

## The Use of Auxiliaries In Optometric Practice

F.H. Griffith\*

*"Every truth passes through three stages before it is recognized. In the first stage it is ridiculed, in the second stage it is opposed, and in the third stage it is regarded as self-evident."*

Schopenhauer

### Abstract

*As demand for health services increases and as capital and operating costs also increase the providers of health services must maximize their productivity while maintaining quality and patient satisfaction. The professions in Ontario, with the exception of optometry, make extensive use of auxiliaries as a means of increasing productivity. In the United States optometric assistants, trained in community and optometric colleges, are used widely. The paper presents a point of view urging the removal of restrictions on the appropriate use of well trained assistants.*

### Abrégé

*Afin de maîtriser le coût croissant des services de santé et de satisfaire une demande croissante pour ces services causée par l'usage de plus en plus répandu des plans d'assurance santé soit publiques ou privés, les professions doivent avoir recours à des auxiliaires.*

*Ce travail présente les raisons tant sociales qu'économiques motivant l'emploi d'auxiliaires, questionne la lenteur de l'optométrie à s'engager dans le système quand la plupart des professions y sont déjà engagées. L'auteur fait une liste des fonctions pouvant être déléguées, discute de l'éthique de ce geste et décrit les trois modèles d'assistants possible et leur formation.*

*Enfin l'auteur soulève l'intérêt publique vis à vis des professions autonomes et leur attitude de monopole et de restriction et recommande l'abolition de toutes restrictions sur l'emploi d'auxiliaires bien entraînés.*

Optometry in Ontario will continue to be confronted with rising costs of capitation and operation, a growing demand for service and some net addition to the number of active practitioners. The economic and social necessity of producing more service while maintaining high quality personal care creates a problem for the practitioner. Unless the practitioner can significantly improve productivity without lowering standards of care the increasing overhead will have to be met at the expense of professional income. Despite the evident necessity of improving productivity little change has occurred in instrument delivery, office design, or techniques which would significantly increase productivity. In optometry in the United States and in other professions in Ontario the use of trained clinical assistants has been shown to be a means of increasing productivity as well as improving professional life style. The desirability of employing clinical assistants has been recognized by ophthalmology and courses are now being taught in community colleges in both Eastern and Western Canada.

In Ontario and in several other provinces, dentistry has responded to this problem very positively. New instrumentation, new instrument delivery systems, new work methods derived from time and motion study, new office layout, and new types of assistants are all helping to provide an increase in productivity. The increase in productivity has been accomplished while maintaining high quality care and patient satisfaction with a reduction in tension and fatigue for both staff and patients. Op-

tometry in the United States has responded strongly in the development of specially trained optometric assistants but much remains to be done in instrument delivery and examining techniques. In dentistry, the development of all of these techniques allows increases in productivity of three to five times—can the same be done in optometry?

The median age of optometrists practising in Ontario in 1974 was fifty. Many factors offset the number of optometrists who will be in practice in twenty years, but it appears that there will be a relatively small net addition. In the same period it has been estimated that the provincial population will increase to 10,763,715 and that the age/sex distribution will demonstrate a higher percentage of elderly people and a higher percentage of females. These demographic trends with the increased percentage of elderly in the population, and the increased numbers of females all indicate increased demand for service.

In the past few years labour contracts have included dental insurance<sup>(1)</sup> with increasing frequency. Many studies indicate that insured populations have higher rates of medical utilization than non-insured populations, and it is reasonable to presume that the same phenomenon would be observable in dental utilization. It is becoming increasingly common for negotiators to include vision and optical care in their contracts and this trend will continue. Increased insurance will be combined with increased visual safety programs, school programs, driver programs, optical company promotion, etc., to stimulate demand.

The population of the province will continue to experience "urban drift". Many studies indicate that urban populations have higher health care utilization rates than rural populations for many reasons including availability, accessibility, income,

\*B.A., Optometrist  
240 McNabb St.,  
Sault Ste. Marie, Ontario  
P6B 1Y5



etc. It can be reasonably assumed that "urban drift" will also increase the demand for optometric care.

The ideal ratio of optometrist to population obviously depends on such factors as those mentioned previously. In the United States<sup>(2)</sup> the current ratio is 1:9321 with significant variations from state to state. Along the Ontario border the ratios range from Illinois at 1:4766 to Michigan at 1:10,907. It would appear that in Ontario the ratio in 1976 was of the order of 1:17,126 and that in 1996 it will be 1:10,251. The supply will improve but whether or not it will improve enough to meet apparent increases in demand is a question. The American Optometric Association<sup>(3)</sup> established that the optimum ratio was 1:7162 under current conditions.

Improvements in productivity will help meet the demand; if at the same time they can improve professional incomes as well as the quality of professional and social life while maintaining the quality of care, there are compelling arguments in favour of the changes which will increase productivity.

"... all of the health professions are faced with the demands for and expectations of greater and more efficient utilization of manpower, combined with the assurance of acceptable quality health care for all citizens."<sup>(4)</sup> The constraints that prevent the substitution of manpower create problems and "far more attention needs to be paid to how these constraints to further manpower substitution might be eased, if not removed entirely."<sup>(5)</sup>

Any ill informed discussion of the use of various types of assistants immediately includes a series of objections around quality, patient acceptance, cost, payment, liability, etc. On the other hand, the extensively documented literature, especially in other disciplines, clearly shows:

1. Patient acceptance is high.<sup>(6)</sup>
2. Quality is at least maintained, if not improved.<sup>(6)</sup>
3. Productivity gains more than offset cost.<sup>(7)</sup>
4. The gains in professional and personal life are substantial.<sup>(7)</sup>
5. Liability insurance is easily obtained and the risk is not exceptional.<sup>(8)</sup>
6. The artificial legal barriers can be

removed by the profession.<sup>(9)</sup>

The assistants who are able to achieve this success must be:

1. well trained for the duties assigned;
2. working against standing orders in well defined tasks;
3. functioning in a physical plant designed to maximize their effectiveness and that of their principal;
4. associated with a principal who has been trained to maximize the effectiveness of his associates and physical plant.

Assistants can produce the same productivity gains in optometry as in the other professions.<sup>(6)</sup> Ophthalmology has been quick to see the advantage, therefore, ophthalmological technicians with a variety of training are increasingly common. In any physician's office a variety of people are taking visual acuities and other tests, however, such help is denied an optometrist. In striking contrast to other professions, where simple repetitive tasks as well as tasks of some complexity are assigned to lesser trained people, allowing the principal to function for most of the time at the highest and most satisfying level of his or her training, optometry demands that the most menial tasks creating the least income be done by the principal.

In the United States there are 23 junior colleges and five colleges of optometry which are conducting formal training for optometric assistants or technicians.

The following section is based on "A National Study of Assisting Manpower in Optometry"<sup>(3)</sup> prepared for Manpower Administration, U.S. Dept. of Labour by Jerome Sherman, O.D. The report states: "because of the limitations on manpower resources, increased emphasis should be placed upon the maximization of existing primary health professionals, through the use of ancillary personnel."

Lone health care practitioners are fast becoming anachronisms. Increasingly they must attain the supervisory role, programming and delegating the more routine duties to various assistants who are under their direct and immediate responsibility and supervision. One may

suggest responsibly, even in the absence of confirming economic data, that it is economically unfeasible for a health practitioner to perform those routine duties which can easily be performed by someone with much less technical training and knowledge. It therefore follows that each profession must analyze every duty performed, decide what blends of skill and theory are needed to perform the task competently and efficiently, and then to establish various training levels which are commensurate with the tasks performed. This report also quotes from "A Proposal for Career-Ladder Training of Ocular Allied Health Personnel". In that report the American Optometric Association is quoted after an in-depth study by a "highly competent and qualified cross section of the A.O.A." as being in favour of three levels of training for ancillary personnel and recognized that "this report constitutes a radical innovation in optometric concept as heretofore expressed. However, the commission feels strongly that the course of technological evolution is of sufficient influence so that total vision care services for the benefit and welfare of the public would be ultimately augmented."

The proposal for "Career-Ladder Training" was also adopted by ophthalmology and a point stressed by both optometry and ophthalmology was that "since it is mandatory that the well-being of the patient be protected at all times through the maintenance of high quality professional care, it is necessary that suitable constraints on the autonomy of ocular allied health personnel be imposed to preclude the possibility of such individuals adopting the role and authority of licensed practitioners of medicine or optometry." Another point of agreement between optometry and ophthalmology is that "any curricula proposed for the training of personnel at one level be designed so that at least some of the academic credits can be applied to an educational program at a higher level in the ocular science field." (This latter principle is currently in effect in the training of expanded duty dental personnel in Ontario). The Commission proposed several practice models but



made the following comments on components of the optometric examination relating to auxiliaries.

### **Case History**

"The majority of eye practitioners take their own case histories in their entirety. An alternative to this is a check list administered by an assistant and then briefly reviewed and expounded upon by the optometrist."

### **Lensometry**

"An ancillary person can take over this duty in its entirety."

### **Visual Acuity**

"This easily performed test can be done by optometric ancillary personnel without overt difficulty."

### **Keratometry**

"The optical construction involved is quite complex but an assistant can be taught to develop the skill to use the keratometer without understanding precisely either the theory of astigmatism or the optics involved."

### **Retinoscopy**

"Later consideration may be given to the eventual downward transfer of this skill. . ."

### **Frame Selection**

"One may conclude that this segment of the service can be performed by the ancillary person with just one minute reserved so the choice can be verified by the optometrist."

### **Dispensary and Prescription Verification**

"The calculated seven minutes spent here by the optometrist can be transferred to the assistant with one minute reserved to the optometrist to 'O.K.' the procedure."

### **Tonometry**

"It has been clinically demonstrated that a trained ancillary person can learn to perform electronic tonometry on all patients over thirty-five years without any decrease in efficiency as compared to the professional man."

### **Visual Field Testing**

"An assistant can readily be in-

structed in the use of a screener without any detailed knowledge of the complexities of the visual pathway. An abnormality will then warrant a detailed field study performed by an optometrist."

### **Visual Skills Testing**

"An assistant can be taught to administer this battery in a very short period of time."

### **Colour Vision Testing**

"The testing procedure is quite simple and can be administered by an ancillary person with no difficulty."

In the "Statement of Need—Grant Proposal", Dr. Brown outlined three types of personnel:

1. the Optometric Assistant/Technician whose training and responsibility will be more directly related to dealing with patients as an aid to the doctor in gathering diagnostic data. This is an existing program of the College. The modified curriculum will place major emphasis on these doctor-technician relationships.
2. the Dispensing Assistant who will be responsible for the technical aspects of providing the ophthalmic eyewear. This is a nine month program with the student having the option of taking an additional three months in fabrication.
3. the Ophthalmic Fabricator shall have the responsibility of generation, fabrication and quality control of ophthalmic eyewear.

Each of these individuals would receive an Associate of Science degree or a Certificate of Proficiency. The functions of the Trainees are listed in Appendix I. The Joint Inter-professional Relations Committee Michigan Ophthalmological Society—Michigan Optometric Association formulated and approved the guidelines in Appendix II. It is obvious that an optician as recognized in Ontario is well trained to fulfill the roles of both the dispensing assistant and the ophthalmic fabricator.

In "Studies in the Economics of the Profession of Optometry", Coate stated: "The results of our investigation support the claim that optometrists are under-utilizing aide input in the production of op-

tometric services. The average optometrist could profitably increase his or her employment of auxiliaries to about two and one half times their present level according to the results in the previous section. According to our estimated production functions, the output of the average optometric practice would increase by about 30 per cent if such an expansion in aide employment took place."

In his study he also concludes, as stated earlier, that "the results appear to be sensitive to the setting in which health services are delivered." The reasons for the reluctance of the majority of Ontario optometrists to fully utilize assistants are a matter of speculation—such factors as unused optometrists' time during a normal day, lack of availability of well trained assistants, unawareness of the advantages, etc. The reasons for the legal enforcement in Ontario of the "prevailing orthodoxy" are also matters of speculation. Among the speculators are those in government whose concern is consumer affairs and combines restrictions. The professions must now be aware of the combines legislation and govern themselves in such a manner as to be seen to be in accord. Dr. Sylvia Ostry, while Deputy Minister responsible for ensuring that Bill C-2 was functioning in the regulation of the professions, has publicly raised questions relating to the licensing mechanisms, possible relationship to a cartel, the fee schedule as price fixing, etc. which are all possible areas for study in terms of the federal legislation. The Deputy Minister raised the question as to whether the prohibitions relating to "the form and manner in which professional services are supplied" are truly in the public interest. She has suggested that the evidence suggests they are more often providing "a substantial effect in reducing competition, impeding innovation and change and raising costs and prices for professional services."

The British Monopolies Commission also expressed a similar concern that was quoted by the Deputy. "Collective arrangements which significantly limit the freedom of the parties in the conduct of their business may be expected to result in higher prices, less efficient use of



resources, discouragement of new developments and a tendency towards rigidity in the structure and trading methods of those businesses. Such collective restrictions tend to reduce the pressures upon those observing them to increase their efficiency. They may also delay the introduction of new forms of service and the elimination of inefficient practitioners."

In commenting on the last statement Dr. Ostry pointed out that most observers would be inclined to express the latter point more forcefully. The Deputy continued saying that "members of the self-regulating professions are strongly encouraged to conform to the 'prevailing orthodoxy' and if they want to remain in good standing, they are severely limited in the kind of experimentation they can undertake. The result has most certainly been to delay the introduction of new forms of service and to lend support to the inefficient and uninnovative practitioners." Continuing to cite various examples of restrictive practices Dr. Ostry mentioned steps to "generally prevent the abuse of power by professional bodies." She states, "In practical terms I would hope that the result would be a more careful consideration of such issues as the functions of para-professionals, and the length of professional training, both of which, of course, directly affect the price of professional services as well as the economic return to existing practitioners." Later in her comments, Dr. Ostry added that "A third response is to focus directly on the activities and rules of the professional bodies and to try to ensure that these are in the public interest."

There are no Collegial restrictions on innovation of instrument delivery and office layout but here again the profession has shown little imagination. Those optometrists in the median age group can remember the dentist's office of their youth and can compare it with a modern open concept office maximizing capital and staff. They will also be able to compare the optometric office of those early days with the one they are in now. How has it changed? The patient and practitioner are in the same position; the practitioner is doing the same tasks, the instruments are delivered in the same way.

Maybe somebody in the early days did in fact create the perfect system; more likely we haven't exercised sufficient questioning to create a demand for greater efficiency. Care is not being provided nor income generated by the exhausting gymnastics necessary in the usual practice setting.

In the immediate future artificial restrictions on the use of assistants which limit innovation in practice must be removed. Ethics cannot be measured by the mix of people providing service any more than can the quality of care. Unless the profession responds positively and forcefully to the need of innovation in the use of auxiliaries and all aspects of the delivery of care it will stagnate into oblivion. Optometry does not have a monopoly in supplying vision and eye care. It is time that those practitioners who do not accept the status quo as perfection are given the right to develop their practice to maximize their skills and investment for the public welfare and their own. As costs go up for staff, space and capital equipment, and as the volume of care that can be provided in a practice reaches its peak, there are only two variables—

1. a positive response to increase productivity through a better delivery system, time management, etc.
2. the net income of the optometrist can be reduced by the increase in costs.

It cannot be argued that any particular combination of skills in an optometric practice is intrinsically unethical. It cannot be stated that an optometrist in Ontario prevented from developing a rational, efficient, high quality, professionally satisfying and economically rewarding practice mode is *ipso facto* more ethical than an optometrist in Florida who has used current knowledge to maximize productivity. Optometry in Ontario stands alone among the professions in maintaining a "push cart" philosophy towards the organization of practice. The Association recognized this situation at the 67th Annual Meeting where the following motions were adopted:

It was moved, seconded and carried that the Ontario Association of Optometrists recommends to the College of Op-

tometrists of Ontario that the College consider a regulation allowing for the hiring of an optician by a member of the College.

It was moved, seconded and carried that the Board of the Ontario Association of Optometrists consider the use of assistants by optometrists, and that the Board make the appropriate recommendation to the College of Optometrists of Ontario.

There can be no real reason for the restriction on auxiliaries so obviously desired by the Association, therefore, it is time that the artificial barrier imposed by the regulations which prevents the ethical maximizing of quality and of productivity should be removed.

There are some optometrists for whom the added problems of managing staff will not be worth the gains in productivity. There are some for whom the added costs are not worth the added return. There are some optometrists who are totally individualistic and do not want an assistant dealing with their patients. There are some patients who only want to see the doctor.

There are some optometrists who will manage staff skillfully and who will derive great satisfaction with a team approach and who will make significant gains in productivity.

There are some optometrists who will realize that an assistant can deal with a multitude of problems allowing them to maximize their interests. Although some optometrists won't believe it, there are even some patients who will ask to see only the assistant.

There is no question that assistants will fit into every practice—there is also no question that where they fit they should be recognized.

#### References

1. Clayton Sinclair—Dental Insurance Boom Survives Life Under Wage/Price Controls—*Financial Times*, March 28, 1977
2. American Optometric Association—*Comprehensive Health Planning Manual*—Division of Public Health Optometry, Committee on Public Health and Optometric Care.
3. H.G. Mote, V.S., M.S., O.D.—A Statistical Survey of Optometric Manpower Needs—*Journal of the American Optometric Association*.

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