# Optometrist consultation

**Submission**

31/01/2011

## RE: Proposed changes to registration requirements

In regarding to the recent discussion paper on the proposed requirement for Therapeutic endorsement for registration as an Optometrist I would like to make the following points:

- It is incorrect to state that from 2014 there will be two levels of practice in the profession. This situation has in fact been the case for at least the past 5 years and neither the public nor the profession have been disadvantaged by this state of affairs.

- The expectation that all optometrists registering for the first time from 2014 have a similar qualification and educational level is reasonable and should apply to any new registration whether from graduate or overseas qualified applicant.

- In the AHPRA document the presence of "two levels" of practice is implied to be a negative thing. In many professions there are two or even multiple levels of practice that do not appear to have any negative impact on these professions either from a public perspective or within the profession itself. Nurses have various grades dependent on their training, doctors are similarly divided by their training. A doctor who trained ten years ago is still allowed to practice as a GP with that level of training whereas a new graduate of medicine must do further study if they wish to work as a GP. Medical and associated professions will always be segregated within their own dominion by experience, recency of qualification and level of further study undertaken.

- The need to branch out into therapeutics has not been driven by grass-roots optometry nor by a public outcry, rather by the academic institutions and some interests within the associations. Currently optometry services are grossly undervalued by the rebate provided by Medicare, but simultaneously the expectation on the practitioner to install new technology and expand our clinical repertoire (therapeutics for example) is increasing. The suggestion that we should openly embrace therapeutics with the cost it entails to undertake the educational component (in direct fees and loss of income for time away from the practice) plus the increased liability it would expose us to and perhaps even more expensive insurance costs, whilst our fees for service decline in real terms each year is simply not a sustainable argument. The AHPRA itself points out that 800 of 4000 optometrists (20%) are therapeutically qualified. If you deduct the educational optometric staff and the recent graduates from Victoria and NSW who are endorsed it is evident that the practicing profession has not jumped to take up therapeutics at all…20% of currently registered

optometrists less those involved in teaching and those who have already qualified with therapeutics in their undergraduate degree leaves maybe only 10% of practicing optometrists have undertaken courses that have been available for perhaps seven or eight years! As I say, this is not a movement coming form grassroots optometry.

- If the AHPRA decides it is a requirement to be therapeutically endorsed to practice optometry and allows say, a 5 year window for practitioners to comply. Where does that leave a 55 year old optometrist who intends to retire in a little over 5 years? Will they be forced into early retirement? Is it reasonable to expect a practitioner with over thirty years of experience to stop practicing? Is it reasonable for them to pay out $15000-20000+ in fees and lost earnings at this stage of their careers when the likelihood they will ever actually write an ophthalmic prescription before they retire is minimal? Would this in fact represent a restraint of trade? Does all that prior experience count for nothing because they cannot write a prescription for FML?

- With the recent removal of chlorsig from the prescription only list, a current non-therapeutically endorsed optometrist can already provide antibiotic cover, some anti-inflammtory cover and allery cover (zaditen, lomide, livostin, Naphcon-A etc etc), dry eye treatment etc. This provides a basic regime of therapeutic treatment already without the need for endorsement and more difficult cases can still be referred as in the past to ophthalmology or within the profession.

I have no difficulty with the requirement of all new registrations after 2014 being required to meet the same educational requirement as recent Australian graduates. Beyond that, the profession should accept that there will be a period, perhaps of many years, where there are practitioners who have different levels of clinical training. This has always, and will always, be the case. Just as my ability to fit contact lenses far exceeds any graduate of recent years, so to will their ability to prescribe therapeutically. Neither they or myself put the public in any way at risk providing we are both aware of our limitations.

Yours,

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