

JOURNAL OF OPTOMETRIC EDUCATION

Volume 5, Number 1
Summer 1979



**The Optometric Residency:
A Look at Its Bloom**

ASSOCIATION of SCHOOLS and COLLEGES of OPTOMETRY

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Association Activities

This issue highlights the activities of the Board of Directors meeting in April in Washington, D. C. and the recent Annual Meeting in Anaheim, California.

Board of Directors Meeting April 5-7, 1979 Washington, D.C.

This meeting centered around the alarming decrease in the number of applicants to the schools and colleges and the corresponding increase in the age distribution of current practicing optometrists. With the number of OCAT applicants having declined for the past four years and the total manpower pool of college-age young people predicted to decline by 18% by 1985, a serious decline in enrollment is predicted by 1981 if the present trend continues. At the same time, the current age distribution of practicing optometrists indicates a severe loss of practitioners in the next ten years.

For this reason, a Project Team on Student Recruitment was established earlier this year for purposes of reviewing the situation and determining what actions ASCO could take to address the problem. At the April meeting the project team, under the auspices of the Council on Student Affairs, recommended that ASCO assume a greater degree of responsibility for the development and distribution of career and recruitment materials for practitioners and college guidance counselors in an effort to encourage additional applicants to the field of optometry.

Because of the need for funds to support these and other educational program activities, the proposed "grass-roots" solicitation already committed by the Board of Directors was expanded to include the full 20,000 membership of the AOA at the April meeting. It was further recommended that an article in the May issue of the *Journal of Optometric Education* be devoted to explaining these manpower issues and encouraging the support of the individual practitioner in manpower recruitment.

The AOA Task Force on Health Manpower and Federal Support for Opto-

metric Education also drew considerable attention. Discussion focused on the role of the educational institutions and the various modes of delivery of health care. The Board determined that an identification of needs and what those needs would accomplish was necessary in order to achieve positive support for optometric education in future health manpower legislation. An advisory group was established to provide input and assistance into the AOA task force on manpower support.

Ms. Joan Weinstock of the AOA Washington Office discussed the 1979 Health budget recisions and projections for 1980. Ms. Weinstock anticipated the mood for future funding would not be favorable, and a committee was appointed to advise the AOA and ASCO Washington offices in efforts to influence future legislation and allocation of funds under present existing authorities.

Dr. Kirk Boatright, dean of the College of Arts and Sciences at Northeastern Oklahoma State University, reported that the new school at Northeastern would be initiated as a two-year program, with an expected first-year class in the fall of 1979. He also reported that attempts are being made to establish an Indian Health Service Hospital to provide clinical experience for the new school. The Board resolved to notify the Oklahoma Optometric Association of its recommendation that a full four-year professional program is a more appropriate direction to undertake and of the serious risk involved in the establishment of a two-year program without reasonable assurance of accreditation and admission to upper division programs.

A resolution was also passed endorsing the establishment of a school of optometry within an academic health center in the State of Florida.

A proposal by the Canadian Association of Schools of Optometry requesting affiliate membership of the Canadian schools as a single organizational representation rather than as individual institutional members was not approved. The Board felt strongly that fractionalization of organized optometric education was not in the best interest of the profession.

A resolution calling for those faculty members who engage in the practice of optometry to meet legal as well as statutory standards of practice and to maintain the highest standards of professionalism in the rendering of patient care services was approved. The resolution further called for those faculty members who are not members of the AOA and state associations to join in an expression of support for organized optometry and its concept of professionalism.

An AOSA resolution requiring a minimum three year pre-admission requirement to optometry school was referred to the Councils on Academic Affairs and Student Affairs for further consideration.

Annual Meeting June 17-18, 1979 Anaheim, California

The final report of the Project Team on Student Affairs was distributed. Entitled, "A Framework for Student Affairs in Schools and Colleges of Optometry," the booklet defines the functional areas of student affairs which specifically concern admissions, financial aid, records, counseling and other areas of responsibility.

The Council on Student Affairs reported that the Project Team on Student Recruitment which was continued at the April Board meeting would be carrying out several of its own recommendations with regard to ASCO recruitment materials.

In light of the serious threat posed by the decline in the student applicant pool, the Board passed a resolution expressing its urgent concern to the American Optometric Association for the matter of student recruitment and manpower development and urged the AOA to immediately make this a matter of highest priority of program development.

The Board was advised that the decline in OCAT takers this year (approximately 17%) will probably continue, although at a slightly decreased rate, next year. Estimates are, based on past experience and that of other professions, that a 10-12% decline can be expected next year.

ies & Board Briefs

A resolution endorsed by the Council on Student Affairs was passed requiring that enrollment termination status of an individual student could not be disseminated without that student's specific prior permission.

The Council on Institutional Affairs reported that a meeting had been held with a research consultant to discuss the planning and development of a system of collecting, storing, analyzing and retrieving standardized clinical data toward evolution of a standardized data base for the schools and colleges. With initial emphasis on the clinical component of such a data base, it was recommended that a pilot program involving two to four schools be developed to institute a standardized clinical data base that would have clinical, management, quality assurance, and educational research applicability.

The Council on Academic Affairs reported that a Professional Development and Administration Curriculum Model had been completed in response to considerable attention on how the practice development and administration curricula in the schools and colleges of optometry were preparing students for this aspect of optometry.

In addition, a subcommittee of the Council on Academic Affairs met to develop curricular information in the area of behavioral science. However, this proved to be a very difficult and demanding task, and the group was only able to accomplish a rewording of the curricular elements in behavioral science. Further attention to the development of a behavioral science curriculum model was recommended as an ongoing activity of the Council on Academic Affairs.

AOA liaison officers, Drs. Jack Bennett and John Tumblin, advised the Board that the career guidance program of the AOA Education and Manpower Division had been approved for funding and that other activities indirectly relating to education would continue to be supported.

A resolution presented by AOSA requesting release time for study days for the National Board Examination was not approved. The Board felt that a

comprehensive recommendation could not be provided because it would interfere with individual schedules of the various schools and that the problem was basically an institutional concern.

The Board moved to support in concept for further study the approach of continuing education programs by correspondence. An ad hoc committee which was assigned to review the proposal recommended that a program be developed which would draw from the resources of all the schools to bring in revenue to the association with the aim to implement it during the 1980 calendar year.

Representatives from the American Optometric Foundation (AOF) reviewed AOF's activities of the past year and sought ASCO's support in reestablishing its relationships with AOF and its representation on the AOF board.

A resolution was passed congratulating AOF President Dr. Harold Davis and the board of the American Optometric Foundation for successfully addressing AOF's critical financial status over the past two years and for continued commitment to support of optometric education and research.

Representatives from the National Board of Examiners in Optometry (NBEO) met with ASCO to request clarification of the distribution policy of the NBEO statistical report and to report that a task force composed of IAB, NBEO, COE, AOSA and ASCO representatives is considering outside validation of the National Board Examination and adoption of the exam by more states for licensure.

A resolution commending Dr. Ashley King, retiring executive secretary of the National Board of Examiners in Optometry, was presented for his dedication and service in assuring the competency of future practitioners of the profession.

The Council on Optometric Education of the AOA advised the ASCO representatives that it had revised its statement on residencies as a result of ASCO input to endorse the policy of approving any advanced educational programs in optometry with no specific programs being named. The Council also stressed the necessity for meeting

with ASCO to discuss funding of site visits at the schools and colleges.

The executive director reported that the International Optometric and Optical League (IOOL) annual meeting in Milan, Italy, had resulted in the development of a revised definition of optometry, the establishment of a group to move toward voluntary certification of all optometry schools which met the IOOL syllabus of optometric education, and the establishment of an Association of European Schools of Optometry.

A resolution commending Dr. Glenn Fry, Regents Professor Emeritus of the Ohio State University, for his 44 years' service to optometry and optometric education and for important research accomplishments in visual science was passed.

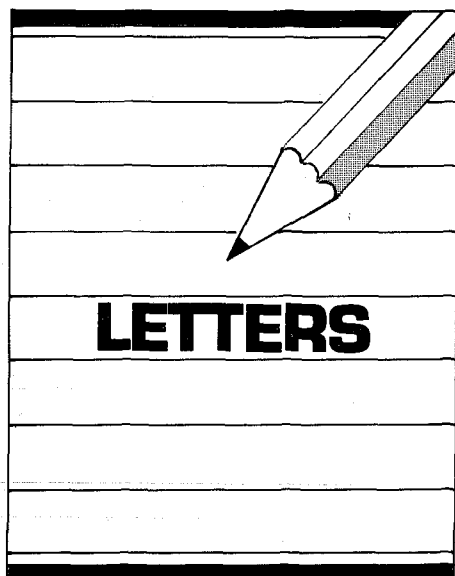
Resolutions were also approved commending Drs. Alden N. Haffner, Frederick W. Hebbard and Jess Boyd Eskridge for their outstanding contributions, leadership and service to the association.

Southern California College of Optometry was congratulated in a resolution on the occasion of celebration of its 75th Anniversary and extended best wishes for continued success and achievement.

A resolution was also passed supporting the concept of regional plans for optometric education and the development of a plan that will adequately address optometric manpower distribution in shortage areas.

New officers for the association were elected. They are: Dr. Alfred A. Rosenbloom, president; Dr. Willard B. Bleything, president-elect; Dr. M. Emerson Woodruff, vice-president; and Dr. Richard L. Hopping, secretary-treasurer.

New chairmen and vice-chairmen for ASCO's three standing councils were also appointed. They are: Dr. Michael Heiberger, chairman, and James Noe, vice-chairman, Council on Student Affairs; Dr. Anthony DiStefano, chairman, and Dr. Paulette Schmidt, vice-chairman, Council on Institutional Affairs; and Dr. Gerald Lowther, chairman, and Dr. Douglas Poorman, vice-chairman, Council on Academic Affairs. □



Dear Mr. Smith:

In looking through the sample copy (Vol. 4, No. 3) of your journal, my concern is with the A.O.S.A. request for a three year minimum entry requirement into optometry school.

The reply of the executive committee makes one think of a reply we heard from the executive committee of Indiana University Medical School in relation to starting an optometry school at Indiana University.

In about 1950 optometry went before the state legislature requesting the establishment of a school within the university. We failed in the first attempt. We were told to get the medical school's blessing for our next try. A committee of the I.O.A. met with the medical school executive committee. Among other things, the secretary of that committee said, "Oh, you want an optometry school at I.U. so you can control the number of optometrists coming into Indiana like we do." We retorted that we wanted to improve optometric education and furnish the people of Indiana competent professionals in the field. We were amazed at the statement, hung our heads, and agreed later that this was only further evidence of the demise in medical ethics at that time.

With the continuing need of well-educated optometrists, this reply to the A.O.S.A. is remarkable. The fact that some optometry schools require students to have four years of previous college work before entering indicates there is not a unanimous attitude in ASCO to take less. And with the tremendous competition to enter, why not secure the future with more maturity of four years of pre-optometry? In the last

few years, we have glibly talked about optometry being a "primary care profession" or a "primary entrance point into the health field." Well, if we are that, we certainly can be that only if we have a broadly based education. Charles Sheard was probably right in his hopes to get all the health professions to start together for the first two years of professional training, then let them branch off into their professions after that.

But if that comes or not, the "primary" philosophy in optometry certainly dictates the necessity of a pretty thorough educational base prior to optometry. The rebuttal to this has often been heard—"there are some students who are ready after high school for professional school." This may all be if we are speaking only of ability to pass courses and pass exams. But maturity comes with years as well as formal education. Little would one ever expect that the clinical would have to push the academic on this point. It almost seems we are still in the days of the proprietary school!

One would hope the Executive Committee would change its mind on its action or that the Board of Directors would rescind the action.

**Kenneth E. Kintner, O.D.
Box 688—517 Lincoln Way East
Mishawaka, IN 46544**

Editor's Note: *I have asked Dr. Alden N. Haffner, Immediate Past President of ASCO, to respond to this and the following letters.*

Dear Dr. Kintner:

Though the schools and colleges of optometry admit the majority of their students with baccalaureate degrees, some outstanding candidates present themselves with two or three years of pre-professional collegiate work. While I personally agree with you that the bachelor's degree would afford an opportunity for persons with broader educational backgrounds, the institutions must also be sensitive to the concern that an additional requirement adds burdens of costs to students already heavily in debt with student loans. Moreover, the issue of the rapidly declining student applicant pool (in all of the health disciplines) is a decided negative deterrent to raising the formal entrance requirements at this time.

The AOSA resolution is presently under consideration by the ASCO Councils on Academic Affairs and Student Affairs. My personal opinion is that the three year requirement ultimately

will become the universally adopted minimum requirement with the overwhelming majority of students entering with the bachelor's degree. ASCO appreciates your thoughtful comments.

**Alden N. Haffner, O.D., Ph.D.
Immediate Past President**

Dear Dr. Haffner:

I recently received a copy of the *Journal of Optometric Education* along with your letter asking for a \$25.00 contribution. Because my life is optometry, I'm enclosing my check, but also for this reason I ask for a few minutes of your time to consider something which has been very heavy in my heart and mind for some time.

I am a 1966 graduate of Southern College of Optometry, one who chose to specialize in developmental vision and vision training because my exposure to Functional Vision (O.E.P. tenets) in school convinced me that this is the *one, real unique* facet of our vision care with makes optometry a separate, distinct, and *valuable* profession. In the past six to eight years I have sensed a decreasing attention to the teaching of the functional vision philosophy in our optometry schools.

The apparent rush toward mimicking medical eye care on the part of our schools is alarming to me not only because it seems to play right into the hands of our medical adversaries, but more importantly because it denies multitudes of Americans the kind of visual attention that only the functional visual approach and understanding can give them. I'm speaking, in great part, of preschool and school age children whose visual abilities are still pliable enough to respond to preventive kinds of care and those millions of children with visually-related learning problems who can be helped by the developmental optometrist.

It's not that I mind O.D.'s choosing as their preference to practice "eyeball" optometry as long as they have, in their educational curriculum, gained enough exposure to O.E.P. optometry to recognize that it is a valid, worthy, and essential ingredient to optometry. If our optometry graduates of today are permitted to complete their curriculum and receive their O.D. without this exposure, then not only will we in functional optometry have to weather the skepticism and accusations of those outside of our profession, but in effect will find our own colleagues expressing the same skepticism. I can't believe our profession

(continued on page 8)

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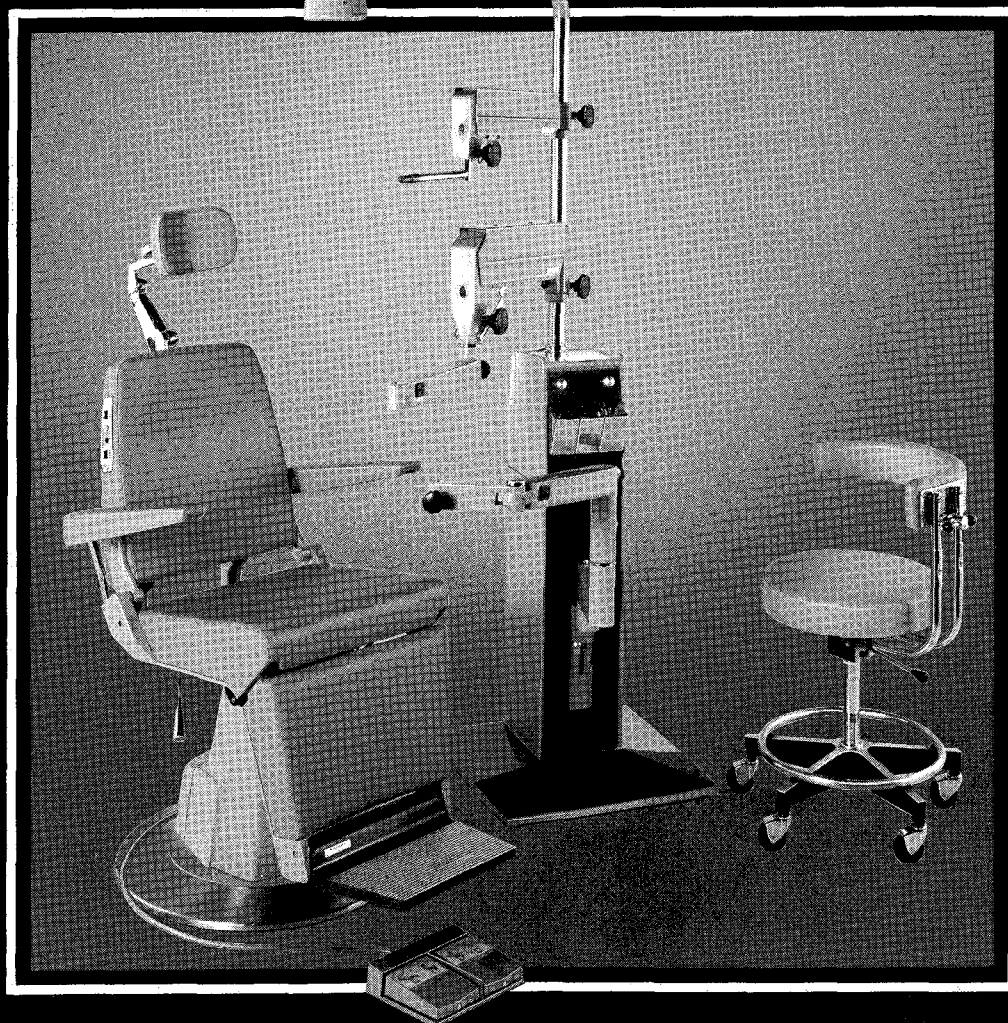
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(continued from page 6)

would knowingly let this happen, but I'm becoming increasingly concerned that some in high optometric educational circles are refusing to see the danger to optometry in this trend.

Please don't misinterpret my feelings. I have kept my continuing education up in the area of pharmacology, use DPA's and retinal photography, fit hard and soft contact lenses, and practice in a retirement community with many "senior citizen" patients. My head is not in the sand when it comes to the realities of providing vision care. But I am as thoroughly and completely dedicated to functional vision and professionalism in optometry on the highest level as I am opposed to "commercial optometry." And it's out of that love for optometry that I write you. Although not many of us O.E.P., C.O.V.D. proponents may be writing letters, many discussions in seminars convince me that I am far from alone in the concerns I've expressed.

My sincerest wish is that you will use your considerable influence to persuade optometric educational leaders to turn the tide in optometric teaching back toward a *balance* wherein the functional vision viewpoint—the backbone of optometry—is given at least equal emphasis in the professional curriculum.

In closing let me express my appreciation, as a practicing colleague, for your dedication to our profession. I know that at the highest levels of inter-professional relations you have always fought for the advancement of optometry, and we all owe you a great "thank you."

Roger W. Graham, O.D.
2436 Bayshore Blvd.
Dunedin, FL 33528

Dear Dr. Graham:

There has been persistent criticism of the schools and colleges of optometry with regard to the matter of functional processes in vision and vision care. But please don't despair. Indeed, progress has been made. Several institutions have introduced significant behavioral science programs into the academic structure including course material in developmental psychology, clinical psychology, learning theory and behavioral modifications. One college, the State College of Optometry, State University of New York, has organized its academic program around four departments, one of which is a Department of Behavioral Sciences and Public Health. Moreover, the Council on Academic

Affairs of ASCO is this year beginning to outline topically those areas of behavioral science which should be in both the curriculum model and material for National Board testing.

Indeed, changes are coming. Today, one or two courses in psychology are required for admission to the schools and colleges of optometry along with the other sciences. And that can be translated to mean changes in the years ahead with regard to functional visual therapy. But what is desperately needed is sound and rigorous applied research to bolster this entire area of vital professional concern. It can be done and with your help, it will be done. ASCO appreciates your thoughtful comments.

Alden N. Haffner, O.D., Ph.D.
Immediate Past President

Dear Dr. Haffner:

I am very interested in optometric education and was very pleased to receive the Winter 1979 issue of the *Journal of Optometric Education*. I was all ready to send the \$25 until I came upon the minutes from your Executive Committee meeting of 9 December, 1978. I was upset to read that the American Optometric Student Association proposal to implement a standard three year minimum requirement for entry into optometry school was disapproved by your Board. The reasoning for this was the "possible exclusion of highly qualified applicants with only two years of undergraduate work." I feel this is not valid reasoning. If an undergraduate is interested in optometry school at the end of his or her second year, then they will be interested in it at the end of their third or fourth year as well. We don't want to fill our optometry schools with highly qualified second-year undergraduates who apply to optometry schools solely because they can begin earlier than other professional schools. Sure, we may lose a few to medical schools or some other profession, but did we want them anyway? We want students who will be proud of their profession, not students who will regret a decision made early in undergraduate school. Let's not trap these qualified second year students. If they are truly interested in the profession of optometry, they will still be there in a year and even better qualified.

This decision has many other implications as well. I am currently an Air Force optometrist. Because optometry schools accept students after two years undergraduate work, optometrists

entering the military come in as 1st lieutenants with no credit towards pay for any professional schooling they have. Medical doctors and dentists come in as captains with four years credit towards pay for their professional schooling. Psychologists and, just recently, podiatrists are also getting credit toward pay for their professional schooling. This is all because of the undergraduate education required by the various professional schools. Optometry is looked upon by certain elements of the service as equivalent to a masters degree. That is, a total of six years of college. Even though many military O.D.'s have seven, eight, or more years of college, we are all treated the same because of the schools' policies of admitting a relatively high percentage of second year undergraduates. Because of this, many of our medical peers and our patients tend to look down upon optometry. Optometrists are put in the position of having to *prove* their professionalism.

I am sending a copy of this letter to the editor of the AOA Journal in hopes that it will be printed. Optometry must make a stand to improve the qualifications of our entering students in order to improve our image as professionals.

Victor T. Nothnagel, O.D.
508 Gooney Bird
K.I. Sawyer AFB
Michigan 49843

Dear Dr. Nothnagel:

When the American Optometric Student Association presented its resolution, it provoked thoughtful and reasoned debate. I personally favor the three year requirement and the State College of Optometry, State University of New York, has long ago imposed this requirement. Other schools have, as well. But the agreement is not uniform. While the military issue and implications as you have so ably presented them in your letter are compelling, some schools do not view them as sufficiently the overriding educational issue. Moreover, there are other substantive issues, some of which I covered in my comments to the letter from Dr. Kintner. Please understand that the paramount considerations must be educational when educational requirements are constructed by the faculties of institutions. I am persuaded that the three year pre-professional collegiate requirement will become the universally adopted standard. ASCO appreciates your thoughtful comments.

Alden N. Haffner, O.D., Ph.D.
Immediate Past President

This year begins my second year as chairman of the Editorial Council of the *Journal of Optometric Education* and the fifth year of publication for JOE. When I was appointed chairman in July, 1978, by Dr. Alden N. Haffner, then president of ASCO, I met with Ms. Harriet Long, managing editor of JOE, and Mr. Lee Smith, executive director of ASCO, to discuss some of the immediate concerns facing JOE and what could be done to remedy them.

At that time, a decision had been made to find a different art director since neither Ms. Long nor Mr. Smith was satisfied with the previous artwork. The last several issues attest to the abilities of Mr. Dan Hildt, the current art director.

As a result of our discussion, we decided some of our concerns were:

1. A chronic shortage of manuscripts;
2. The need for a wider audience;
3. Need for more advertising;
4. Establishment of an Editorial Board;
5. Refinement of the refereeing process; and
6. Referencing by Index Medicus or some other indexing service.

To hopefully remedy several problems simultaneously, we contacted two individuals at each member institution of ASCO to serve for a three year period on the JOE Editorial Board. The result was almost universal acceptance. The board members were asked to assist in two ways. First, to occasionally referee a manuscript, and second, to stimulate interest among fellow faculty members to submit papers of an educational nature to JOE. The names of the members of the board were published for the first time in the Winter 1979 issue of JOE.

Along with this, the refereeing process was refined and guidelines were adopted for reviewing manuscripts. When a manuscript is received, copies of it will be sent to two reviewers in the area of expertise with identification of the author removed. The reviewers will be asked to make a choice as to one of four recommendations regarding publication. Following the receipt of the reviewers' recommendations, the author will be notified and asked to make any necessary changes if indicated before the manuscript is accepted for publication.

From the larger Editorial Board, four people were selected to serve as members of the Editorial Council. I am happy to say that Dr. Robert Rosenberg, Dr. Tom Lewis, Dr. Henry Hofstetter and Dr. Penelope Kegel-Flom have accepted my offer to serve. It is their task to assist the chairman and managing editor in gathering ideas for future issues and to assist in advising on editorial policy and other management decisions.

The Editorial Board held an informal meeting at the Academy meeting in December, 1978. After discussing the recent history of the *Journal* and some of its problems, alternatives for solutions were discussed. One suggestion which was put forth quickly and adopted was the inclusion of an abstract page. Dr. Robert Rosenberg of the State University of New York, State College of Optometry, has agreed to survey the health professions' educational literature periodically and provide the *Journal* with abstracts.

In addition, Dr. Felix Barker, II, of the Pennsylvania College of Optometry has agreed to survey current resource materials and provide the *Journal* with a synopsis of pertinent information.

Other changes which are either under consideration or have already been implemented are:

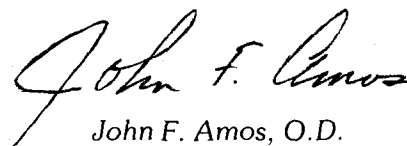
1. A review of current publications and resource materials;
2. Change in reference format to Index Medicus style;
3. Change in running titles to include issue and volume number; and
4. Gradual transition from present format to more scholarly journal.

To date, the first problem mentioned remains the primary area of concern. The *Journal* encourages the submission of all manuscripts which are related to or are of interest to optometric education. If we are able to continue receiving quality material, then we should be able to move on to other important matters within the next several months.

Our primary objectives for the coming year will be:

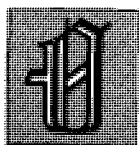
1. To reach a broader audience of those in practice;
2. To become referenced by the major indexing services;
3. To gain broader support among the member institutions; and
4. To implement suggestions for adding new features and columns.

With the continued help of the JOE Editorial Board, the Editorial Council, and the faculty, administration and student body of the member institutions, we should be able to make JOE the highest possible quality educational journal for the profession.


John F. Amos, O.D.
Chairman, Editorial Council

IN DEFENSE OF PROFESSIONALISM

Alden N. Haffner, O.D., Ph.D.



One year ago, I conducted these commencement ceremonies and I did so with the knowledge that I would, a few days thereafter, announce my leave from that which had been my academic and professional home for many years. For me, all of the thoughts, spoken and implied, had special meaning and some had particular poignancy. It, indeed, has been quite a year for me and, I am sure, an adjustment for the college community. The search for the position of Associate Chancellor for Health Sciences is nearing completion and a decision by the State University of New York is expected soon.

However, today's discussion is not about me but, rather, about you who are our new colleagues, your families, your careers, our profession and our college. My commencement message will be brief but, I hope, nevertheless important.

If there is one theme that is constant throughout the generations, it is that of change. The events of a profession are replete with change. Like those of all human endeavors, there is a constant flux—of the times, of circumstances and of people. Professions, too, have changing circumstances. They are accorded roles and status by the people who mold and influence the community's attitudes and its culture and these, too, change with the times. And so it is with the circumstances of the health professions today—and, as well, with our profession, yours and mine. And it is about an aspect of one of those changing circumstances that I want to address my remarks today.

Professionalism is under attack in health care and its dimensions are serious, pervasive and, in some respects, frightening. This attack is particularly severe because it occurs at a time when a variety of forces, in the community and in government, have come together. Professionalism increasingly seems to be viewed with distaste and is rejected as an ideal. And the rejection appears as an emerging crisis-theme in every health discipline. Optometry continues to have its share of attention in this regard. But it is not alone.

This tearing apart of professionalism has many aspects to it and I hasten to analyze for you my perceptions of five of its important elements:

The license to practice is not a franchise . . . It is yours to hold as a social contract obligating you to professional utility, social purposefulness and advancement of the sciences of the discipline.

Alden N. Haffner, O.D., Ph.D., is Associate Chancellor for Health Sciences, State University of New York, Albany, New York.

A Commencement Address to the State College of Optometry State University of New York

International House, New York City
Sunday, June 3, 1979

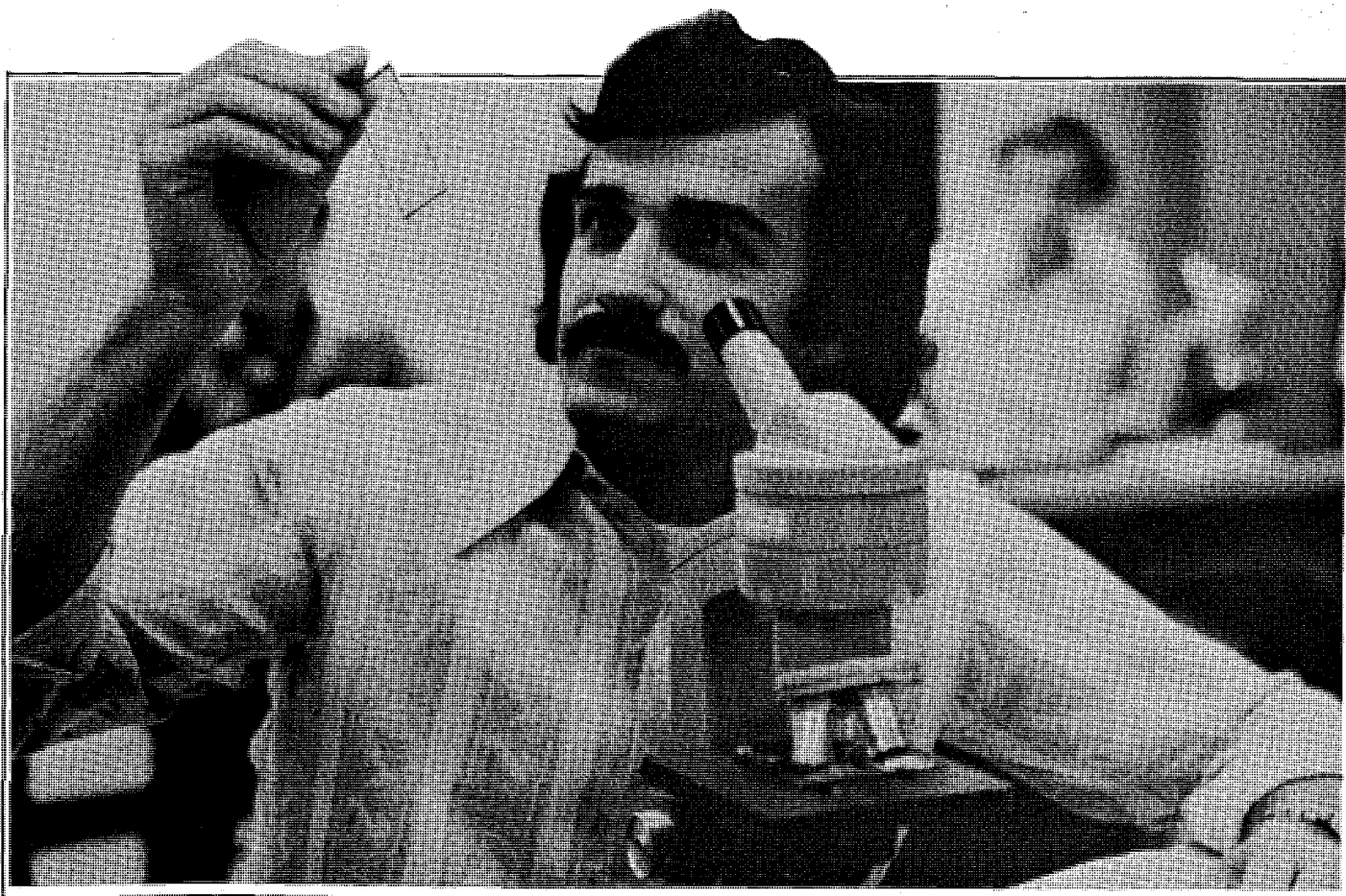
1. The communities of the nation believe that health care costs are so high as to approach a level of exorbitancy. And the community clearly lays a major portion of the blame on *that modus in the disciplines known as professionalism*. Professionalism is frequently equated by the people with aloofness. That "distance" or deference, designed by the professions, is viewed as socially and fiscally costly. Moreover, the "pedestal syndrome," occasioned by the conferral of a doctorate, tends to be viewed as the entitlement to professionalism. What has in the past been understood as deserving of a sense of respect by the public is now looked upon with increasing disdain and even resentment.

2. Governments, at several levels, have undertaken to assault the behavior of professionalism in emphatically direct ways. Nowhere has this been more vivid than by the rules, adopted with the force of national law, by the Federal Trade Commission. Under the guise of seeking to increase com-

petitive forces, advertising by practitioners is permitted and even encouraged. And those who decry the advertising as creating for the health care disciplines a market-place environment—namely, *the professions*—are portrayed as being against the best interests of the patient as the consumer of care.

3. There is another aspect to the freer reign on advertising that is used by its promoters. It is that advertising will increase the fulfillment of the consumer's "right to know" all about health care services in advance of, during, and following receipt of them. To argue against loosening the strictures on health care advertising in the light of today's public and governmental attitudes is almost to be placed as an adversary to the patient's interests as a consumer.

4. It has been said, too frequently to be ignored, that professionalism leads the practitioner too much toward the care of conditions, diseases and dysfunctions and that humani-



tarian concerns of health care are subverted or largely ignored. Indeed, the charge is made that professionalism and humanistic goals are today not consistent.

5. We are told that practitioners of the health disciplines who hold the public trust of a license must become more accountable. State governments demand increasing public accountability and are being reinforced in those demands by communities of the many publics. Perhaps the most serious demand for accountability relates to competence in the skills of the discipline and in the maintenance of continuing competence in order to justify sustaining of the license. That this demand for accountability has even been made raises a fundamental question about the public's and government's confidence in professionalism.

Indeed, the attack upon professionalism of the health caring disciplines I fear lies deeply rooted in the community and is reflected by government. It cannot be ignored. For if allowed to progress unanswered, the very nature of the future constructs of society's knowledge-centers in health care—its professions—may be destroyed.

My colleagues, I rise to defend professionalism and let me tell you why.

I am deeply committed to professionalism in several very fundamental ways. First, the concept of professionalism in the health caring disciplines has, as a major precept and goal, the advancement of science and the never-ending pursuit of new knowledge. Professionalism invokes an attitude about knowledge that is respectful. Its potential in the application of knowledge for the well-being of people and for societal advancement is rooted firmly in its concept. Weaken professionalism, and I fear that its knowledge-directed fabric will itself be weakened. I need not spell out the human consequences of this possible evolvment.

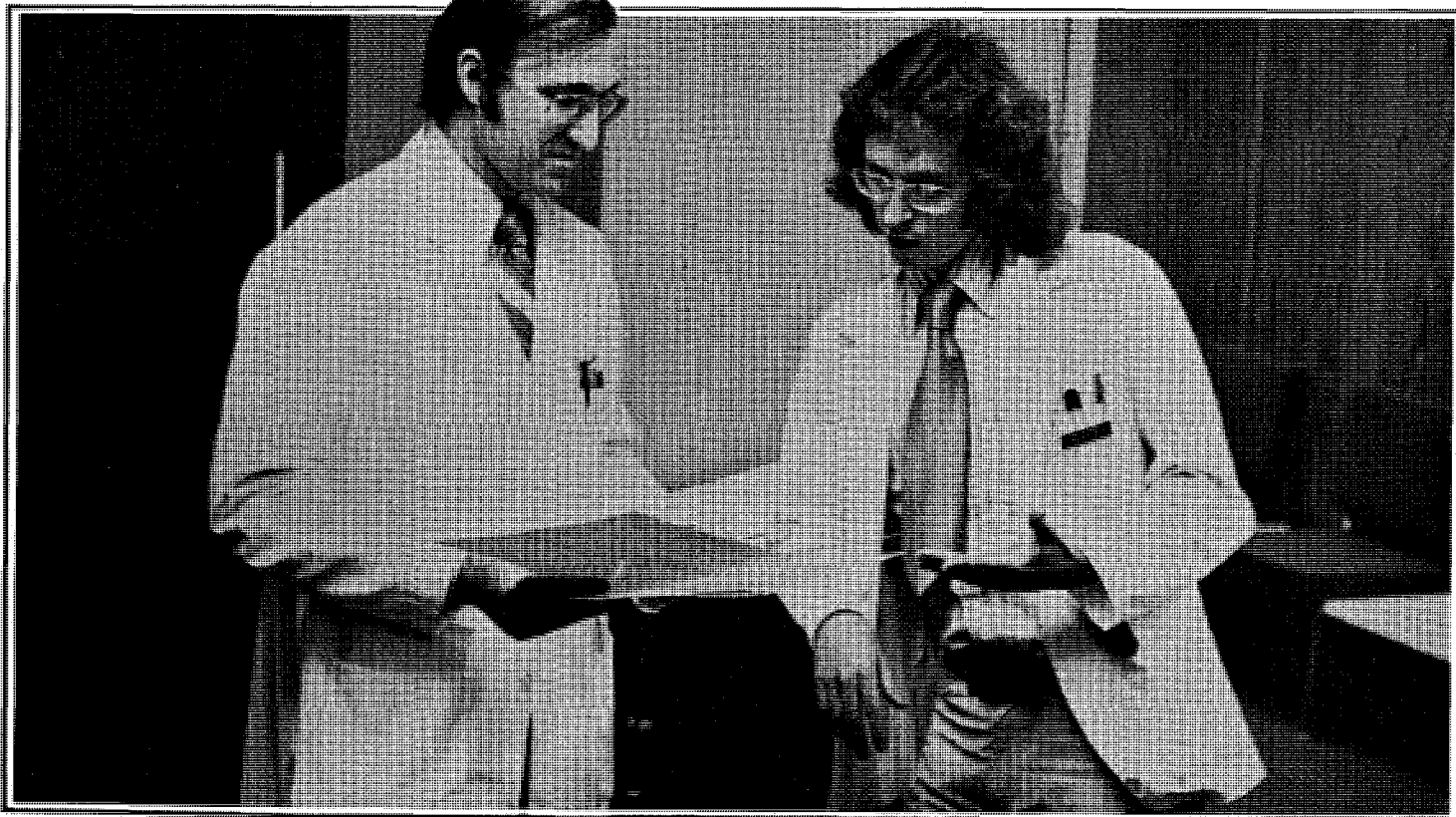
Second, there are manifest differences between those occupations which are accorded the status of professions and the many more which are vocational specialties. The social philosophers and sociologists such as Harvard's great Talcott Parsons, who very recently passed away, defined the extents of responsibilities which the community accords to the professional. Government does it differently. It constructs through statute the entitlements of authority to carry out the terms and conditions of the license to practice. Reduce the authorities of the health caring disciplines, and the very foundations which determine that they are professions become eroded.

I am concerned that these elements are present in our society. What has been built in this century is an enormously talented structure of professions of health caring disciplines. The tenets to which each profession is committed are those of professionalism in behavior and in scientific performance.

My colleagues, there is enduring purposefulness to professionalism in health care. I reject the unjust claims made upon it. Cost factors come about as a result of the organizational, financing and delivery methods into which so much of health care is structured. ***Professionalism is not the culprit.***

Competitive forces should not be increased except in the absolute pursuit of better and more knowledgeable clinical care. Marketplace behavior will reduce health care to that of a bartered commodity devoid of those personal and humanitarian components so essential to quality service performance. ***Professionalism is not the culprit.***

Professionals gain their advertising properly from the recognition of the fundamental ethical decency and scientific standards of their daily performance. Without question, that includes the continuing education of the consumer about patient health problems so that *understanding* is achieved—and *understanding* by the patient is the proper goal, not



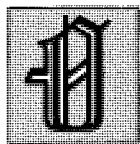


*Be the change-agents for
community good and for the
betterment of the visual
welfare of people everywhere.*

simply the consumer's right to know. Indeed, the promotion of better understanding by the patient is the appropriate role of the health care professional. **Professionalism is not the culprit.**

Intellectual excitement in health careers by professionals has been translated into extraordinary advancements for the care of human disability. Social historians will record the twentieth century as a golden age. The flowering of these achievements in the clinical health professions have come about because of the talents and dedication of those who were committed to such social idealism. I pray that it continues unabated. **Professionalism is not the culprit.** Professionalism is the virtue that encouraged progress.

Particularly in our own discipline of optometry have very firm lines in the last few years been drawn. There seems to be, however, confusion as to the contour and boundary of those lines. Let me attempt the clarification as I see it **for the future of our profession as a profession.**



Optometry is a clinical health care endeavor rooted firmly in vision science and the other related basic and applied sciences. Cumulatively, that body of knowledge constitutes what the public has accorded as the role and status of a profession. Our quest for new knowledge matches our commitment to humanistic concerns in the performance of our professional duties. Changing economic times, manpower circumstances and public expectations and attitudes regard the technical functions of ophthalmic dispensing as properly belonging in the business environment of the marketplace. But that environment is no place for professional, scientific and humanistic health care based upon eight college and professional school years of disciplined study. I concede to the marketplace environment what belongs there. But the therapeutic surrounds of the clinic, the hospital, the office, the HMO and the health center are the appropriate and only environments of the optometrist as the practitioner of a profession.

Professor Burton J. Bledstein, in his brilliant thesis entitled *The Culture of Professionalism*, said:

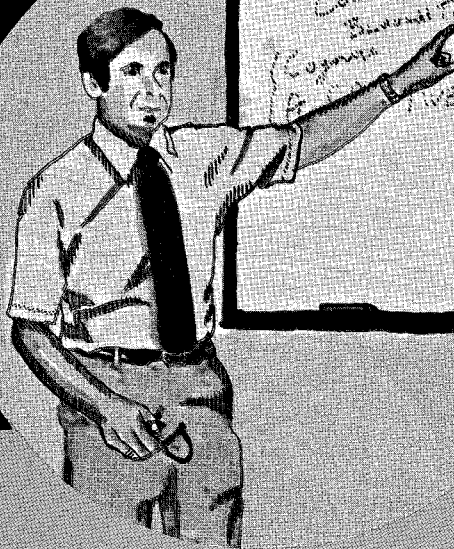
Perhaps never before within the last century have we as Americans been so aware of the arrogance, shallowness, and potential abuses of the vertical vision (professional behavior) by venal individuals who justify their special

treatment and betray society's trust in invoking professional privilege, confidence and secrecy. The question for Americans is, "How does society make professional behavior accountable to the public without curtailing the independence upon which creative skills and the imaginative use of knowledge depend?" The culture of professionalism has allowed Americans to achieve educated expressions of freedom and self-realization . . ."

To my colleagues of our college, the task for the many years ahead will be to imbue more securely the special qualities of professionalism into the fabric of optometry and to help to rationalize the boundaries and contours of our beloved discipline. The leadership of the college in this regard is no less important than in our determination as academic colleagues to pursue relentlessly new knowledge and understanding in the sciences of our special areas of expertise. The performance of the latter in no way diminishes our responsibilities of the former.

To my new colleagues who are today beginning careers as doctors of optometry, I bid you well in your life's work. Be the change-agents for community good and for the betterment of the visual welfare of people everywhere. I plead with you to hold professionalism and its precepts close to you throughout your important endeavors. The license to practice is not a franchise. It is a public trust given to you by virtue of the knowledge, understanding and skills implied by the degree which is today conferred upon you. This license is owned by and is an instrument of the state. It is yours to hold as a social contract obligating you to professional utility, to social purposefulness and to the advancement of the sciences of the discipline.

And to the families and friends of this talented group who are being recognized today, the Empire State, through its generous investment of resources in the State University of New York, has made professional education in optometry possible because it understood the critical human and scientific values to be derived. It is now time for those values to find their expression in the communities of the state and nation. They will have a lifetime to demonstrate how social commitment and professional expertise can be creatively matched. Indeed, that is where the really meaningful achievements are. I have every confidence that you will be as proud of them for those accomplishments as we are for their important attainments thus far. □



The Association of Optometric Educators:

Professional Enhancement and Communication

Deborah Adler-Grinberg, O.D., Ph.D.

The Association of Optometric Educators began in 1970, born out of two educators' realization of the value of

sharing and exchanging ideas and materials and of mutually searching for solutions to the multitude of problems educators face. Dr. Darrell Carter of the University of California School of Optometry and Dr. Dorothy Bergin of the Southern California College of Optometry surveyed their colleagues at the various schools and colleges of optometry, attempting to measure the interest for an organization that would facilitate communication between faculty members. The initial response was enthusiastic with comments pointing out how such an organization was long overdue.

At the 1970 American Academy of Optometry (AAO) meeting, optometric educators representing thirteen of the fourteen schools of optometry in the United States, Canada and Mexico met to decide if such an organization was desired, and if so, what should its goals be. Two more meetings were held over the next few days, and the skeleton of

the Association of Optometric Educators (AOE) was formed.

Growth and Development

The early growth of the AOE was fostered by the American Academy of Optometry in two ways. For one, the meetings of AAO attract a great number of optometric educators. Secondly, the Academy graciously provided physical facilities for the AOE meetings. The AOE, however, is an independently functioning organization, with important ties to the Association of Schools and Colleges of Optometry (ASCO) as well as to the AAO.

The expressed purpose of AOE is "to promote professional enhancement and communication among faculty members of the various schools and colleges of optometry." To achieve this purpose the AOE has had an annual section meeting under the auspices of the AAO, held an annual business meeting, published a directory of optometric edu-



Deborah Adler-Grinberg, O.D., Ph.D., is President of the Association of Optometric Educators and Assistant Professor at the College of Optometry, University of Houston, Houston, Texas.

cators and provided various activities throughout the year. Such activities originally suggested were faculty exchanges, counseling and mediation services related to faculty-administration relations, circulation of a newsletter and workshops on teaching methods and evaluation of students and/or faculty.

A constitution was developed and by January, 1971, the AOE was in existence. Dr. Darrell Carter was its first president, with Dr. Dorothy Bergin as secretary and an executive committee composed of the officers and one representative from each of the then fourteen schools of optometry in the United States, Canada, and Mexico.

Enthusiasm Increases

During 1971 the AOE attempted to act as a source of communication with Congress for support of the federal aid for health education bill. Although AOE's input was not vigorously encouraged by the AOA at that time, the AOE would seem to be an important group in development of legislation concerning optometric education. Other activities of the AOE were begun, with the directory of educators completed and a full program on optometric education presented at the 1971 AAO meeting.

The early enthusiasm of AOE's organization continued into 1972, with increasing membership, recognition, and participation in the section on optometric education. The Council on Optometric Education of the AOA and ASCO requested establishment of liaisons with AOE. With the steady growth in the number of optometric educators, concern was expressed as to their salaries in comparison with those of optometric practitioners. Therefore, data compiled by the AOA Council on Optometric Education reflecting the salaries at the schools of optometry was distributed to AOE members. Most salaries were significantly lower than the private practitioner. One implication is that it is therefore difficult to attract outstanding optometric graduates into optometric education. This is an example of an area in which the AOE can be an important mediator.

During 1973 and 1974 the AOE functioned as a source of information for optometric educators along with organizing the section on optometric education at the AAO meeting. In January, 1975, the AOE presented a Teacher's Institute, a three-day workshop on theoretical and practical optometry. Sponsored by ASCO, the goal was to enhance optometric education by pro-

viding the participants with useful and practical information and experiences. Fourteen educators attended the institute, held at the Southern California College of Optometry. The original plan was to then present other programs for educators in the biological sciences, visual sciences, and clinical areas. Although the workshop was successful and received with great enthusiasm, the plans for additional workshops have been delayed until adequate financial support can be generated.

Settles Into Yearly "Appearance"

The AOE, in 1975, 1976 and 1977, settled into making a yearly "appearance" at the Academy meeting. The need and desire for such an organization did not decrease; only the energy put into it declined. In an attempt to revitalize AOE, a full program was organized for the 1977 Academy meeting. A dinner business meeting was held, followed by two days of educational seminars and technical presentations. Dr. Samuel Brown and his colleagues of the Office of Educational Development of the University of Alabama in Birmingham presented seminars on clinical evaluation in optometry, alternative teaching methods and small group dynamics. These programs were intimately relevant to the optometric educator and his/her role as a teacher, evaluator and participant. The technical talks were designed to highlight advances in the field. Impact resistant lenses, tonometers, and pharmaceutical agents were discussed. The optometric educators were able to get to the forefront of technical development in these areas, certainly a necessary place to be for those who train tomorrow's optometrists.

The 1977 meeting was enthusiastically acclaimed by the twenty-two educators present. The response encouraged the executive board of AOE to arrange more programs of this nature. In order to encourage greater attendance, it was suggested that perhaps the AOA meeting, held in mid-June each year, would be a better time for the AOE meeting. Looking into this possibility, Dr. Sidney Wittenberg, Immediate Past President of the AOE, has begun arrangements for a full program for optometric educators at the 1980 AOA meeting to be held in June, 1980, in Denver, Colorado. The meeting will have at least three parts: a papers program; seminars on faculty skills, faculty development, and other topics relevant to the optometric educator; and a business meet-

ing. Technical lectures by manufacturers may also be included.

More Participation Needed

The rudimentary outline of the 1980 AOE meeting is being formulated at the present time. There is a need for more people to aid in organizing the meeting. If you are at all interested, please send a note briefly stating what kind of help you can give or in which area you would like to be involved to: Deborah Adler-Grinberg, O.D., Ph.D., College of Optometry, University of Houston, Houston, Texas 77004. A call for papers will be sent in January of 1980.

The present officers are: Deborah Adler-Grinberg, O.D., Ph.D., (Houston), President, and Michael Cohen, O.D., (Pennsylvania College of Optometry) Secretary-Treasurer. They are committed to making AOE a viable organization as we enter the 80s and encourage your support and participation. A membership drive (dues are still \$4.00 per year) will begin in September, 1979, with a new directory of optometric educators to be developed at that time. A faculty representative at each optometry school will handle the membership matters. □

ACADEMIC DEAN ILLINOIS COLLEGE OF OPTOMETRY

Illinois College of Optometry, optometry's oldest and largest institution with an enrollment of 585 students, seeks an Academic Dean to work with and supervise faculty and division chairmen, provide leadership in curriculum development and in innovative instructional program planning and in coordinating and expanding academic programs including research both within the school and with area institutions. The applicant should have appropriate knowledge about and experience with health science education. OD degree not required. TIAA retirement and other fringe benefits at competitive levels are available.

Salary commensurate with qualifications. Send applications, nominations and resumes to:

Chairman, Dean's Search Committee
Illinois College of Optometry
3241 South Michigan Avenue
Chicago, Illinois 60616

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The Optometric Re

Willard B. Bleyth

The Council on Academic Affairs of the Association of Schools and Colleges of Optometry (ASCO) began a study of optometric residency programs in 1974 which resulted in proposed initial guidelines the following year.¹ An ad hoc committee of the Council on Academic Affairs had presented preliminary guidelines to the ASCO Board of Directors in December, 1974. Following this, a discussion paper was prepared and circulated widely throughout the profession requesting comments and recommendations. Having received a thorough critique from nearly every educational institution, the International Association of Boards of Examiners in Optometry and several optometric centers, another draft was prepared. The study continued into 1976 with the CAA submitting a final report at the ASCO Annual Meeting in June, 1976.²

There the subject lay essentially dormant until interest in developing residencies was shown by the Veterans Administration and subsequently the Council on Optometric Education of the American Optometric Association. The

challenge was to define and develop standards for optometric residencies. An ASCO committee was appointed in June, 1978, with their recommendations being approved by the ASCO Board of Directors the following October. The final report was filed in January, 1979.

Graduate Health Professions Education

Formal graduate health professions education started in the field of medicine in the early part of the twentieth century. Internships were offered by a variety of hospitals, and by 1910, 70 percent of the graduates were voluntarily seeking this type of post-M.D. experience.³

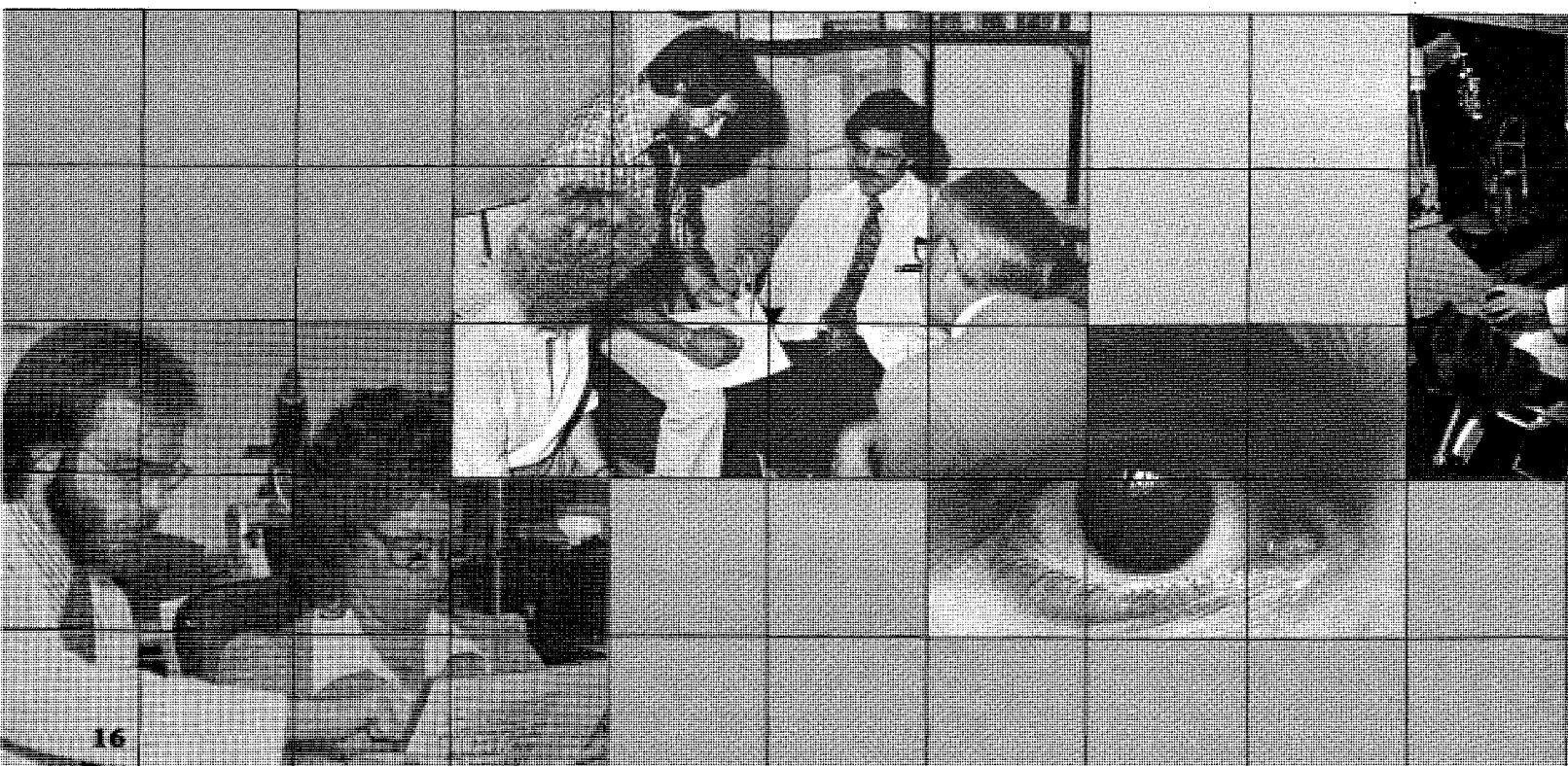
Starting in 1915 medical schools began to require an internship as part of the formal education of a physician. This practice was later discontinued, however, primarily because faculties were uncomfortable with their lack of authority over the education of interns in hospitals, and by 1955, all schools had abandoned the required internship. When residencies in the multiple specialties began to develop in the period 1920-1930, informal overtures were made to the schools of medicine to assume the responsibility for residency

education as well as undergraduate medical education, but there was essentially no response from the schools.³

This situation prevailed for many years until the Council on Academic Societies of the American Association of Medical Centers (AAMC) held a conference in 1968⁴ and recommended medical faculties to assume responsibilities for graduate medical education. This concept was endorsed later by the AAMC in 1974. That same year The Coordinating Council on Medical Education (CCME)⁵ issued a statement requiring the assumption of corporate responsibility by institutions, organizations or agencies that offered programs in graduate medical education.

As a parallel, the specialty boards within medicine also developed in the 1920s and 1930s. Over the past thirty years the boards have grown in authority, not only because board certification has today attained the status of pseudolicensure, but because the requirements of the boards for the various residency programs have shaped the entire direction and contour of graduate medical education.⁶ The Council on Medical Education of the American Medical Association and the American Board of Medical Specialties currently recognize twenty primary and two conjoint examining and certifying boards.⁷

Willard B. Bleything, O.D., M.S., is Dean of the College of Optometry, Pacific University, Forest Grove, Oregon.



Residency: Its Bloom

ing, O.D., M.S.

Along with the pattern set by medicine, other health care disciplines have gradually adopted the residency concept in graduate education. For example, there are, at present, eight specialty programs requiring post-graduate training within the dental profession. In addition, a residency program is offered in the general practice of dentistry, a non-specialty area.⁸ Residency programs in pharmacy grew from the internship concept and have as their focus the development of clinical specialty skills as well as administration in hospital pharmacy.⁹

Podiatry has also moved into post-doctoral residency training. Along with the felt need to expand on undergraduate podiatric education was the catalyst of podiatric medicine being included in the Standards of the Joint Commission on Accreditation of Hospitals in 1970 which provided for the clinical privileges to podiatrists.¹⁰

Residency programs in optometry started to appear in 1963¹¹ with the establishment of a residency in Orthoptics and Vision Training at the Optometric Center of New York. This was followed by the Optometric Center creating a sister residency in Vision and Child Development in 1967. These were initially offered as fifteen to eighteen-week summer programs and combined didactic and clinical work.

From 1974 through 1978 the residency concept within optometry seemed to flourish with numerous programs starting at various sites, including Veterans Administration hospitals and outpatient clinics and clinics of and affiliated with schools and colleges of optometry. Table 1 is a compilation of residency programs connected with schools and colleges of optometry in existence in 1978 as a result of a survey conducted by a Committee on Residencies, Association of Schools and Colleges of Optometry. While there are some that date back to 1974 the vast majority of these programs were initiated between 1977 through 1979, and, as such, their relative "youth" makes any evaluation difficult at this time.

In March of 1977¹² representatives from some institutions known to offer advanced clinical programs met to exchange general philosophies, educational and research programs and construction of guidelines for the organization of future residency programs. No further activity by this particular group has been reported; however, as noted earlier a special committee of ASCO along with the Council on Optometric Education have given the whole topic considerable thought during this past year.

Residency Guidelines Adopted

Responding to the recommendations of the special Committee on Residencies, the Board of Directors of the Association of Schools and Colleges of Optometry in October, 1978, adopted the following guidelines:¹³

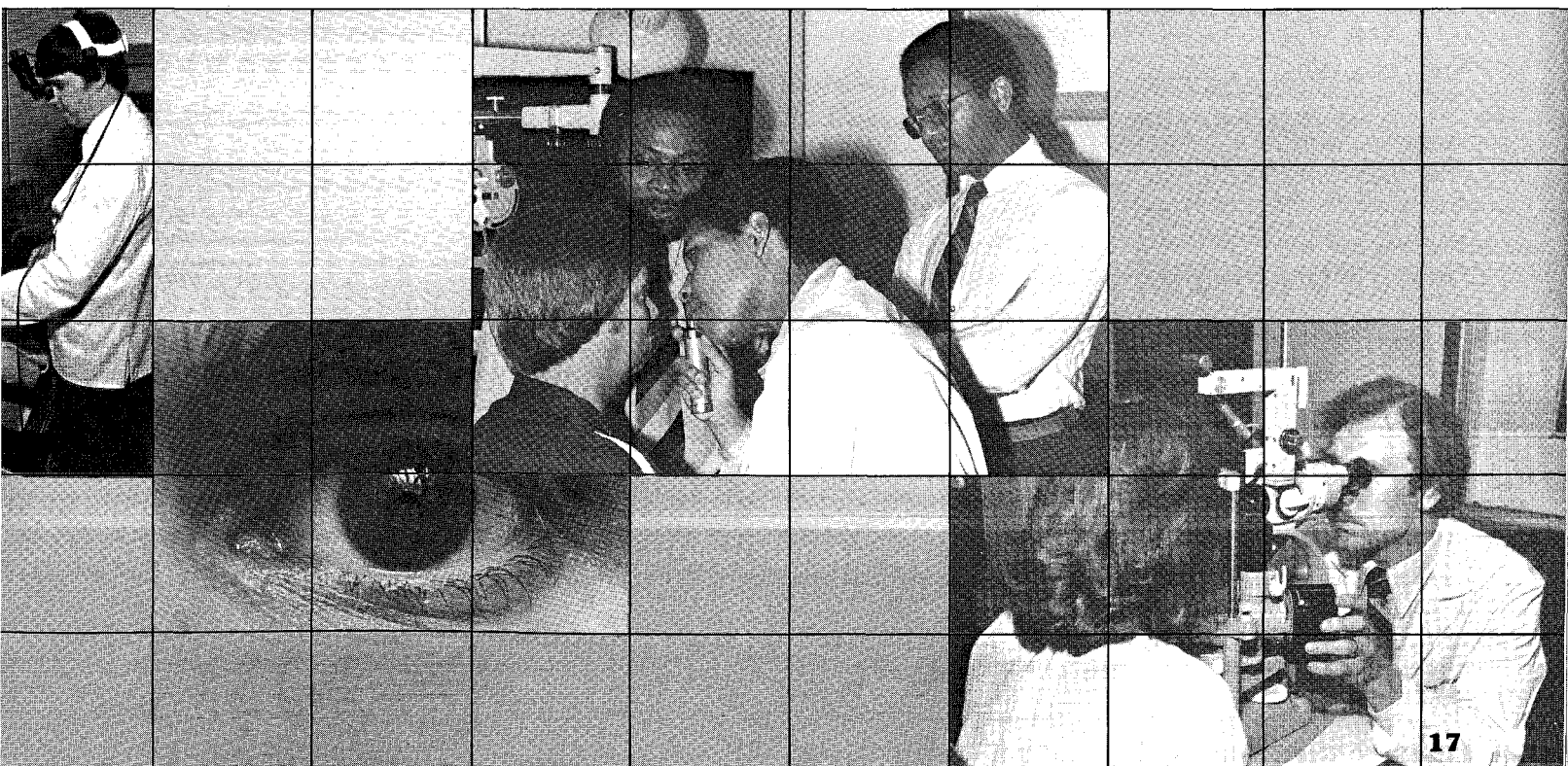
DEFINITION

A residency* is an academic post-graduate program of prescribed length and content, usually in an area of specialization, which is available to fully qualified clinical practitioners. A residency program is clinical in content, and has as its goal the development of unique skills and competence in specific areas of optometric education. It includes a body of knowledge beyond that effectively covered in the undergraduate professional program.

CRITERIA

The rationale for clinical residencies arises from the need for patient care of visual and ocular problems whose prevalence does not permit the development and maintenance of expertise in the professional program or in general practice, yet is sufficient to justify

*Adopted from the *Requirement for Approval of Advanced Education Programs in Optometry*, Council on Optometric Education, American Optometric Association, January, 1976.



the development of an optometric specialty. Residency programs should therefore meet the following criteria:

- **Need**—the residency program should be in an area in which there is an identifiable visual care need that cannot be adequately met by those trained in the O.D. professional program.
- **Knowledge and Skills**—the residency should be in an area in which there is an accepted body of published knowledge supported by ongoing research which requires the development of special clinical skills and techniques.
- **Optometric Areas**—the residency should be in an area within the recognized scope of optometry.
- **Clinically Based Programs**—though classroom and laboratory experience should be a part of the residency program, optometric residency programs should be clinically based and patient care oriented.

PROPOSED RESIDENCIES

I. Pediatric Optometry

A. Defined Area of Practice—to evaluate, diagnose and treat visual and ocular problems of children, visual and ocular problems of binocular vision and

ocular motility, and visual problems associated with learning and developmental disorders.

B. Objectives of the Residency Training Program:

- To develop a knowledge of the epidemiology of visual and ocular problems of children, of binocular vision and motility problems, and visual problems associated with learning and developmental disorders.
- To develop a knowledge and understanding of genetics, child development, vision and ocular development, and the assessment of the pediatric and infant vision and ocular health status.
- To develop a knowledge and understanding of the ocular disease, the congenital, and the hereditary anomalies associated with infants and children.
- To develop a knowledge and understanding of the sensory, integrative, perceptual, and motor processes of binocular vision, and the knowledge and skills for the diagnosis and treatment of binocular vision and motility problems.
- To develop a knowledge and understanding of the visual problems asso-

ciated with learning and developmental disorders and the knowledge and skills for their diagnosis and treatment, including multi-disciplinary approaches.

II. Rehabilitative Optometry

A. Defined Area of Practice—to evaluate, diagnose, and manage visual and ocular problems associated with congenital anomalies, ocular and systemic disease, degenerative processes, aging, and trauma which result in low vision and other visual impairments.

B. Objectives of the Residency Training Program:

- To develop a knowledge of the epidemiology of low vision and other visual impairments.
- To develop a knowledge and understanding of the congenital anomalies, ocular and systemic diseases, degenerative processes, aging, and trauma which result in low vision and other visual impairments.
- To develop the knowledge and skills needed for the examination and evaluation of the patient with low vision and other visual impairment.
- To develop a knowledge and understanding of the requirements for efficient visual performance of the visu-

Table 1
OPTOMETRIC RESIDENCIES* SCHOOLS AND COLLEGES OF OPTOMETRY

Institution	Program Title	Program Affiliate	Length of Prog.	Date 1st Offered
University of Alabama, School of Optometry	Family Practice Optometry Low Vision-Rehabilitation	— —	12 mos. 12 mos.	Aug. 1978 Aug. 1978
University of California, School of Optometry	General Optometry General Optometry ¹	— — Vet. Admin. Hospital, Salt Lake City, UT	3 mos. 12 mos.	June 1978 Aug. 1977
Illinois College of Optometry	Veterans Administration Residency ²	Vet. Admin. Hospital, Kansas City, KS	12 mos.	Sept. 1975
Indiana University, School of Optometry	Vet. Admin. Hosp. Optometry Residency ³	Vet. Admin. Hospital, Lexington, KY	12 mos.	July 1976
New England College of Optometry	Rehabilitative Optometry Rehabilitative Optometry Rehabilitative Optometry Rehabilitative Optometry Pediatric Optometry	Vet. Admin. OP Clinic, Boston, MA Vet. Admin. Hospital, West Haven, CT Vet. Admin. Hospital, Newington, CT Vet. Admin. Hospital, West Roxbury, MA — —	12 mos. 12 mos. 12 mos. 12 mos. 12 mos.	May 1975 Oct. 1978 Oct. 1978 Oct. 1978 Sept. 1979
The Ohio State University, College of Optometry	Contact Lenses ⁴	— —	21 mos.	July 1977
Pennsylvania College of Optometry	Pediatric Optometry ⁵	— —	12 mos.	July 1974
Southern California College of Optometry	Children's Vision Rehabilitative Optometry	— — Vet. Admin. OP Clinic, Los Angeles, CA	12 mos. 12 mos.	July 1977 Oct. 1978
Southern College of Optometry	Optometric Medicine: Primary Care	Memphis Health Clinic, Memphis, TN	12 mos.	Sept. 1978
State University of New York, State College of Optometry	Vision Training Ocular Pathology and Special Training Primary Care	— — — — Genesee Valley Gp. Health Association, Rochester, NY	12 mos. 12 mos. 24 mos.	July 1974 July 1977 July 1978

*Information in Table 1 furnished by each school or college of optometry as a result of a survey conducted by a Committee on Residencies, ASCO, 1978.

Notes:

1. This program has since been deactivated.
2. A Clinic Fellowship is also offered that has some characteristics similar to a residency program.
3. A Faculty Development program is also offered that has some characteristics similar to a residency program.
4. This is a combined residency-graduate program divided between clinical work and graduate courses culminating in an M.S. degree along with a certificate of residency.
5. A Fellowship in Primary Care Optometry is also offered that has some characteristics similar to a residency program.

Pacific University, College of Optometry, has offered a Master of Science graduate program since 1952 that has as one tract an emphasis in clinical optometry and therefore has some characteristics similar to a residency program.

ally handicapped patient and the use of special ophthalmic devices, low vision aids, special contact lenses, and ocular prosthetics for such patients.

- To develop a knowledge and understanding of gerontology, social and emotional problems of the handicapped, rehabilitative methodology, mobility training, and legal and social service benefits for handicapped patients.

III. Hospital Optometry

A. Defined Area of Practice—to evaluate, diagnose, and manage vision and ocular problems found in hospitals or similar institutions and to work as a member of the health care team for the care of such patients.

B. Objectives of the Residency Training Program:

- To develop a knowledge of the epidemiology of health, vision, and ocular problems in hospital and institutional environments.
- To develop a knowledge and understanding of the social, emotional, and cultural characteristics common to patients in institutional environments.
- To develop a knowledge and understanding of the health care delivery mechanisms in institutional environments and to participate in cooperative institutional health care delivery.
- To develop the knowledge and skills necessary to detect and manage vision, ocular, and other health care problems of patients in institutional environments.

Now, while it was thought desirable to adopt guidelines that could bring about more consistency in program offerings, many felt there was still a place for further innovation and development. As a result of this concern the following resolution was also passed by the Board of Directors of ASCO at their October, 1978, meeting:

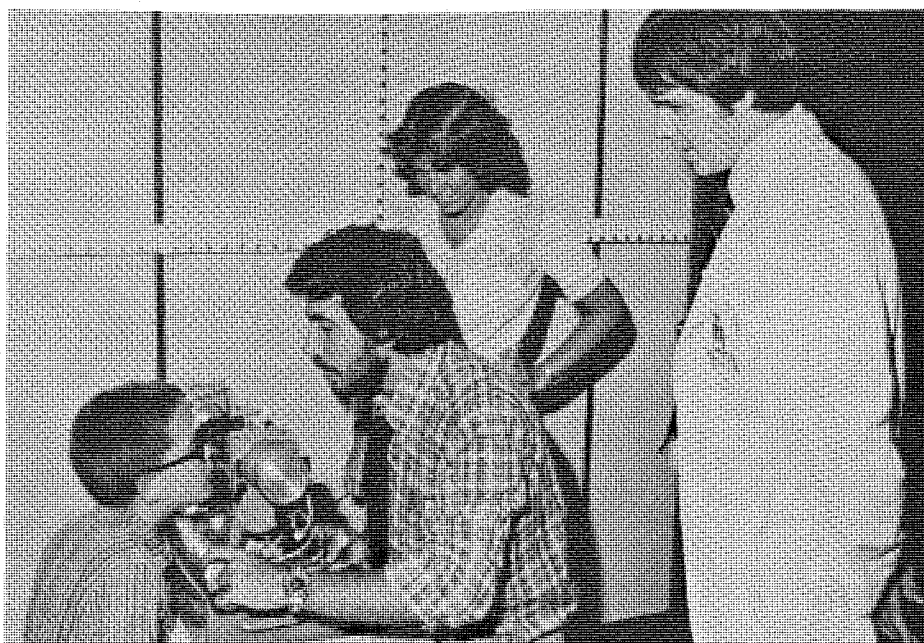
Whereas, The Council on Optometric Education has requested that ASCO develop guidelines for the development of residency programs in optometric education; and

Whereas, The Association of Schools and Colleges of Optometry has recommended three residency programs with appropriate guidelines in: A. Pediatric Optometry

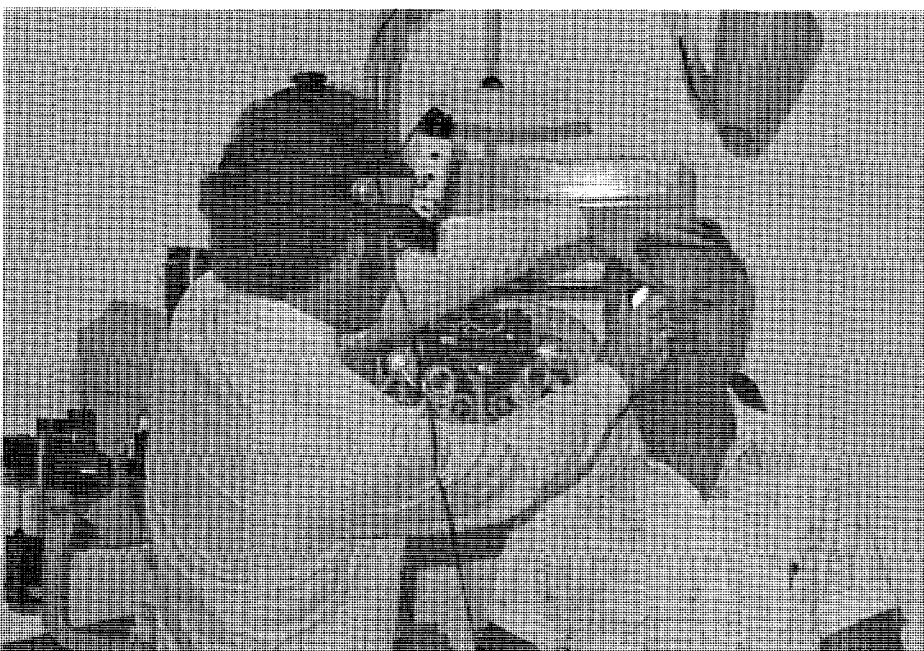
B. Rehabilitative Optometry

C. Hospital Optometry; and,

Whereas, the Association of Schools and Colleges of Optometry wishes to preserve the options in residency development;



A major part of the Children's Vision residency program at the Southern California College of Optometry involves patient care. Here resident Dr. Richard London examines a strabismic patient while students look on.



James Rubin, O.D., Hospital-Based/Interdisciplinary Optometry Resident at Kansas City Veteran's Administration Medical Center is seen performing binocular indirect ophthalmoscopy on his patient. The KCVAMC VICTORS Program (an acronym for Vision Impairment Center to Optimize Remaining Sight) is a low vision program designed to provide care on a regional basis to visually impaired veterans with some remaining vision.

Now, therefore, be it resolved, that the Association of Schools and Colleges of Optometry recommends that the Council on Optometric Education consider the criteria for approval of residencies be related to the clinical educational opportunities, and the exceptional optometric training resources and the commitment of the institution for such program rather than any specific categories or titles at this time; and

Be it further resolved, that optometric institutions be encouraged to experiment with such development.

Subsequent to their passage, both the *Guidelines* and *Resolution* were sent to all ASCO member institutions, the Veterans Administration and the Council on Optometric Education.

The subject of optometric residencies occupied a major portion of the agenda for the Council on Optometric Educa-

tion at their Spring, 1979, meeting. This resulted in adopting the following policy:

It is the policy of the Council on Optometric Education to grant approval of programs in residency that meet the standards of the Council as expressed in the *Requirements for Approval of Advanced Education Programs in Optometry*.

References within the above publication of the Council on Optometric Education contain the following comment:

The evaluation of a residency program will be based on requisites which are the same as standards applied to undergraduate education:

A. The minimal criteria in regard to facilities, programs, faculty, content, administration and the like needed to provide adequate residency training; and,

B. Evaluation of whether or not the proffered residencies adequately and legitimately fulfill their professed and purported objective of increasing competence, skill and involvement beyond the average exhibited without them.

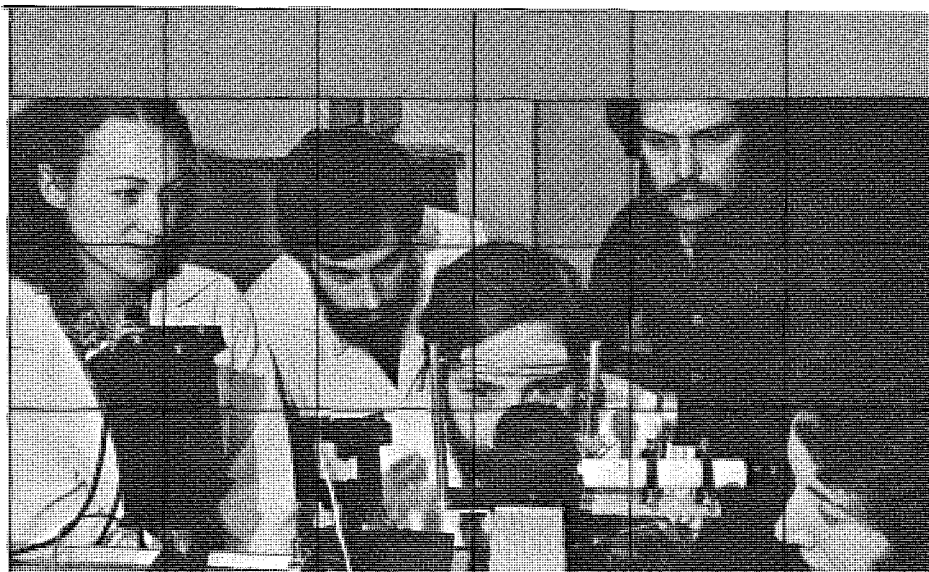
Significance of Actions Taken

At this point, one might be tempted to ask, "Where does this lead us?"

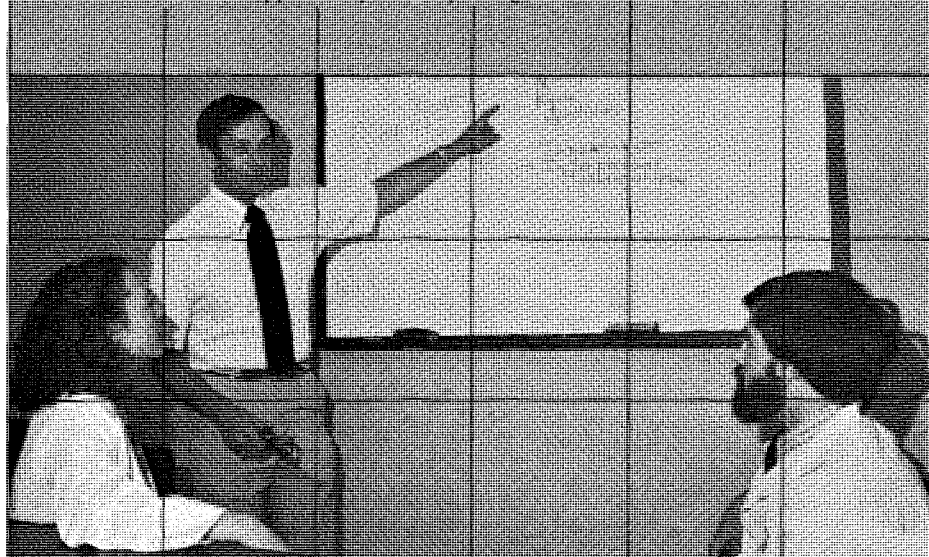
Not unlike those health care professions who began prior to optometry, this profession is experiencing the same trials. While many would argue optometry is a specialty at the onset and therefore should not be further subdivided, this does little to address the issue of an ever increasing base of knowledge within the discipline of requiring the development of special clinical skills and techniques. Given the current state of optometric residency program development, it would seem naive to argue the need does not exist. If one accepts this tenet, then it is appropriate to move forward to the issue of the form of optometric residencies that should exist.

As a start, a comparison with the sister health professions can be made and specific residencies noted which might fall within four, more-or-less, generic groups:

1. *Anomaly oriented*; e.g., binocular vision, aniseikonia, etc.
2. *Demographic oriented*; e.g., pediatric, occupational, etc.
3. *Anatomy oriented*; e.g., cornea, pathways, extraocular muscles, etc.
4. *Technique oriented*; e.g., contact lenses, vision training, electrodiagnostic, etc.



Residents (left to right) Linda Thornberry, David Cook and Randi Suray (foreground) at the State University of New York, State College of Optometry, observe Michael McQuillen seated in the research apparatus of Dr. Philip Krueger.



Dr. Ivan Sushoff, Director of Internships and Residencies at the State University of New York, State College of Optometry, makes a point during one of the mini courses that comprise the didactic portion of the program.



Low Vision Rehabilitation Specialist, Ms. Martha Thompson, M.A., is an integral part of the VICTORS Low Vision Program at KCVAMC. From staff members and other departments within the Medical Center (Audiology, Internal Medicine, etc.), the optometry residents learn the importance of interdisciplinary care when managing their low vision patients.

Using this approach, the Council on Academic Affairs of ASCO first described four potential titles: 1) low vision and special aids; 2) binocular vision and visual aspects of learning; 3) environmental vision; and 4) vision function. These were later reduced to the first two since the latter two, it was felt, fit better into the concept of an academically focused graduate degree program rather than a clinically focused residency program. From these beginning discussions came two of the currently adopted titles: Pediatric Optometry (binocular vision and visual aspects of learning) and Rehabilitative Optometry (low vision and special aids). The third title, Hospital Optometry, was added later to address the needs of various institution-based practices such as those within the Veterans Administration.

As mentioned earlier, most of the residency programs within optometry have been a development of the past two years; few have had the opportunity to address the issue of formal accreditation. Such review could change the national scene markedly:

1. Costs: In terms of educational management, residency programs can be expensive. Typically, resident students do not pay a tuition but instead are paid a stipend by the parent institution while they are in training. In academic year 1978-79 these stipends ranged from \$9,600 to \$13,500 on an annual basis. Now, it is realized a certain amount of the resident's time is in the direct supervision of or actual delivery of patient care, and therefore, it could be argued that professional service fees revenue is generated. However, it should also be noted that a significant patient fee income would have to be generated to offset the cost of the stipend paid and instruction furnished the resident. This means institutions developing residencies could face major budgetary adjustments as they implement these programs.

2. Patient Population: Particularly due to the specialty area concept central to a residency program, it is imperative the parent institution have a sufficient patient population base to give the resident an acceptable level of clinical exposure.

3. Faculty Expertise: Another major educational consideration is the presence of faculty appropriate to the theme and curriculum requirements of the residency.

4. Critical Mass: Still another factor that sometimes escapes review is the issue of critical mass or minimum numbers. Graduate optometric education

should never approach the class size numbers of undergraduate optometric education. However, it is important to remember certain minimums need to be maintained. Learning can be enhanced by seminar-style discussions which are a common delivery mode at this level of education. This implies, for the best learning environment, residents should have the opportunity for group process learning. This group need not be limited to residents of the same breed nor to optometric residents per se but could easily include others from educationally compatible disciplines. The point remains: residents should not be trained in isolation to obtain the maximum benefits of their program.

What Does the Future Hold?

One of the concerns expressed in the early steps of optometric residency development was that of over fragmentation—over specialization—within the profession. Concurrent with this concern is the drawing away from general practice that the introduction of specialty practice tends to create. This concern seems valid if anything is to be learned from the experiences of medicine and dentistry.

The citizens Commission on Graduate Medical Education (AMA) reflected on this issue in 1966 when they reported, "A problem of today is the complexity, the fragmentation, and the inflexibility of standards for graduate medical education."¹⁴ . . . There has been an almost uniform trend for increasing numbers of graduates to enter

residency training in one of the medical specialties so that currently the large majority of young physicians are identified with a specialty and fewer and fewer are available as family physicians.¹⁴

The U.S. Department of Health, Education and Welfare has also expressed this same concern:¹⁵

The provision of health care has become increasingly fragmented in part, as a result of the increased specialization of health care providers. In the medical profession, overspecialization has been well documented. In dentistry, data indicate that the percentage of practitioners pursuing a specialty has tended to increase steadily over the years. There is concern that continuation of this trend may lead to an undesirable degree of specialization in the profession . . . It is anticipated that increased training opportunities in the general practice of dentistry will influence greater numbers of dentists to pursue careers in general practice, thus averting a potential over-specialization problem in dentistry.

There is a message in all this.

As optometry wets its feet with the introduction of residency programs and the implied specialization, it is imperative attention be given to the preservation of a strong general practice emphasis within the profession: to do otherwise would be to undermine one of the profession's most unique strengths as perhaps its most important service to the public. □

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Profile: The School of Optometry

Introduction and History

The first act governing the practice of optometry in a Canadian province was passed in Manitoba in 1909. In that same year, optometrists in Ontario organized the Ontario Association of Optometrists and began to press for similar legislation and by 1911 a bill was brought before the legislature. There was much opposition to forming a "closed corporation" and the bill was withdrawn. Activity by the Ontario Association toward this end did not cease, and in 1919, an Optometry Act passed the house and became law. The Board of Examiners established by this new legislation acted immediately to establish a program of education and in 1920, arrangements were made for a one year program at the Toronto Technical School.

In 1925, the Board established its own school, the College of Optometry of Ontario, located in the city of Toronto. This school existed until 1967 as the only institution providing optometric education in the English language in Canada. The course begun in 1925 was two years in length and this curriculum persisted until 1931 when a third year was added. From 1937 until 1952, the College had a loose affiliation with the University of Toronto which provided

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The University of Waterloo, School of Optometry, is sited on a campus of over a thousand acres of rolling land.

the basic science part of the optometry program. The profession supported the educational process through license fees, gifts and donations. These sources and student fees provided the total budget. The only public funds received from 1925 to 1967 came from the Canadian Federal Government, between 1945 and 1952 in support of veterans of World War II.

In 1954, the University of Toronto ended the affiliation agreement, and the College of Optometry revised its curriculum to a four year program and began to grant the Doctor of Optometry degree. Simultaneously, it hired basic science faculty and also instituted a two year postgraduate O.D. program for practicing professionals. The Board of Examiners sought university affiliation vigorously from the decade of the forties onward, but its efforts were continually frustrated. In 1958, initial discussions were held with officials of the newly established (1957) University of Waterloo, but little progress was made.

The report of the Royal Commission on Health Services in Canada (1964) stimulated optometrical efforts to seek university affiliation in that the reports stated optometrists would have to be employed in the health system only if the general level of education and training were improved. By 1965, the Board had a further impetus to resolve the educational status in that the University of Toronto gave notice of its intention to

expropriate the college buildings for an expansion of its campus. Vigorous efforts directed toward the Ontario government were initiated and concurrently a dialogue was opened between the Board and the President of the University of Waterloo.

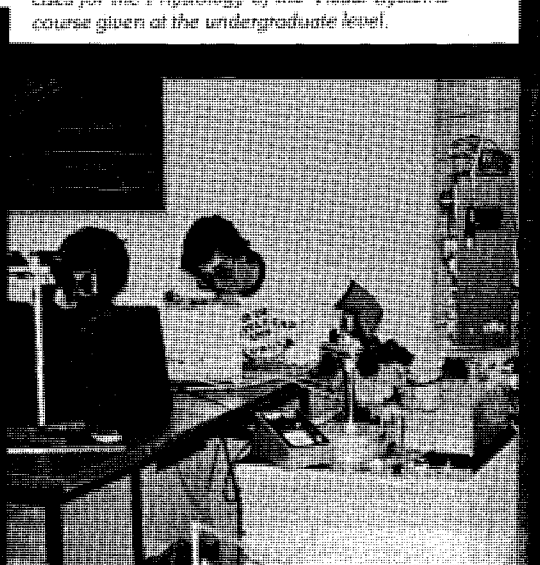
This effort culminated in the government agreeing that it would support optometric education within a university, and a University Senate Committee which investigated optometry's science base agreed that the discipline did indeed merit a place within sciences taught at a university. The Ontario government, after considerable deliberation agreed to provide financial support to the University for a School of Optometry. The way was paved for the College of Optometry of Ontario to end its illustrious existence, and on July 1, 1967, on the anniversary of Canada's 100th birthday, the School of Optometry, University of Waterloo, came into being. On this same date the Ontario government brought payment for optometrical services under the Health Insurance plan. This latter event was to play an extraordinary role in the development of clinical training in optometry but was, at the time, not recognized as being an item of more than passing importance.

Location

The region of Waterloo consists of four townships and three major cities,

Second professional year students experiment with model telescopes and microscopes.

A graduate student prepares laboratory exercises for the Physiology of the Visual Systems course given at the undergraduate level.



University of Waterloo

M.E. Woodruff, O.D., Ph.D.

Kitchener, Waterloo and Cambridge. Kitchener-Waterloo are twin cities with populations of 130,000 and 40,000 respectively. There are approximately one half million persons living in the Waterloo region which is slightly north and west of the City of Toronto and about 70 miles distant. The region is heavily industrialized but also has a strong agricultural base. The city of Waterloo has a long history of the provision of post secondary education in that it has been the site of a number of church colleges dating from the late 1800s. It was the affiliation of several of these that brought the University of Waterloo into being in 1957.

The University of Waterloo is sited on over a thousand acres of rolling land bisected by a stream which broadens into two small lakes, one on each of the north and south campuses. The south campus, which is fully developed, contains the following faculties: Engineering, Science, Mathematics, Psychology, Social Science, Arts, Environmental Studies and five church colleges. The School of Optometry is an entity within the Faculty of Science but is budgeted separately from the other faculties. There are also administrative and student services buildings, a bookstore, libraries, a Health Centre and student residences.

The University has approximately 15,500 students on campus and

approximately eight to ten thousand part-time and correspondence students.

The President, Dr. B.C. Matthews, and Vice-President Academic, Dr. T.A. Brzustowski, have been very supportive of the School of Optometry and have advanced its objectives by all means within their discretion.

Facilities

The School of Optometry is presently the only academic building on the north campus. Its location on the eastern perimeter of the campus provides easy access for the public to the clinical facility.

The optometry building was designed by a firm of architects whose designer, Glen Hadley, is both the son of an optometrist and the brother of a Waterloo graduate in optometry. This background, plus long and in-depth consultation by Mr. Hadley with faculty, resulted in the production of a design which proved to be not only extremely functional, but physically attractive.

The building has ground level access on the first floor of its clinical facility, which occupies the lower two floors. The clinic has a "reception area," administrative offices, a dispensary, patient waiting rooms, thirty-six rooms for oculo-visual assessment, a four room module for binocular vision assessment and treatment, a ten room module for contact lens clinic, and a three room suite houses pediatrics. Health assess-

ment, field assessment, ocular photography, electrodiagnosis, ultra sound, aniseikonia and adaptometry clinics are each allocated to individual rooms designed for their specific function. A two story annex at the rear of the building houses electronic, metal and wood shops, photographic dark room, drafting and a stores section on its first floor. Animal storage facilities are also housed on the first floor. The second floor of this annex contains faculty and graduate student research laboratories and an optical manufacturing facility supportive to the faculty's clinical operations.

The third floor also has ground level access, since the building was constructed into a hillside. On this floor there are classrooms, geometric optics laboratories, library carrels, theatre and faculty offices as well as a faculty lounge, student locker rooms and lounge. The fourth floor provides laboratories for Physiological Optics, Anatomy, Physiology, Ocular Health Assessment, General Vision Examination Techniques, Binocular Vision Examination Techniques, Contact Lenses and Audio-Visual control.

The grounds surrounding the building are beautifully landscaped and the trees, grass and flower beds contrast the building's dark red-brown brick.

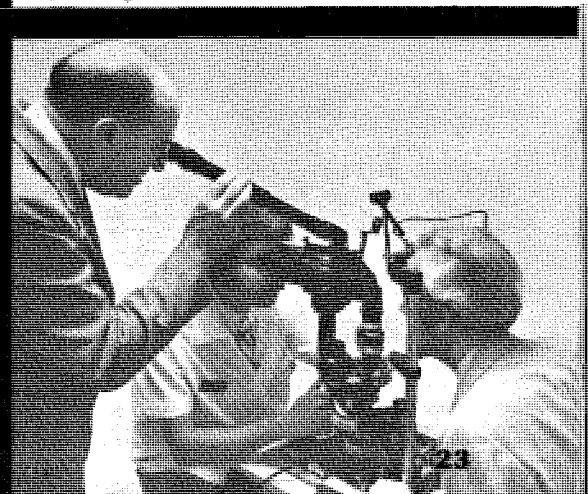
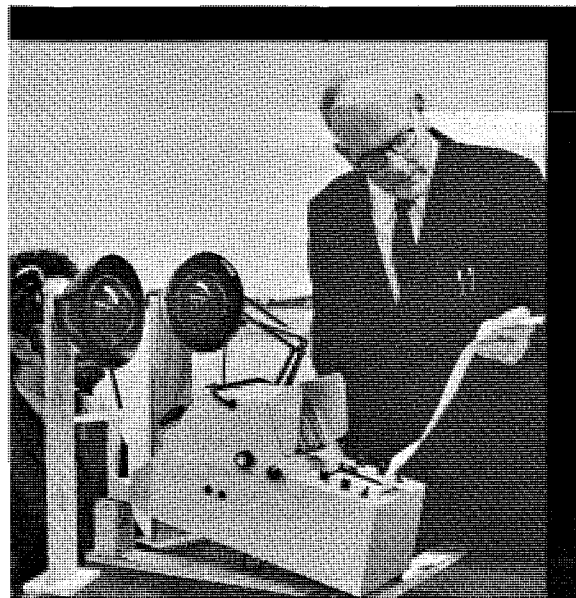
Administration

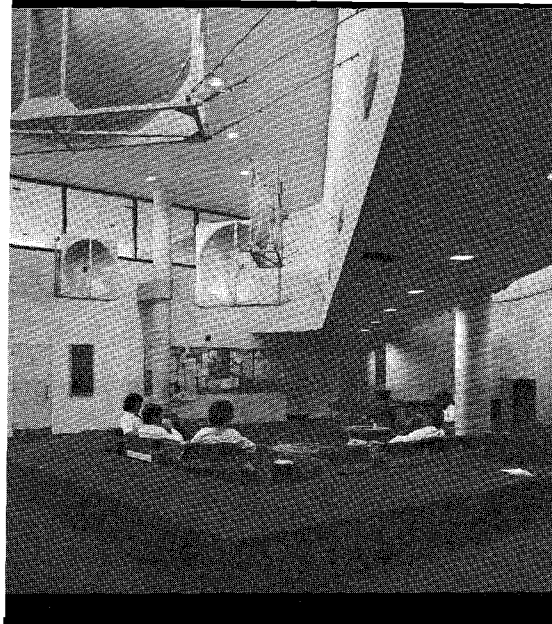
The school is administered by a Director, M.E. Woodruff; an Assistant Director, W.S. Long; and an Adminis-

Professor W.D. Wright at work in one of the many well equipped laboratories.

The faculty office corridor provides entry to pleasant, roomy working areas.

Dr. E. J. Fisher (left) examines a patient as part of his assigned activities.

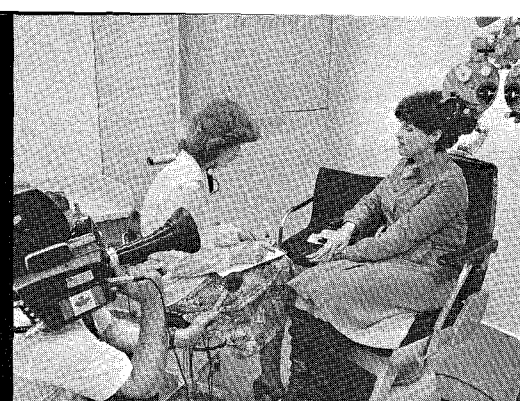




The student lounge is well used by the student body, providing food and beverage services and access to the locker rooms.



Five reception staff receive patients and handle patient records and financial transactions. Patient records are stored in motorized cabinets which permit thirty-second retrieval. All input for communication in the clinic is centralized through the reception desk and all calls for clinicians and optometric interns are made by visual input via terminal to right of the door in center of photograph.



The clinic's services are heavily utilized. Here a local TV personality, Ms. Betty Thompson, has her eyes examined.

trative Council consisting of four elected and one appointed department heads. Dr. W.S. Long represents Optometry, Dr. George Woo represents Graduate Studies, Dr. C.W. Bobier represents Physiological Optics, Dr. T. David Williams represents Life Sciences and Dr. R. Pellowe is the Chief of Clinics. Mrs. Judi Carter is the Financial and Administrative Advisor to the Director and Mrs. B. Clemmer is the Academic Administrative Assistant. Mrs. Gwen Hinch is the clinic administrative secretary.

The academic secretarial pool has five secretaries, and the clinical operation requires six. The academic laboratories require two full-time demonstrators, and the optical laboratory employs two full-time licensed dispensing opticians, a technician and a secretary. The electronic, machine and wood shops keep three full-time technicians fully occupied. The school's operations also require a full-time storekeeper with the capability of carrying out minor instrument repairs. Optometry shares one-half of the time of an animal caretaker to maintain animal quarters supportive to research, physiology and anatomy laboratories.

On July 2, 1967, the original faculty, consisting of Professor E.J. Fisher, Director, Associate Professors W.S. Long, C.W. Bobier, W.M. Lyle and M.E. Woodruff met to begin the operation of the School of Optometry. Their immediate task was to carry on the education of three years of students originally enrolled at the College of Optometry and to bring a clinical facility into being to support these students. This group was also to recruit further faculty and to implement a new curricu-

lum planned during the preceding year in conjunction with a committee from the University of Waterloo and in consultation with the Council on Optometric Education of the American Optometric Association.

From the inception of the optometry program at the University of Waterloo, the faculty committed itself to academic and clinical excellence. To achieve this objective academically, faculty have been recruited on the basis of demonstrated achievement or the possession of advanced degrees and high potential.

To achieve clinical excellence, the faculty further decided to found an Optometric Care facility which was to place equal emphasis on the delivery of high quality vision care services to all sectors of the public with vision care needs and on teaching optometry students to render optometric care.

Clinical Program

It was decided that the clinic was to charge the scale of fees established by the Ontario Association of Optometrists. Since the clinic competes with other eye care personnel rendering care, it does not discount its fees for services. Agreement was obtained with the University administrations, that all clinical income was to accrue to the School of Optometry for improvement of the program.

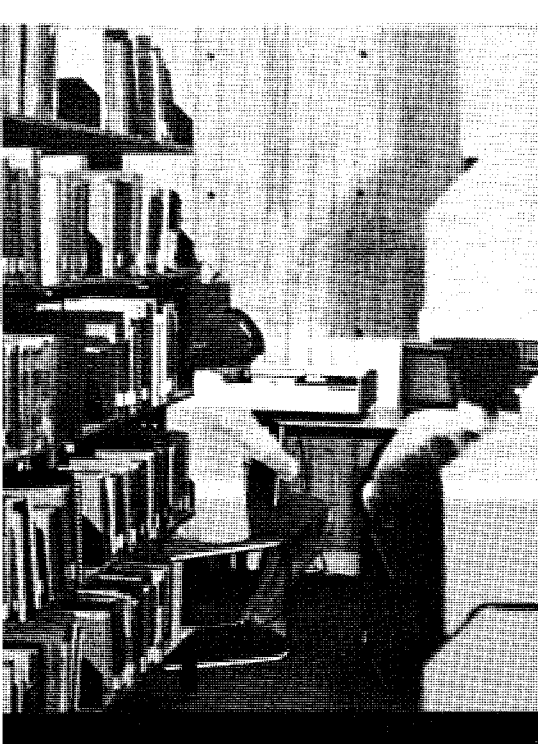
Early in its operation, the school sponsored a meeting of government, the Ontario Association of Optometrists, the College of Optometrists, and University and public health authorities to establish areas of unmet need for vision care. Thereafter, the clinical program addressed itself to establishing programs of service delivery and teaching which explored and documented

these needs and developed methods for meeting them. From this development, the school now has exceptional programs in Low Vision under Dr. George Woo; Contact Lenses under Dr. Murchison Callender; Binocular Vision under Drs. W.S. Long, C.W. Bobier, and C. Dalziel; Ocular Health Assessment under Drs. W.M. Lyle, T.D. Williams, and A. Cullen; Gerontology under Drs. R. Pellowe and D. Buck; Mental Retardation under Dr. M.E. Woodruff; and Pediatrics under Drs. J. Rosner and R. Wiggins.

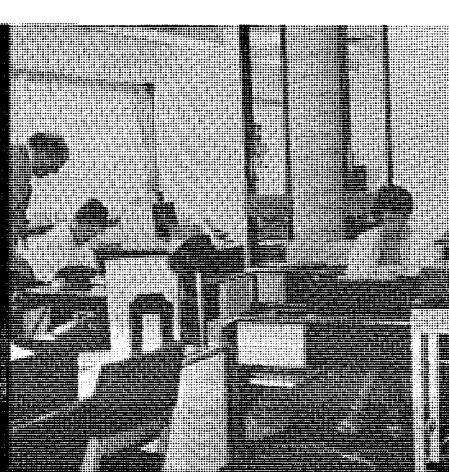
Programs for northern communities, deaf children and Amerind peoples are managed as part of a Community Health Program under the Chief of Clinics, Dr. R.D. Pellowe, with support from other faculty. Electrodiagnostic clinic has recently been assigned to Dr. John Lovasik, the first O.D. graduate from the University of Waterloo to complete a Ph.D. degree program.

These clinical programs have been supported by three fully equipped mobile clinics, each of which have two examining lanes. In the summer, between the last two years of optometry training, students entering the senior year have extensive clinical experience in the various service delivery programs. Currently, students receive a stipend of up to \$640.00 per month for their work within the program. The main clinic at the School of Optometry currently handles 35,000 patient visits per year. As a result of these clinical programs, most students have been responsible for approximately seven hundred patients and may have participated in a clinical experience with up to four hundred additional patients.

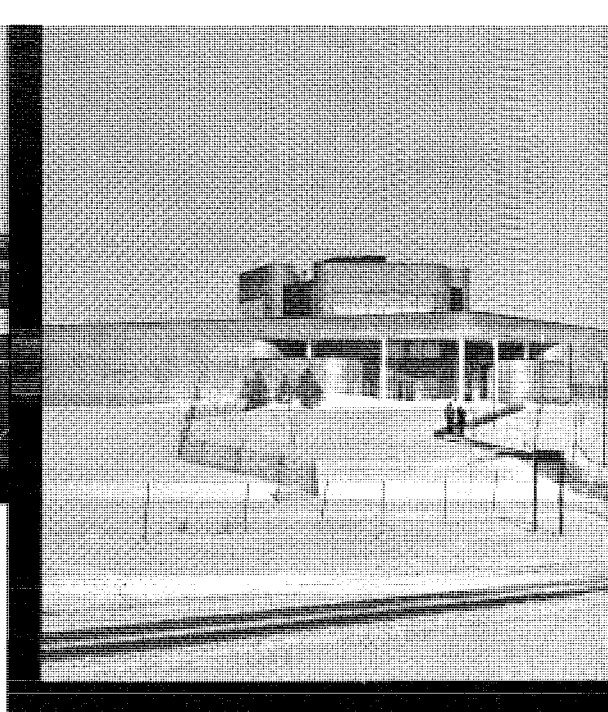
The clinic's reputation for quality service delivery results in a broad spectrum of the public using its facilities. During the twelve years of clinical operations, eight optometrists have established practices in the region; and these practices, plus those of pre-existing practi-



Among the thousands of books, bound periodicals, study slides and audio and video tapes is the appropriate equipment to use this material in the resource library.



The administration of the faculty requires the time of six full-time assistants and secretaries. A CRT terminal links the office to the main computer permitting a reduction in repetitive typing of volume mail and quick correction of edited research papers.



Waterloo winters give an ever varying appearance to the school but only rarely interfere with its operation.

tioners, have not been adversely affected by the school's extensive activities. Indeed, the high profile resulting from the community health activities of the school have enhanced the image of optometry, and this has increased the utilization of optometric services. The school and the K-W Optometrical Society liaise closely to minimize potential problems. A majority of local practitioners teach in the school's clinic part-time.

The quality of care rendered in the school's clinical programs has recently been evaluated by the Optometry Review Committee, a body established by Provincial statute for evaluating the quality and quantity of services paid for under the Ontario Health Insurance Plan (O.H.I.P.). Post review, the school was commended for the quality of care and excellence of its records. The fees paid to the school from the plan permit the operation of many of its programs. Increasingly, the school's vision care delivery services are requested by groups or administrators of health facilities.

Academic Program

The academic curriculum was not neglected during the development of the clinical program. In the academic program there are currently eight individuals with the rank of professor, five of whom hold doctoral degrees in addition to masters degrees and O.D. qualifications, and the remaining two have

O.D. degrees. Only one professor does not have an O.D. degree, and he is a Bioengineer. All professors with O.D. degrees have extensive clinical experience in the private practice of optometry.

There are seven persons holding the rank of associate professor and of these, five hold doctoral and masters degrees. The remaining two are both candidates for doctoral degrees. Six of these professors also hold the O.D. degree.

There are three assistant professors, all of whom have M.Sc. and O.D. degrees. One has a doctoral degree, and both the others are candidates for doctoral degrees. An additional four professors with doctoral degrees from other University departments, such as Biology, Chemistry, Psychology and Pharmacy hold cross appointments in the faculty. Two M.D.'s with specialties in anesthesiology and public health are appointed as adjunct professors, as are a lawyer and two optometrists.

Eight Doctors of Optometry hold the full-time rank of clinical supervisor. The rank which was created to facilitate the administration of the University of Waterloo, equates with various professorial ranks in responsibility and salary. Thirty-five Doctors of Optometry are employed in part-time teaching in the clinical program.

The objective of the undergraduate program is to create vision scientists who can apply their knowledge within clinical and environmental settings. To this end, didactic portions of the program are supported by science laboratory experience whenever course content lends itself to laboratory activity. The lecture-laboratory tiers are then followed by a clinical laboratory before the

student has an opportunity to engage in clinical applications with patients.

An affiliation with the McMaster University Health Sciences Centre was formally established in 1971, with the establishment of a joint committee jointly chaired by the Dean of the Medical Faculty and the Director of the School of Optometry. Considerable interchange of faculty has occurred, particularly in pathology and pharmacology teaching. The two groups also cooperate in such areas as continuing education of personnel. Currently, two optometric residencies to be sited in the McMaster teaching hospital's family practice unit are in the planning stages.

The undergraduate curriculum contains all those elements necessary to prepare a graduate to play the full scope and role of an optometrist in the Canadian health care system. The school is accredited by the American Optometric Association's Council on Optometric Education, as was the program of the College of Optometry; thus, its basic science curriculum and optometry content is similar to those of American schools and colleges.

Applications for enrollment continue strong in that approximately six qualified students apply for the sixty available spaces in each class. Current funding provisions and the fact that Waterloo is the only source of optometric education in the English language in Canada force the school to limit enrollment to Canadian citizens or landed immigrants. This causes concern among faculty, many of whom owe a debt of gratitude to Ameri-

can graduate schools for their advanced degrees.

Research

Of the eighteen full-time professors, fifteen have substantial research programs in progress and the majority have substantial research funding from federal or provincial granting agencies such as Canada's National Research Council, the Medical Research Council, the Ontario Ministry of Health and Welfare and a number of foundations and associations. The faculty has instituted a biennial inventory of research projects and publications. The 1976-78 inventory showed a total of 168 papers published, the majority of which were in refereed journals. The range of research in progress is very broad and includes psychophysics; color vision; electrophysiology relating to color perception; absorption of radiant energy; cortical cellular activity in accommodation; comparative optometry of various bird, fish and animal eyes; protein content of tears in soft and hard contact lens wear; the relative visibility of various symbols under astigmatic and nonastigmatic viewing conditions; the epidemiology vision care of ocular condition of pre-school, retarded, and other populations; the detection of diabetes mellitus by the use of enzyme impregnated strip; drug side effects on the visual system; ophthalmic material standards; chromoretinoscopy; biochemistry of visual pigments; vision care delivery systems and many other areas amenable to exploration through optometric science.

Dr. William Lyle has recently been appointed Editor of the *American Journal of Optometry and Physiological Optics*, an honor earned by his high achievement in research and scholarship.

Graduate Study

The school put forward a brief for a Masters of Science Program in Physiological Optics in 1970, and after assessment by the Council of Ontario Universities Graduate Committee, it was approved to commence in 1972. Since that time, eight persons have completed the degree and two students are in the process of completing their theses. Five students are currently enrolled in the program. A brief for a Ph.D. program was submitted to the Ontario Council in 1977. The Council employed Drs. G. Fry, W.D. Wright, and P. Kaiser as appraisers during the process of evaluating the faculty's capability to operate a Ph.D. program. The Ph.D. program

was approved to commence in September of 1979.

Residency Program

A one year residency in General Optometry was begun in 1971 and has been maintained. Residents who remain a second year continue to advance their education and skills in areas of their choice during this second period. In the fall of 1979, the school implemented a new component of the residency in which residents are instructed in how to teach clinical optometry effectively. This program was made possible when Dr. Mitchell Samek, a Waterloo M.Sc. (1975, Physiological Optics), returned as an assistant professor after completing the requirements for his Doctorate of Education in Health Sciences Education. Dr. Samek also assumed responsibility for improving the

A major objective of the [new] residency is to create personnel with the capacity to become clinical teachers and researchers of exceptional merit.

teaching skills of residents, clinical supervisors and faculty.

In the fall of 1979, a new residency program is scheduled to commence operation. Various residencies have been structured within the M.Sc. program such as Low Vision, Binocular Vision, Contact Lenses, Pediatrics, Mental Retardation, Family Practice, and General Optometry. However, a resident not wishing to complete the required research and thesis will be given a Diploma of Residency after successfully completing written, oral and clinical assessments. The new residency has requirements for structured didactic, laboratory, clinical activity and teaching components. A major objective of the residency is to create personnel with the capacity to become clinical teachers and researchers of exceptional merit.

Interprofessional Relationship

The Ontario Health Disciplines Act of 1974 (optometry part) legislates three members of the faculty to important

tasks in the governance of the profession. The University must nominate one member of the Governing Council. There must also be a member of the Registration Committee who is a member of faculty, and similarly, a member of the Complaints Committee must also be chosen from the faculty. Thus, there is considerable liaison between the School of Optometry and the College of Optometrists in relation to governance of the profession, its standards and its education.

The various provincial associations also depend upon the School of Optometry for expertise to support governmental activities, continuing education, and to provide expertise to study specific problems which arise in the delivery of professional services.

The school also provides continuing education for the profession in an extensive program of over six-weeks duration annually in May and June. There are usually in excess of four hundred optometrists participating in these courses for personal upgrading and to meet mandatory education requirements. In 1979, the school provided a course in pharmacology available to all optometrists from the Province of New Brunswick in order that they might use the diagnostic drugs available to those optometrists who possess a certificate of qualification on Pharmacology.

The Future

With relatively stable funding for both undergraduate and graduate programs and with a faculty, the majority of whom are now entering the most productive parts of their careers and whose qualifications and experience provide expert coverage of all aspects of optometric science, plus a student body drawn from a substantial pool of superior students, the faculty has great optimism about its future. The health, social, and educational authorities of the Canadian provinces have recognized the need for optometrical services and, in general, support the optometric education of young men and women.

The 479 Doctors of Optometry who have graduated from this great University since 1968 have already made their mark on the profession and its image. Their effect will increase as their numbers exceed the nearly 25 percent of Canadian practitioners which they currently represent. The added stature of Canadian optometrists which will result from the vigor of this educational base is awaited with excitement as the profession enters the year 2000. □

An Optometric Clinical Practicum Examination Model

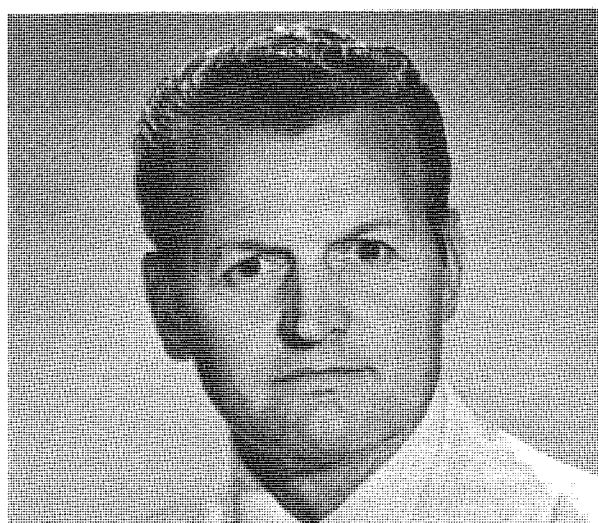
Jess B. Eskridge, O.D., Ph.D.

The process of credentialing health manpower is gaining more and more attention each year. Concern has been expressed about the quality of the present credentialing procedures, the apparent professional control of the credentialing process, and the need to verify continuing competency of licensed practitioners. All of those directly or indirectly involved in credentialing—the candidates, the profession, the government, and the patients—must be assured that the process is in fact providing practitioners who are capable and competent in the delivery of optometric health care.

The explosion of technology and the deluge of knowledge that has occurred in general and optometric health care in recent years has had great impact on the scope and perspective of optometric education and the practice of optometry. These changes are serving to distinguish the recent graduates of schools and colleges of optometry from the graduates of a few years ago.

State board examiners in optometry are also concerned about the credentialing process and the changes in optometric education and practice, and realize their responsibility to increase the accountability and improve the validity of their individual credentialing procedures. Several years ago the International Association of Boards in Optometry (IAB) and the National Board of Examiners in Optometry (NBEO) joined together in an effort to improve the process of credentialing. Their first project was to produce guidelines for a practical clinical examination that would serve as a model for use by state board examiners in optometry. The following is the product of their years of effort.

Though the model appears to be technique-oriented in its approach, it is not meant to be so. The clinical examination should be designed and administered so as to evaluate the ability of each candidate to utilize both knowledge and clinical skills in the delivery of competent optometric health care.



Jess B. Eskridge, O.D., Ph.D., Professor and Chairman of the Department of Optometry at the University of Alabama in Birmingham School of Optometry, is immediate past chairman of the ASCO Council on Academic Affairs.

I. Purpose

The delivery of optometric health care requires the utilization of optometric knowledge and skill. The written part of a licensing examination is designed to determine if the candidate has developed an adequate knowledge base for the delivery of optometric health care. The clinical or practical part of a licensing examination should be designed to test the utilization of optometric knowledge and skills in the delivery of optometric health care. The thrust of the clinical or practical examination should not be just an evaluation of mechanical ability and skills, but an evaluation of the ability of the candidate to utilize both knowledge and clinical skills in the delivery of competent patient care. The purposes of the clinical examination model can then be stated as follows:

- To determine if the candidate has developed the ability to select the specific information that is needed for the care of any given patient.
- To determine if the candidate has developed the necessary skills to obtain and record clinical data efficiently, accurately, and effectively.
- To determine if the candidate has developed the ability to interpret, understand and utilize clinical data in the process of differential diagnosis and decision making in the delivery of good patient care.

- To determine if the candidate has developed the necessary knowledge and skills to administer optometric therapy effectively and efficiently in the delivery of good patient care.

II. Examination Format

The examination format selected for this clinical examination model is the utilization of the systems approach to optometric patient care. Optometric patient care responsibilities can be conveniently divided into the following arbitrary systems: general health evaluation and management, ocular health evaluation and management, ocular motility evaluation and management, refractive status evaluation and management, fusional ability evaluation and management, and visual performance status evaluation and management. Though there is great overlapping, all optometric knowledge and skills needed to provide appropriate and competent patient care can be placed in these categories.

This examination format can be utilized in several ways, but it is particularly suited to a series of modules or stations, with each station being assigned a particular segment of the optometric patient care responsibilities. Using this approach, the following five stations are suggested:

- Station No. 1 → General health evaluation and management, Ocular health evaluation and management, Optometric emergency service.
- Station No. 2 → Refractive status evaluation and management. The design, fitting, specification, evaluation, verification, and adjustment of ophthalmic materials.
- Station No. 3 → Ocular motility status evaluation and management, Fusional ability evaluation and management, Visual performance ability evaluation and management.
- Station No. 4 → Contact lens design, evaluation, verification, fitting and management, Prosthetic aids evaluation and management.
- Station No. 5 → Low vision patient evaluation and management, Low vision aids fitting, design, verification, and management, Environmental vision procedures.

III. Examination Design

No examination can really be exhaustive. All tests or examinations are cross-sectional sampling procedures, i.e., a candidate is evaluated in certain areas and the assumption is then made that testing in other areas would yield essentially the same results. This, of course, may or may not be true, but the limitations of time require that such testing procedures be used. If the candidate spends approximately 30 minutes at each station, it will take nearly three hours to complete the full examination.

It is suggested therefore that this time be used very efficiently and heavily biased toward the evaluation of clinical skills and patient care decision making. Written tests, evaluation of slides, oral evaluation of didactic material are appropriate for the written examination, but should be minimal or even avoided in a clinical practical examination. The essential purpose of the clinical part of the examination (to evaluate the competence of clinical skills and patient care decision making ability of the candidate) should be acknowledged and accomplished.

Four basic testing approaches to be used at each one of the testing stations are suggested for the clinical practicum examination model. These are:

- Have the candidate identify a testing procedure or instrument. Have the candidate clearly indicate when it is used, demonstrate how it is used, and discuss what information is obtained.

- Have the candidate perform a certain test or use a specific instrument and record the data. Have the candidate evaluate and explain the significance of the data in the delivery of patient care.
- The candidate is presented a patient with certain symptoms or possible problems. Have the candidate select the appropriate clinical procedures for this particular patient, perform the procedures, record the results, and indicate the significance of this information in the management of this particular problem.
- The candidate is presented a patient with a specific identified problem. Have the candidate select and administer the appropriate therapy and indicate the prognosis.

The utilization of these testing approaches will require ingenuity, imagination, and considerable preparation on the part of the examiners. The answers as well as the questions must be carefully prepared and considered.

IV. Procedures for Each Station

Although the information from any one testing procedure can often provide information for more than one of the systems mentioned above, to be thorough and to reduce overlapping of testing, it is suggested that certain tests and procedures be assigned to specific testing stations. For any given examination, a few tests and procedures can be selected from the following lists for each station.

• Station No. 1 (General health, ocular health, emergency care)

1. History
2. Evaluation of physical characteristics
3. Evaluation of socio-emotional characteristics
4. Blood pressure
5. Ophthalmodynamometry
6. Glucose evaluation (dextrostix — Ames Eye Tone)
7. Exophthalmometry
8. Cardiopulmonary resuscitation
9. Care for the fainting patient
10. Heimlich maneuver
11. Care for the patient with acute glaucoma
12. Transillumination
13. Swinging flashlight test (Marcus Gunn)
14. Visual acuity with and without a pinhole
15. Slit lamp
16. Fundus evaluation (direct and indirect ophthalmoscopy, Hruby lens, contact lens)
17. Gonioscopy
18. Tonometry
19. Use of appropriate pharmaceutical agents
20. The Schiømer tear test
21. Evaluation of tear break-up time
22. Fluorescein studies
23. Rose Bengal staining
24. Conjunctival smears
25. Corneal esthesiometry
26. Keratotomy
27. Electrodiagnostic evaluation (ERG/EOG/VER)

28. Photography
29. Photostress test
30. Dark adaptation ability
31. Scotopic visual acuity
32. Amstar Grid test
33. Monocular color vision evaluation
34. Tangent screen
35. Goldmann perimetry
36. Automated perimetry

• **Station No. 2** (*Refractive status, ophthalmic materials*)

1. History
2. Visual acuity
3. Use of pinholes
4. Retinoscopy
5. Automated refractors
6. Keratometry
7. Interpupillary distance measurements
8. Subjective determination of the cylinder
9. Subjective determination of the sphere
10. Balancing procedures/binocular refraction
11. Near refraction procedures
12. Determination of the near addition
13. Cycloplegic examination
14. Ophthalmic lens design (single vision, multifocals, size lenses, prism, etc.)
15. Ophthalmic frame design and fitting
16. Writing an ophthalmic prescription
17. Evaluation and verification of ophthalmic frames and lenses
18. Adjusting ophthalmic frames and lenses

• **Station No. 3** (*Ocular motility, fusion, visual training, visual performance*)

1. History
2. Evaluation of the lids
3. Evaluation of pupillary reflexes
4. Evaluation of accommodative ability
5. Evaluation of version ability
6. The Hirschberg test
7. The Cover test
8. Heterophoria measurements
9. Fixation disparity measurements
10. Deviation following occlusion
11. Evaluation of vergences
12. Forced ductions
13. Evaluation of convergence
14. Park's procedure
15. Test for incomitancy
16. Nystagmus evaluation
17. Dynamic skiascopy

18. Determination of the AC/A ratio
19. Evaluation of fusional ability/presence of suppression
20. Stereopsis testing
21. Evaluation of convergence ability
22. Evaluation of fixation status
23. Esionometry
24. Ocular dominance testing
25. Color vision deficiency
26. Hand-eye coordination testing
27. Perceptual motor testing
28. Visual motor sequencing
29. Eye movement evaluation during specific tasks

• **Station No. 4** (*Contact lenses, prosthetic aids*)

1. Patient history
2. Pre-fitting contact lens evaluation (lid configuration, keratometry, slit lamp, tear layer thickness, tear break-up time, etc.)
3. The advisability of patient wearing contact lenses
4. Refractive procedures with contact lens patients
5. Initial contact lens design and selection
6. Contact lens placement and removable techniques
7. Proper handling of contact lenses with correct solutions
8. Evaluation of contact lens fit (slit lamp, fluorescein)
9. Writing contact lens prescriptions
10. Modification of hard contact lenses
11. Cleaning contact lenses
12. Evaluation of contact lenses and verification of contact lens parameters
13. Patient training in the use, care, and handling of contact lens solutions
14. Problem solving in contact lens fitting (tight lenses, loose lenses, improper centering, staining problems, red eyes, etc.)
15. Prosthetic aid history
16. Evaluation of the fit of a prosthetic aid
17. Care and handling of a prosthetic aid

• **Station No. 5** (*Low vision, environmental vision*)

1. Low vision history
2. Low vision visual ability evaluation
3. Identification of the specific cause of the low vision
4. Use of optical aids (microscopes, telescopes, loupes, etc.)
5. Use of non-optical aids (pinholes, stenopaic slits, light sources, etc.)
6. Use of specific aids (field expanders, night vision devices, laser canes, closed circuit television, etc.)
7. Writing low vision prescriptions
8. Evaluation, verification, and adjustment of low vision aids
9. Patient training in the use and care of low vision aids
10. Patient education of agency assistance in low vision
11. Rehabilitation psychology

12. Genetic counseling
13. Selection of appropriate low vision aids
14. Environmental vision analysis (radiation, toxicity, pollution, flying objects, etc.)
15. Job analysis for visual requirements (stereoacuity, color vision, visual fields, visual acuity, contrast sensitivity, mobility, etc.)
16. Design and/or modification of ophthalmic materials for environmental use
17. Color vision aptitude assessment

V. Evaluation Examples

- Present the candidate with an ophthalmodynamometer and ask him to indicate when it is used, describe how it is used, and indicate what information is obtained. Have the candidate use the instrument on a patient and record the data.
- Have the candidate perform the swinging flashlight test and record the data. Have the candidate describe what results can be obtained from the swinging flashlight test and indicate their significance.
- Present the candidate with a patient who has an intermittent exo deviation and symptoms of horizontal diplopia and some difficulty reading, and ask him to select and perform those test procedures needed for complete diagnosis and then indicate their significance in therapeutic management.
- Present the candidate with a patient who has a tight fitting hard contact lens. Ask the candidate to care for the patient properly.
- Present the candidate with a patient who has a paretic muscle and ask him to identify the paretic muscle and suggest appropriate therapeutic management.
- Present the candidate with an optical low vision aid and ask him to evaluate it, measure it, write the prescription and indicate the probable use of such an aid.
- Have the candidate discuss tear break-up time. Ask him when it is used and what the results indicate. Ask him to perform the test on a given patient, record the results, and discuss their significance.
- Present the candidate with a glaucoma suspect and ask him to select and perform those procedures needed to properly manage such a patient. Ask him to record the results and indicate their therapeutic management significance.
- Present the candidate with a patient who has an improperly centered contact lens. Ask the candidate to evaluate the patient using any procedures that he chooses and to recommend appropriate therapeutic management.
- Present the candidate with bifocal lenses mounted in a frame and ask him to evaluate and measure the lenses and frame and give the specifications of the frame and lenses.
- Have the candidate demonstrate a technique of dynamic retinoscopy. Have the candidate record the data and discuss the significance of the data and what added information would be required to interpret or utilize the data in patient care management.
- Present the candidate with a patient that has a special visual field defect. Have the candidate plot the visual field, describe the visual field defect, indicate a probable cause, and outline an appropriate patient care procedure.
- Present the candidate with a patient who has reduced corrected visual acuity in one eye, and ask the candidate to select and perform those testing procedures needed for diagnosis and then indicate their significance in therapeutic management.

- Present the candidate with a patient who desires contact lenses, and ask the candidate to select and perform those tests needed to fit a contact lens and then indicate their significance in therapeutic management.
- Present the candidate with a patient who has been diagnosed as having reduced positive fusional vergences, and ask the candidate to select and perform at least two methods of increasing the positive fusional vergence in the patient.

VI. Administration Comments

This clinical practicum examination model is a guide to be used as desired by clinical examiners. The examination design, the testing stations, the list of testing procedures assigned to each station, and the evaluation examples are given for convenience and to be of assistance to the clinical examiner. If the examination is to be effective, the clinical examiner must prepare well, understand the examination procedure, be able to explain it to the candidate, and make certain that the candidate knows exactly what is expected of him—particularly, with regard to the following:

- The candidate must perform the test and procedures designated by the clinical examiner.
- The candidate should understand that his performance on each test item will be closely observed and rated by the clinical examiner.
- The candidate should understand that the Board of Examiners will make a final determination as to the acceptability of his performance.

The clinical examiner should remain with the candidate while the candidate is performing the tests and procedures, to observe him closely, to make notes, and to evaluate his performance. The evaluation of the candidate would best be accomplished with a rating or grading and a brief comment or statement about the candidate's overall performance. Rating and grading is, at times, very difficult, and brief written statements of observations and impressions by astute, experienced clinical examiners may prove to be of great value in making the final determination, particularly in borderline cases where the mathematical scores may not reveal a true or complete picture of the candidate's clinical ability.

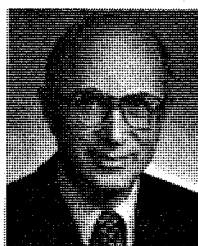
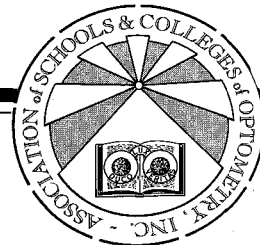
The rating or grading of a candidate can be done in several ways. It is suggested that the candidate receive an overall evaluation at each testing station in the following three areas:

- Data collection skills → the ability to perform tests, record data, and analyze and evaluate the quality of the data.
- Patient care decision making skills → the ability to integrate all data and information and select additional tests for differential diagnosis or confirmation if needed, and to develop an appropriate therapeutic plan.
- Interpersonal relations → the ability to communicate and work effectively with patients and colleagues, and to have sincere concern for patients and their health care needs.

It is also suggested that the rating or grading be made using a numerical scale such as that given below:

- 1 → Unsatisfactory — Unacceptable performance — A level of performance indicative of incompetent clinical ability.
- 2 → Inferior — Substandard performance — A level of performance indicative of essential weakness in clinical ability.
- 3 → Satisfactory — Acceptable performance — A level of performance which meets minimum standards indicating competent clinical ability.
- 4 → Excellent — Capable performance — A level of performance indicative of thoroughly capable clinical ability.
- 5 → Superior — Outstanding performance — A level of performance indicative of superior understanding and clinical ability.

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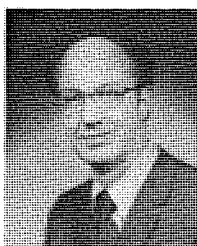


**Alfred A.
Rosenbloom, Jr.
O.D., M.A.
President**

Dr. Rosenbloom, President of the Illinois College of Optometry, Chicago, is a 1948 cum laude graduate of ICO. He holds membership in many professional organizations and is presently Chairman of the Section on Optometric Education of the American Academy of Optometry. He also serves as optometry's first representative to the Special Medical Advisory Group (SMAG) of the Veterans Administration and as consultant to the Optometry Review Committee of the Department of Health, Education and Welfare's Bureau of Health Professions Education and Manpower.

He has held three terms as a member of the American Optometric Association's Council on Optometric Education, optometry's professional accrediting body, and is currently a member of the AOA Council on Clinical Optometric Care.

Ten years following his selection as Illinois Optometrist of the Year, Dr. Rosenbloom was awarded the coveted Distinguished Service Award by the Illinois Optometric Association in 1978 for his 30 years of service to the profession. He is an internationally recognized lecturer in the field of low vision and has contributed more than 75 original papers and editorials in allied health profession journals.



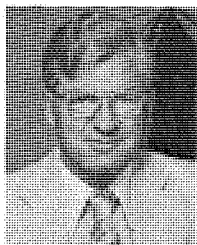
**Willard B.
Bleything
O.D., M.S.
President-Elect**

Dr. Bleything is Dean of the College of Optometry at Pacific University, Forest Grove, Oregon. In addition to numerous civic and professional affiliations, Dr. Bleything is Past Chairman of

the Commission on Continuing Education of the American Optometric Association and is a member of the Board of Regents of Beta Sigma Kappa, International Optometric Honorary Fraternity. He has also served as President of the Oregon Optometric Association and President of the Oregon Board of Optometry.

In 1977, Dr. Bleything was appointed optometric consultant to the Surgeon General, USAF, and also serves as Biomedical Science Corps consultant to the Air Force Reserve Medical Management Committee of the Office of the Surgeon General.

Listed in "Who's Who in the West," he has received the President's Award of the Oregon Optometric Association, the American Association for the Advancement of Science Research Award, and has been recognized as Outstanding Biomedical Sciences Corps Officer of the Year, USAF Reserve. In addition, he has contributed more than 45 articles to the *Oregon Optometrist* since 1951.



**M. Emerson
Woodruff
O.D., Ph.D.
Vice-President**

Dr. Woodruff is Director of the School of Optometry, University of Waterloo, Waterloo, Ontario, Canada. As chief academic and administrative officer of the School, Dr. Woodruff serves on the Council of the College of Optometrists of Ontario, the regulatory body for the provinces of Ontario, and as Chairman of the Ontario Council of Health Sciences, a group representing the chief administrative officers of all University Health Science programs outside of medicine.

During the past five years, Dr. Woodruff has carried out extensive research in the field of vision of deaf children, the mentally retarded and nursery school children. He has lectured to numerous societies on a wide variety of clinical and theoretical subjects and has testified as

an expert witness for the Indiana and Wisconsin State Boards and several Canadian Royal Commissions.

He is presently a member of the Canadian Optometric Association, the Ontario Optometric Association, a Fellow of the American Academy of Optometry, a member of the American Optometric Association and the Association for Research in Ophthalmology.

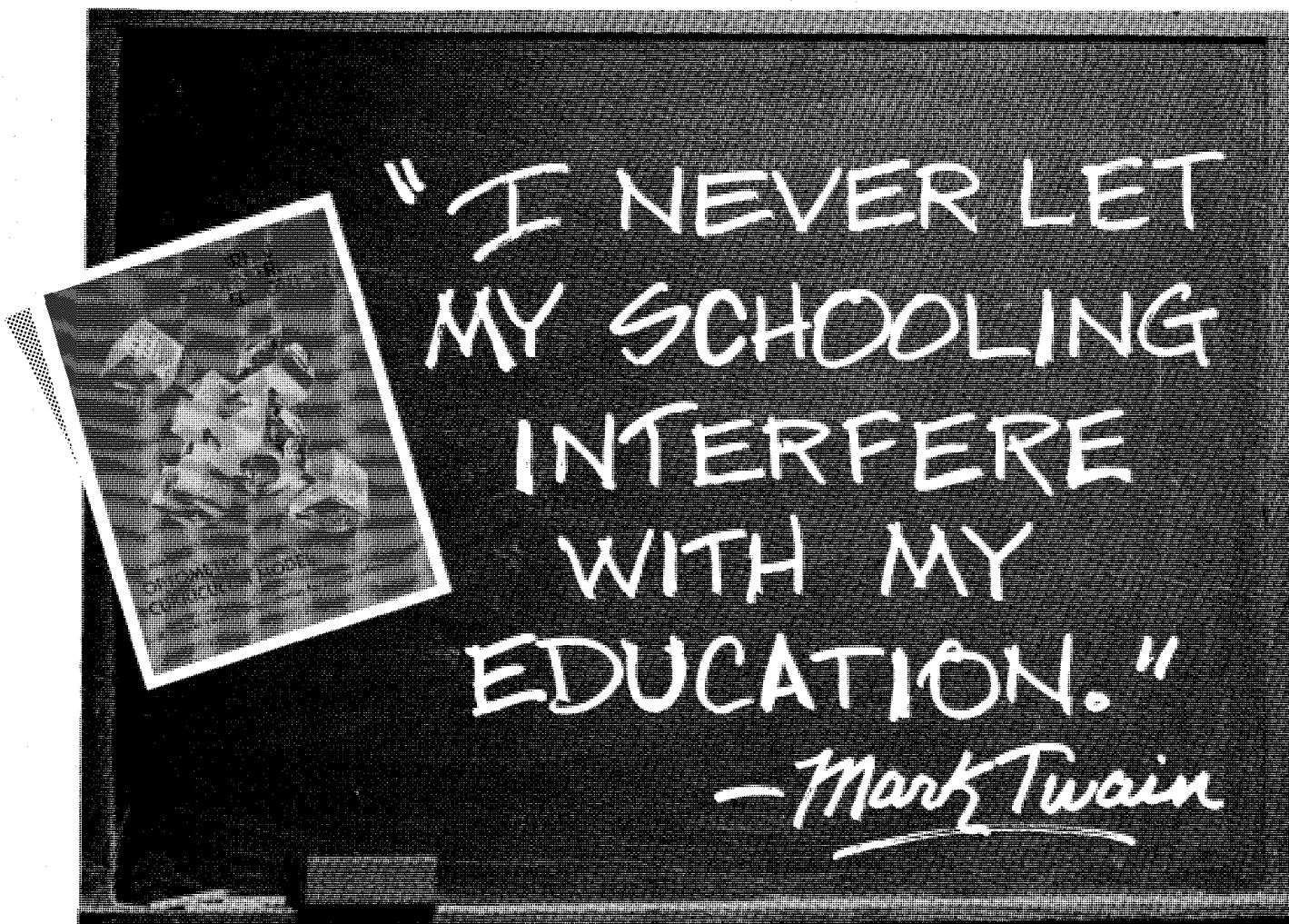


**Richard L.
Hopping, O.D.
Secretary-
Treasurer**

Dr. Hopping is President of the Southern California College of Optometry, Fullerton. He is a Trustee of the Association of Independent California Colleges and Universities, a member of the Health Manpower Training Assistance Review Committee for the Veterans Administration, a member of the Health Advisory Board for the State of California and serves as Chairman of the Section on Primary Care Optometry for the American Academy of Optometry.

He served for six years as an officer of the Ohio Optometric Association including President in 1964. He was elected to the Board of Trustees of the American Optometric Association in 1966 where he served in a number of offices within the organization and as its President in 1971-72.

Besides his extensive involvement in many civic and professional organizations, Dr. Hopping has been the recipient of numerous awards and honors including the Optometrist of the Year for the State of Ohio, Outstanding Young Man of the Year for the City of Dayton and one of the Ten Young Men of the Year for the State of Ohio in 1961.



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