The practice of optometry varies, as does the involvement of optometrists in the care of individuals with glaucoma. Their role in treating eye disease, glaucoma in particular, is relatively new. The first state (West Virginia) passed a therapeutic enhancement to its scope of practice in 1978, and presently, 49 states allow optometrists to provide glaucoma treatment.

**TRAINING AND EXPERIENCE**

There are several reasons why an optometrist may or may not be involved in the treatment of individuals who have ocular hypertension or glaucoma. When a state’s scope of practice changes, further education and testing are required of optometrists before they are allowed to modify their scope of practice (new graduates upon licensure are usually afforded the enhanced privileges). Some practitioners never obtain the training/testing and thus are not involved in treating patients with glaucoma. Others, after completing the necessary education and training, are not comfortable treating patients with glaucoma and decide not to pursue it. Still other optometrists do become involved in treatment and management.

Each optometrist’s involvement may vary depending on his or her training and experience. Some limit their care to individuals with ocular hypertension or mild glaucoma. In these cases, when a patient requires more than one or two glaucoma medications, his or her IOP is not controlled, or disease progression is suspected, the practitioner makes a referral to a glaucoma specialist. There is a limit to what most optometrists are comfortable managing, because they recognize that glaucoma can be a blinding disease, and they will refer patients when those limits are approached. Naturally, limits vary among individuals.

In my experience, only the rare optometrist will willingly manage a patient with advanced disease without a glaucoma consultation. That said, optometrists sometimes find themselves in difficult situations. For example, they may practice in remote areas where glaucoma specialists are not available. Those practitioners may manage certain conditions because there is no other option.

**REFERRALS**

All optometrists, no matter their level of licensure, are expected to diagnose the condition or at least to recognize that a problem exists and refer the patient to another practitioner. It is in the area of the diagnosis that most referrals by optometrists to ophthalmologists related to glaucoma occur. Owing to their conservative nature, most optometrists will refer patients for a suspicious appearance to the optic nerves and questionable visual fields. Some of these patients turn out not to have glaucoma but rather to be poor takers of visual field tests or to have large but healthy optic nerves. Many optometrists struggle to make the appropriate referral given the difficult nature of diagnosing glaucoma.

Optometrists commonly refer patients whose IOP is not properly controlled, those who have difficulty instilling eye drops, and those whose adherence is dubious. Selective laser trabeculoplasty (SLT) is an apt consideration in these cases. Often, the patient is sent back to the referring doctor after SLT treatment, because postoperative management is relatively simple. Optometrists in Oklahoma and Kentucky are permitted to use a laser for anterior segment procedures, including SLT. In these states, if they do not perform laser procedures, optometrists may refer patients to other optometrists.

Optometrists who are uncomfortable managing patients with glaucoma themselves may choose to comanage these patients with an ophthalmologist. In this arrangement, the patient may alternate between visiting the optometrist and the ophthalmologist. The results of perimetry and other testing can be transferred between the practitioners. The patient continues to be (Continued on page 41)
a part of the optometrist’s practice but has access to needed expertise. The intervals between visits and how often each eye care specialist evaluates the patient will vary based on the level of care required and each practitioner’s preferences.

When a patient has advanced glaucoma or unstable disease for which medical and laser options have been exhausted, he or she will be referred to a glaucoma specialist for consideration of filtration surgery. Barring extenuating circumstances, optometrists are rarely involved in postoperative care in these cases. Another common referral is for the individual with narrow angles who the optometrist feels is at risk of an acute angle-closure attack. This is another challenging referral because of the subjectivity of angle assessment. An ophthalmologist may wonder why a certain patient was referred, and an optometrist may not understand why one ophthalmologist is more likely to perform a peripheral iridotomy than another.

PRACTICE MODELS
Approximately 40,000 optometrists practice in the United States, with about 1,350 graduating from schools and colleges of optometry every year. New graduates are well trained in all therapeutic areas, including glaucoma. Approximately 20% of optometrists work with ophthalmologists. Some of them are employed by ophthalmologists, other optometrists work side by side with ophthalmologists in health care institutions, and certain optometrists employ ophthalmologists to come into the practice to provide care.

The role that each optometrist plays when working with an ophthalmologist varies. Some optometrists perform refractions and assist with postoperative care. Others are involved in the treatment and management of patients with eye diseases such as glaucoma. Roles depend on communication between clinicians as well as the needs of the patients and the practice.

CONCLUSION
Efficiency in eye care is important as resources decrease and the number of patients with glaucoma rises. Optometrists and glaucoma specialists can develop and maintain a healthy working relationship if both use their training and expertise to their greatest extent. Communication between both parties is essential.

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