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ORTHOPTICS AND PROFESSIONAL ACCOUNTABILITY

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Sooner or later the members of the orthoptic profession will have to think more seriously about the matter of professional accountability. It will be necessary to consider to whom the profession is accountable—the general public, the employer or the government. As professionals we have always considered our first obligation was to the welfare of the patient. Certainly we owe it to the general public that our standards should be as high as possible. This means continual study to keep up to date with our fast moving technology and increased knowledge of the neurological control of eye movements and binocular vision.

Those orthoptists working closely with ophthalmologists in routine clinical work or in research owe it both to the patient and their employer to be as accurate as possible in their work and to be able to maintain a good rapport with the patient. The government on the other hand is paying for orthoptic education and is subsidising hospital clinical orthoptics and will also expect high quality standards.

This seems to answer in the affirmative the question of whether accountability involves quality assurance. But how is this to be judged and implemented? Peer review has been suggested but is difficult to organise in a small profession and is difficult to accept. Is re-registration the answer? Most professionals reject the idea of fronting up for regular examinations as a way of re-registration, annual payment of registration fees, in my opinion, is just a way of obtaining revenue, it does not ensure quality maintenance, and conference attendance if not accompanied by attention and comprehension will not control quality. Meaningful continuing education whether formal or informal could be the means by which members of the profession fulfil their obligation to the public to be as proficient as possible. For some people one form of continuing education may be by achieving higher tertiary awards.

The present education of orthoptists in Australia results in the acquisition of a Diploma of Applied Science in Orthoptics (a UG2 award) and it is hoped in the near future that a UG1 Bachelor of Applied Science degree will be commenced in both Schools of Orthoptics. Thus it will be possible for these graduates to progress if desired to a PG1 post graduate diploma, either in some area of orthoptics or in some other field. Standards of tertiary education are continually being reviewed by both the colleges providing it, by appropriate government boards and by the professional bodies most concerned. External advisory committees monitor the current programmes and courses being planned for the near future. Every member of the profession should be aware of the importance of both the undergraduate and postgraduate courses under review and consider whether they are relevant for today's orthoptists.

It is not impossible to imagine that before long masters degrees in orthoptics will be planned. At present those orthoptists wishing to progress in the academic field must obtain a masters degree in some other field at another tertiary institution, i.e. a university. Orthoptists hoping to make a career in the training schools of the near future

will have to obtain masters degrees or doctorates to move up the scale through lectureships to heads of school. Most promotions will also depend on the amount of publications and research undertaken. These are also important areas for the average orthoptist to undertake if possible. The new degree course will encourage this by including more research methodology in the curriculum.

However, not all orthoptists wish to move into academia and so some other methods must be sought to assist them to maintain professional viability. Attendance and participation in conferences, seminars and special non examinable courses may be the answer. The Orthoptic Association of Australia is doing its best by running special continuing education courses at the time of each annual conference and the Cumberland College of Health Science's continuing education section combines with our state branch of the Orthoptic Association of Australia in presenting short courses in N.S.W. on subjects requested by our members. None of these include any form of testing of knowledge nor is there any peer review involved. The committees planning continuing education seminars need constant help and advice to ensure that they are providing the material required to help the practising professional remain in touch with current trends of the profession.

The difficulty in designing continuing education courses is to know at what standard to present them. In some cases members who have been away from practice for several years really need refresher courses but at present our numbers are too small for such courses to be viable. If these orthoptists are really serious about a desire to be re-educated it is possible for them to enrol as non-standard students in the School of Orthoptics, doing only the orthoptic or ophthalmology subjects required, but most reject this alternative. Others are more recent graduates who feel the need to keep up to date and who have a good basic knowledge of the subject. The problem of content of the course, whether this should be orientated towards ocular motility and binocular vision or to ophthalmology, depends upon demand.

So far I have been concerned with individual members of the profession and their own accountability. What about the profession as a whole? All health professions are under the microscope at present, the government is concerned with costs and the media have made the taxpayer aware that he has a right to some say in how his money is being spent. During a recent visit to Australia Dr William Scott said that all professions who wish to have their cut of the health cake must make sure that they are delivering the goods. He suggested that continual research and review of our work is necessary, otherwise we will be found wanting. We must justify the money being spent on our education and for our services in the community.

Our Association has done a great deal in the past few years to increase the awareness of our profession both in the eyes of government departments and the general public. Our councils are aware that they cannot slacken their efforts in these directions and members can be assured that much is being done for them; however every member of the profession should be aware of the problems that are involved and play their role in helping to raise and maintain high standards.

I have not touched on the very real problem of the legal and ethical implications of professional accountability. These include the individual's right to continued practice once a qualification has been obtained and the patient's right to insist on quality control. There are many other aspects to this problem which are frightening to consider but may have to be faced eventually. In the long run though, however much our Association does for us by improving our public image—however much our education is improved—in the final analysis it is the individual orthoptist who is responsible for his/her own professional outlook. If professionally responsible members continue to be dedicated to the concept of professional accountability and if individual orthoptists by personal continuing education achieve and maintain high standards of expertise the profession itself will be able to maintain a place in the health care system.