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Subject: Therapeutics and General Registration
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Submission to the Optometrist Registration Board

from Ian Breadon, Optometrist in private practice, therapeutically qualified.

The case for optometrists to have therapeutics access has been successfully prosecuted in Australia over the past twenty-five years,
and the arguments which persuaded governments to allow this remain unchanged, and are principally that it is in the interests of the
ocular and general health of the Australian public.

Optometrists are adequately trained to recognise and diagnose anterior eye disease, have better diagnostic instrumentation than general
medical practitioners, and are widely dispersed in the community including in regional areas without access to ophthalmologists.

Access to optometrists is easier and cheaper than the alternative routes to primary eye care, and the impending shortfall in
ophthalmological capacity to manage the secondary and tertiary eye care of an aging population mean that optometrists will be required
to provide more therapeutic eye care than is now the case.

The work of informing the general public, general medical practitioners, pharmacists and ophthalmologists that primary eye care
is available from local optometrists is well advanced, as evidenced by referral patterns seen in optometry in the suburbs and country.
That these patients are not seen in corporate chain practices is not surprising, as it is policy in at least one of the two major chains
that patients presenting for therapeutic care be redirected to independents who are therapeutically qualified.

The decision not to see these patients is likely to lead to an erosion of the skill base of optometrists practising in this mode,
and will eventually even impede their ability as refractionists as they lose the skill to look behind lowered visual acuities for possible causes.

All new optometry graduates are required to be therapeutically competent, and it is only reasonable that all other new entrants to general
optometric registration in Australia be required to meet this standard. Eventually it is desirable that there be only one standard for registration
in Australia to minimise confusion and give the public the confidence that it will receive a uniformly high standard of care.
The argument that overseas optometrists should be allowed to enter practice in Australia with a lower standard than new graduates
implies a continuation of two standards of practice in perpetuity, and this would reduce

the ability of Australian optometry to provide the best care to patients and lead to confusion in the community.

This would change the face of optometry in Australia by starting a race to the bottom in eye care standards.

It is unfortunate that there is a large rump of existing practitioners who are not therapeutically qualified, and for whom the number of available clinical placements limits access to therapeutics. The Registration Board should encourage professional institutions to be more innovative in offering training programmes, and also encourage their take-up by optometrists. There is a clear signal that therapeutic practice is a part of optometry, and most of the current group of unqualified optometrists should be expected to undergo training over the next ten to fifteen years. The knowledge base is not new to optometrists, and if the clinical placement programme can be managed, including a component in optometric practice, the logistics are feasible.

It is important that the improvements offered to Australian optometric patients in the past fifteen years be consolidated, not eroded as would be the case by allowing new entrants to Australian practice without therapeutic qualifications.

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