the University of Alabama in Birmingham / UNIVERSITY STATION / BIRMINGHAM, ALABAMA 35294

the Medical Center / SCHOOL OF OPTOMETRY

April 6, 1977

MEMORANDUM

TO: Dr. George P. Fulton

FROM: Dr. Henry B. Peters

SUBJECT: Dr. Bobo's Minority Report

You have sent me Dr. Bobo's Minority Report presented to the Health Education Authority March 23, 1977 and asked for my comments.

Dr. Bobo first quotes the definition of optometry you gave in Appendix A of the Needs Study. I have already indicated that this is an incorrect and inadequate definition and is no longer used by DHEW nor is it consistant with State laws. A report to the Congress (1976) prepared by DHEW uses the definition of optometry prepared by NAS/IOM as follows:

> "The Doctor of Optometry (O.D.) is a health professional who performs eye examinations to determine the presence of visual, muscular, or neurological abnormalities, and prescribes lenses, other optical aids, or therapy, such as eye exercises to enable maximum vision. Optometrists are trained to recognize disease conditions of the eye and ocular manifestations of other diseases, and to refer patients with these conditions to the appropriate health professional."

Second Dr. Bobo states that the optometry student has had no medical training working with patients who have eye disease or on whom drugs were used under the supervision of ophthalmologists or other M.D.'s; and further, only a few of the thirteen schools have any M.D.'s on their faculty, they teach in classrooms only, and there is no ophthalmologist on the staff of any optometry school. These allegations are simply not so. The facts are as follows (and I have the documentation to back this up if you need it):

- There are 13 accredited schools of optometry (12 in U.S., 1 in Canada)
- All schools have ophthalmologists on faculty or in clinics (total 56)
- All schools have regular referral procedures for ophthalmological consultation
- Other M.D.'s teach general and systemic disease in 7 schools, public health and epidemiology in 4 schools, segments of courses including psychiatry, pediatrics, pharmacology, internal medicine, endocrinology, etc., in 6 schools (total of 24 M.D.'s)

- Ophthalmologists teach, diagnose, treat and consult in optometry clinics (23) and affiliated clinics of optometry schools (31) where optometry students participate.

Thirdly optometrists may legally use drugs for diagnostic purposes in 18 States, - not in South Carolina.

Dr. Bobo makes the case that all physicians are trained in diseases of the eye and provide primary eye care. This is just not so as the curricula of most medical schools will attest - less than 20 clock hours on the whole consideration of the eye. Most physicians will support me in this, in fact, ophthalmologists have been at some pains to discourage other physicians from treating eye disease. They are certainly not trained in the differential diagnosis of eye disease nor its treatment.

Optometrists are trained to detect ocular disease and ocular manifestations of systemic disease, and to make preliminary diagnosis for appropriate referral.

Then Dr. Bobo addresses the costs of optometric education vs. ophthalmological education. Ophthalmological sources give the cost of training an ophthalmologist, post high school, at approximately $200,000. Optometric (and NAS/IOM) studies indicate the cost, post high school, of training an optometrist at $60,000 or less.

Dr. Bobo discusses the Aron study on utilization and makes some unsubstantiated claims of the activity of ophthalmologists. There is confusion over what is being counted: Aron's study looked at "complete visual analysis" figures only. If all patient encounters (visits) are counted, the number of patient encounters per day per optometrist would be 22.8, not 5.7. This 22.8, is the number that should be compared to a similar survey (none reported only Dr. Bobo's estimate) which might result in 30 to 40 patients per day. On this point it is essential to know the type of service rendered - e.g. monitoring the progress of a chronic disease could take only a few minutes per patient visit.

Dr. Bobo then attacks the cost to South Carolina of a school of optometry and by a bit of hocus-pocus comes up with $200,000 per optometry student per year. This is manifestly false. The cost would be not more than $12,000 per student per year and, depending upon start-up and training grants, could be substantially less. His statements are so patently false that I don't see any need to belabor them.

He refers to the schools "putting out a lot of graduates. The present schools, at maximum capacity, will put out slightly over 1,000 graduates per year. This number will just barely keep up with attrition - ("white male separation rates:" death, disability and retirement). Experience with in-migration and out-migration of professionals in optometry do not support the thesis that South Carolina can obtain the optometrists it needs by this method. He says "There is national evidence suggesting that the supply of optometrists from the optometry schools in the nation will be sufficient to double the number of optometrists in practice by the year 2000." This is plain poppy-cock. The simplest kind of mathematics gives a lie to this statement.

There are approximately 20,000 optometrists.
They leave practice (death, disability, retirement) at about 3.5% per year.
Present schools, currently at maximum capacity, graduate 1,000 per year.
The population in the U.S. increases at about 1.5% per year.
Therefore, to maintain present ratio of optometrists to population require 1,000 per year.

Finally Dr. Bobo addresses the possibility of clinical training in affiliated clinics within the consortium model. His statement, and that of Dr. Donald, implied that there would not be adequate teaching resources to support such a program. Dr. Donald stated "there are two basic types of practitioners, one who delivers health care and one who teaches it." This is, again, patently false. Medical schools, dental schools and optometry schools depend on practitioners who teach their clinical knowledge and skills to students on a part-time basis. I'm sure that this is true of residency programs and general medical education programs at the clinical level even in South Carolina. The limitation they are talking about is on clinical training and it is precisely this that is frequently best taught, and most often taught, by community practitioners who are on the staffs of hospitals and clinics affiliated with professional schools. There are many underserved populations and areas in the three States that would provide, at an appropriate time in the school's development, the opportunity for affiliated clinics. There is federal support available for such development through AHEC, Special Project Grants, Veterans Administration Hospitals, etc.

Thank you for the opportunity to set the record straight on these important issues, as H.R. Holman states in Hospital Practice 11, 11 (1976) "the Medical establishment is not primarily engaged in the disinterested pursuit of knowledge and the translation of that knowledge into medical practice; rather in significant part it is engaged in special interest advocacy, pursuing and preserving social power."

Henry B. Peters

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