

Optometry's Conventional Role: Current Practice Patterns

Catriona Barrett^{1*} and James Loughman²

¹DIT Centre for Eye Research Ireland, Environmental Sustainability and Health Institute, Dublin, Ireland University of Kwazulu Natal, South Africa

²Dublin Institute of Technology, Lower Kevin Street, Dublin 8, Ireland

Glaucoma, the world's largest cause of permanent blindness, is detected by optometrists. The most prevalent glaucoma subtype, primary open angle glaucoma (POAG), is insidious, progressive, and irreversible, posing a serious public health threat. POAG is primarily discovered by opportunistic case-finding during routine eye examinations because population monitoring is neither cost effective nor feasible. The great majority of glaucoma and ocular hypertension patients are diagnosed by opportunistic case-finding by community-based optometrists, according to evidence from the UK [1]. There are no formal guidelines for glaucoma identification in optometric practise in Ireland, as there are in many other nations. The Association of Optometrists Ireland (AOI) issued guidelines for optometrists in 2009 outlining the procedures that may be performed during a routine eye exam, and this document does mention the examination of patients at risk of glaucoma, stating that intraocular pressure measurement and visual field assessment should be performed on all patients deemed to be at risk of glaucoma. The instruments utilised for these tests, as well as the technique for identifying patients at risk of glaucoma, are not well defined, leaving a lot of space for variance between doctors. Optometric offices that want to give state-funded eye exams in Ireland must first sign a contract outlining the scope and content of the exam [2]. The contract optometrist agrees to 'provide eye examinations and advice to the best of his/her knowledge and ability for eligible persons. Using suitable instruments and equipment in a suitable manner' and to 'carry out all tests judged to be necessary to determine the patient's need for vision care as in both sight and health provided that the exact format and content will be determined by the optometrist's professional judgement.' It can be deduced that the scope of the eye exam is quite extensive, and optometrists are responsible for determining the patients' needs [3].

Though the established standards for examination strategies are not precisely defined, they include refractive correction and ruling out any kind of ocular pathology, including glaucoma. Optometric training in Ireland has progressed from a part-time, evening certificate to a full-time, four-year honours degree programme, and optometrists are now highly qualified health care professionals [4]. Optometrists are expected to make pragmatic decisions about whether investigations can feasibly be carried out during an eye examination based on an individual's presenting complaints and risk factor profile as the range of technology and examinations used in optometry practises has evolved. Anecdotal evidence implies that optometry practises and practitioners have a wide range of equipment and practise boundaries, yet there is no accurate data on common glaucoma case-finding techniques in Ireland. The goal of this study was to evaluate existing practise tendencies among optometrists in Ireland, with a special focus on the tests performed in glaucoma case-finding. This current practise standard benchmark will be beneficial in assessing future expanded services scheme equipment and training requirements. The amount of interest among optometrists in expanding their scope of practise was also investigated in order to provide insight into how the profession might evolve in the coming years. A study was created to look into community optometrists' current glaucoma detection practises. In order to inform the survey's methodology and substance [5], a review of similar foreign research

was done. The survey was validated once it was developed: it was first examined by a question construction expert to ensure that it did not contain any leading, ambiguous, or double-barreled questions, and then a pilot survey was sent to 20 community optometrists. A total of 70 optometrists from a Dublin-based glaucoma referral refinement scheme were chosen at random for the pilot group. The pilot's feedback was incorporated into the final survey design, which had four sections addressing various aspects of optometry practise. The second portion was created to determine the types of equipment accessible in practises and to determine how confident optometrists are in completing various examination techniques [6].

Respondents were asked which tonometers they had in their practise, whether they performed tonometry themselves or assigned it to support personnel, and which approach they preferred for intraocular pressure (IOP) screening during routine eye exams [7]. Respondents described how they usually examine the fundus. Direct ophthalmoscopy, binocular indirect ophthalmoscopy (BIO) using a slit lamp and condensing lens, binocular indirect ophthalmoscopy (BIO) using a headset and condensing lens, or 'other please specify' were the options. A follow-up question asked optometrists to rate their proficiency with slit lamp BIO. They were questioned to reply on a five-point scale, from 1 (unable to do slit lamp BIO) to 5 (able to perform slit lamp BIO) Participants were also asked to indicate the different sorts of investigative equipment they possessed in their job [8], including the precise model of perimeter if one was available, as well as other more specialised equipment like optical coherence tomography, gonioscopy, and pachymetry.

References

1. Resnikoff S, Pascolini D, Kocur I, Pararajasegaram R, Pokharel G.P et al. (2004) Global data on visual impairment in the year 2002. *Investig Ophthalmol Vis Sci* 82:844–851.
2. Quigley H.A., Broman A.T (2006) The number of people with glaucoma worldwide in 2010 and 2020. *Br J Ophthalmol* 90:262–267.
3. Burr J.M, Mowatt G, Hernández R, Siddiqui M.A.R, Cook J et al. (2007) The clinical effectiveness and cost-effectiveness of screening for open angle glaucoma: a systematic review and economic evaluation. *Health Technol Assess* 28:111–190.
4. Mowatt G, Burr J.M, Cook J.A, Ramsay C, Fraser C et al. (2008) Screening tests for detecting open-angle glaucoma: systematic review and meta-analysis. *Investig Ophthalmol Vis Sci* 49:5373–5385.

***Corresponding author:** Catriona Barrett, DIT Centre for Eye Research Ireland, Environmental Sustainability and Health Institute, Dublin, Ireland, E-mail: catriona.barrett@dit.ie

Received: 05-May-2022, Manuscript No: omoa-22-64775, **Editor assigned:** 06-May-2022, PreQC No: omoa-22-64775 (PQ), **Reviewed:** 20-May-2022, QC No: omoa-22-64775, **Revised:** 26-May-2022, Manuscript No: omoa-22-64775 (R) **Published:** 31-May-2022, DOI: 10.4172/2476-2075.1000167

Citation: Barrett C, Loughman J (2022) Optometry's Conventional Role: Current Practice Patterns. *Optom Open Access* 7: 167.

Copyright: © 2022 Barrett C, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

5. Bowling B, Chen S.D.M, Salmon J.F (2005) Outcomes of referrals by community optometrists to a hospital glaucoma service. *Br J Ophthalmol* 89:1102–1104.
6. Myint J, Edgar D.F, Kotecha A, Murdoch I.E, Lawrenson J.G (2011) A national survey of diagnostic tests reported by UK community optometrists for the detection of chronic open angle glaucoma. *Ophthalmic Physiol Opt* 31:353–359.
7. Myint J, Edgar D.F, Kotecha A, Murdoch I.E, Lawrenson J.G (2010) Barriers perceived by UK-based community optometrists to the detection of primary open angle glaucoma. *Ophthalmic Physiol Opt* 30:847–853.
8. Dada T, Kusumesh R, Bali SJ, Sharma S, Sobti A et al. (2013) Trabeculectomy with combined use of subconjunctival collagen implant and low-dose mitomycin C. *J Glaucoma* 22:659–662.