotation sites.

Another significant event occurred in 1998, when Oklahoma passed the first law authorizing the use of lasers by optometrists for certain procedures. While this led to more schools adding laser content to didactic courses, no other school outside of Oklahoma initiated laser use in the clinic. In the specific case of IUSO, a didactic and laboratory course dedicated to laser and minor surgical procedures was not introduced into the curriculum until 2012, one year after Kentucky became the second state to allow laser use.

In terms of other scope expansions, in 2014 intralesional steroid injections were first performed in IUSO clinics. The introduction of laser procedures into the Bloomington IUSO campus clinic services came in 2015. These included selective laser trabeculoplasty (SLT), laser peripheral iridotomy, and YAG laser capsulotomy procedures. Roughly one year later, the clinic added intense pulsed light treatments for dry eye patients. A few years after this, minor surgical procedures were added to the services provided in the campus clinic. Procedures utilizing radio frequency (RF) scalpels, incisional blades, surgical scissors, RF epilation, etc., begun. The final scope expansion to date occurred in 2023, when IUSO began performing corneal cross-linking (CXL) in our Bloomington clinic. This adds a clinical service not being provided in our immediate area and allows students to witness first-hand the CXL procedure that is now performed by optometry in a small number of states.

There are several additional areas of scope expansions that IUSO is poised to implement. The likely next to be introduced will be anterior chamber drug implantation, as more drugs will soon be available to be delivered by this method. It is also likely Botox injections around the eye will be offered at IUSO clinics in the near future. While the procedure is taught in the curriculum, it has not yet been offered in the clinic. Finally, while similar to other procedures already offered, IUSO clinics are certainly evaluating procedures such as RF meibomian gland treatment devices and the newly introduced direct SLT device. These could well be future procedures added to existing services.

Reflecting on a career spent in optometric education and especially in clinical care, it is rather amazing to start with clinical practice that involved limited diagnostic drug use, progressed to routine DPA use and then to extensive TPA use, and ends in lasers, cross-linking, and increased minor surgical procedures. I am extremely grateful for the opportunities and experiences afforded me early on and throughout my career. Hopefully, our recent graduates will continue to be passionate about optometry, but at the same time be just a little dissatisfied. I look forward to seeing where this dissatisfaction takes the profession of optometry in the future.