Primary Care Optometry: Are We All on the “Same Page”?

“Primary care” is a term that enjoys widespread use in optometry as well as in medicine. In optometry, however, the root meaning of primary care is not always well understood. Unfortunately, all too often the words “primary care” are used in reference only to medically related eye treatment. This is a very limiting view of the scope of primary eye care. In fact, primary eye care encompasses the broad scope of optometric practice. A narrow view of primary care as that part of eye and vision care related to medical diagnosis and treatment of the eye can inappropriately and misleadingly limit the view of the profession from within the profession and outside of it. In turn, it limits the public expectations for care provided by optometrists. Fortunately, most optometrists share the broader and more appropriate view of the scope of optometric practice as the primary eye and vision care provider. It is important to this profession’s advancement that we clarify the real meaning of primary care optometry and avoid it being portrayed as a term that is limited to the growing medical eye care responsibilities that the primary care optometrist is now trained and authorized to provide. Clarity is needed in advancing the appropriate professional relationships with healthcare colleagues. It is needed in advancing legislative responsibilities within a broad primary eye/vision care provider responsibility. Clarity is also needed as training institutions advance their curriculum and define residencies. In fact, clarity in using the term “primary eye care” is critical to the profession. The greater the extent to which optometry has the necessary debate and discussion to provide that clarity, the faster the profession will advance in its ability to fully provide the best care for the public.

To understand how we got to this point, a brief history of the development of this issue is in order. In medicine, like in other disciplines, primary care has traditionally been used to refer to the total breadth of general practice. This encompasses all aspects of clinical care, including a working knowledge of specialty care as well as the ability to apply the art and science of medical care in practical terms through appropriate practice management. The knowledge of specialty care is different than providing the specialized care. However, the primary care medical provider needs to recognize and have an understanding of what options and services are available to best serve the patient. The best outcome of the patient is thus served when the primary care provider understands secondary care at least well enough to know what the next level of care entails. Over the years, as medical care has become more specialized, it has developed “primary” caregivers and specialty caregivers. Additionally, the specialty model has introduced the concepts of secondary and tertiary care providers. As a profession, optometry in general has been slow in embracing the medical philosophy of primary, secondary, and tertiary models of care. Perhaps this has been because of our strong roots in the functional and refractive sciences or because we were not recognized as medical providers by insurance companies. It may be related to the fact that optometrists historically rarely referred to other optometrists. In short, there has been really very little secondary or specialty care awareness within optometry despite the emergence of specialized areas of practice in the profession. Thanks to years of hard work and forward thinking by many, this has all changed. Parity in Medicare billing in 1987 was a huge step. The addition of therapeutic services, inclusion onto medical insurance panels, and the ability to have large numbers of optometrists providing medical care in hospitals, multidisciplinary medical clinics, ophthalmology practices, and laser surgery practices has also advanced our experiences and skills. Great strides have been made in this area in the military and especially the Department of Veterans’ Affairs. The biggest change for the average private optometrist is that the use of therapeutic services (pharmaceutical and minor medical procedures) is now the “norm” and expected in practice. Furthermore, the proliferation of new technologies, new devices, new imaging, advanced diagnostics, new surgical techniques and procedures, and even expanded types of contact lenses has set up differing levels of specialties within all eye care fields.

The practice of primary eye/vision care is central in optometry even as optometry expands into specialty areas. We need greater consensus on the use of the term “primary eye care.” The problem is that in optometry, we sometimes inappropriately use the term to mean something quite different than the historically used meaning related to general practice. When most states were working on legislation to allow the use of diagnostic pharmaceutical agents for optometry, it was argued as needed to allow optometrists to better detect ocular disease. Improved diagnostic ability improved care through appropriate referrals for treatment. The next logical step in providing better care for the public was the legislated use of pharmaceuticals to treat eye conditions. However, when the majority of states started passing legislation allowing therapeutic use, terminology related to primary care became confused. As optometry gained momentum in the treatment arena, all the new medically (i.e., pharmaceutically) related treatment capabilities were mischaracterized as “primary care.” Treatment of anterior segment disease, and then glaucoma treatment and management as well as other previously medicine-only ocular treatments, suddenly became the responsibility of the “primary care” optometrist.

As a result, the words “primary care” in optometry became synonymous with the expanded use of medically based procedures and
Primary care optometry is the comprehensive management of a patient's visual function, ocular health, and related health care. The primary care optometrist, therefore, assumes ongoing responsibility for the total visual, ocular, and related care of the patient. This will naturally involve a breadth of knowledge over every subject that would impact the visual and ocular systems. It demands a base of knowledge in many areas, including binocular vision, contact lenses, refractive surgery, pediatrics, refractive care and ophthalmic lenses, developmental vision, low vision, ocular disease management, including glaucoma, ocular surgery comanagement, geriatrics, and occupational vision. Any and all of these areas may be equally important in primary care. This does not mean that the primary care optometrist must be an expert in each of these areas, but it does mean that the doctor must understand them well enough to manage the case accordingly. This management will vary as indicated by the patient's condition and/or as required by the practitioner's expertise and interests. Education of the patient and potentially the patient's family is also a critical element of primary care. The doctor also must be able to coordinate and manage the patient's care with a wide range of other specialties, including ophthalmology (both secondary and tertiary care), family practitioners, nurses, other optometrists, teachers, social workers, and family members. Primary care involves the integration of many areas of knowledge and expertise. It is the ability to manage, integrate, and oversee all of these areas for the benefit of the patient that is the essence of primary care.

The profession must not lose sight of its roots—as the caregiver of refractive and vision care while at the same time embracing the challenges of expanded scope of practice in more pharmaceutical and medical directions. Instead, it must see its optometry school graduates as the general eye and vision care professionals practicing primary care in the broadest sense. These primary care graduates should be expected to provide full eye/vision care to the vast majority of those who consult them. They must also have the knowledge and training to assure that all who seek their consultation find appropriate care whether from them or from those to whom they refer. The separate issue of how we deal with specialty practice in optometry, its training, and the intraoptometric referral patterns that make these emerging specialties a reality is a separate important area for ongoing discussion that I leave for all of us to pursue!

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