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ARTICLES

Culture and Communication
Enid-Mai Jones, M.Ed.
ASCO's director of career promotion and student affairs outlines the dynamics of culture and how it shapes the ability to communicate effectively.

Cultural Competency and Optometric Education
LeVelle B. Jenkins, O.D., F.A.A.O.
The author discusses the EYECARE model designed to give optometric institutions, organizations and practitioners a template for incorporating cultural competency into their prospective areas of eye care delivery while adhering to the CLAS (Culturally and Linguistically Appropriate Services) standards in health care.

Chief Academic Officer Survey on Teaching Cultural Competency in Optometric Education
Kimberly A. Lambreghts, O.D., F.A.A.O.
Beth Schultz, O.D., M.S., F.A.A.O.
A survey by ASCO's Chief Academic Officers provides data on cultural competency training programs for faculty and students.

Intercultural Sensitivity: Educating Educators (ISEE) — Training Optometric Faculty to Educate Students
The paper describes the first phase of an inter-institutional program of development sponsored by ASCO and designed to increase awareness among faculty and staff of the growing disparities within our health care delivery system and their effect on optometric patient care.

Assessing Cultural Competency in Optometric Faculty
Aurora Denial, O.D., F.A.A.O.
Elizabeth Hoppe, O.D., M.P.H., Dr.P.H., F.A.A.O.
Nancy Carlson, O.D., F.A.A.O.
The purpose of this pilot study is to establish the faculty's knowledge of cultural competency and to evaluate their responsiveness to training.

FEATURES

Think Tank - Culture and Diversity
Optometric leaders identify ways in which diversity and culture have impacted optometric education over the past 20 years and predict future issues.

My Best Day in Optometric Education — Challenges and Rewards
Kenneth E. Brookman, O.D., Ph.D., M.P.H., F.A.A.O.

Cultural Awareness in Optometric Teaching and Patient Care Special Issue — Sponsorship Letter
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Resources in Review
Cover photo: The Multi-Cultural Association of the Illinois College of Optometry recently held its International Night which featured students and faculty singing, dancing, and showing off ethnic fashions. This event raised money for student scholarships. Photograph by Dominick M. Maine.
### Association of Schools and Colleges of Optometry

The Association of Schools and Colleges of Optometry (ASCO) represents the professional programs of optometric education in the United States. ASCO is a non-profit, tax-exempt professional educational association with national headquarters in Rockville, MD.

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This issue of Optometric Education highlights a special theme by describing ways in which the schools and colleges of optometry celebrate diversity and embrace cultural awareness.

A recent study by Soroka, et al., found that doctors of optometry provide care to patients of all racial and ethnic groups, on parity with the distribution in the U.S. population.¹ As the authors in this issue of Optometric Education point out, diversity of cultures within the U.S. continues to expand at a dramatic rate. Optometric educators have a responsibility to help prepare students to meet the potential challenges that will face them while providing care to a diverse patient base. Educators will need to make sure that our graduates have the skills required to serve a variety of cultures that may differ from their own.

Increased diversity will be reflected not only in the patients seeking optometric care but also in the students enrolled in the schools and colleges of optometry who represent all cultural groups through diversity in race, ethnicity, religion, sexual orientation, and disability. Communication styles, learning styles, and interpersonal relations may differ dramatically among students of different backgrounds.

This issue captures a snapshot of the status of diversity awareness and cultural competency educational programs within the schools and colleges of optometry. Some of the programs target students, while others are directed towards faculty and staff. All share the goals of helping our profession grow and assisting doctors of optometry to provide optimal patient care.

What is culture and why is cultural sensitivity important? I was faced with these questions recently as a participant in several discussion groups, training sessions, and workshops. Is culture in the eye of the beholder as others define us? Is it how we identify ourselves? Many of us are members of a variety of different cultural groups, and understanding our inherent values is a first step in understanding others.

The Health Services Resource Administration, Bureau of Health Professions (HRSA), reminds us that there is not a single definition of cultural competency that is universally accepted. Definitions and terms vary among health care practitioners and in health professions education. HRSA suggests that most definitions have a common element, which requires the recognition of one's own culture in order to understand the culture of a patient. We also lack a consensus about how best to provide the necessary knowledge, skills, experience, and attitudes to effectively serve diverse populations. Some individuals even doubt the legitimacy of teaching cultural competence.²

As the authors in this issue point out, cultural competency is most often thought of as a continuum. Each of us may be at a different point along the spectrum, but let us hope that this issue will help us all to progress just a little further along the path, helping us to grow in knowledge and learn skills that will improve the quality of our teaching and patient care.

We are grateful to CIBA Vision, a Novartis Company, for its invaluable support of this special issue on cultural awareness. (See letter from CIBA Vision on page 76). Thanks are also due to Vistakon, Division of Johnson & Johnson Vision Care Inc., which sponsored the mini-grants for the diversity/multi-cultural symposiums at the schools and colleges of optometry that are discussed in this issue. A subsequent grant from Vistakon will enable additional workshops.

¹ Soroka M. Profiling the contemporary general practice of doctors of optometry: a national survey of optometric patients commissioned by the National Board of Examiners in Optometry. Optometry, Journal of the American Optometric Association, in press.
Diversity comes in many forms and is rich in its many contributions to our society. Whether it is racial, ethnic, cultural, or gender diversity, the common denominator is the need to be personally, clinically, and professionally aware of its existence, respectful of its attributes, appreciative of its needs, and responsive to its demands.

An increase in gender diversity within optometry has been most evident over the past 20 years; however, increases in racial, ethnic, and cultural diversity have been considerably more modest, as has the consequent impact upon optometric education. The greatest impact of diversity upon optometric education will come in response to the increasingly challenging societal demand to train practitioners who are as diversity competent as they are clinically competent. Practitioner concordance with the racial, ethnic, and cultural features and nuances of a highly diverse society will be tantamount to clinical competence as requisites for quality care, patient satisfaction and professional success.

Edwin C. Marshall, O.D., M.S., M.P.H., F.A.A.O.
Professor of Optometry
Associate Dean for Academic Affairs and Student Administration
Indiana University School of Optometry
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Department of Public Health
Indiana University School of Medicine
Executive Director
National Optometric Association

Does Optometry reflect the American landscape of its cultures and populations?
Is it addressing the unique sub-populations and reflecting their sensitivities and visual needs?
Are the schools aggressively recruiting the best and the brightest from these sub-cultures?
Are the schools teaching their students to be compassionate in delivering care for the lifestyles of the sub-cultures?
Are the schools actively recruiting faculty who represent the world’s diversity?

If Optometry is to be accessible and accountable as eye care provider for the masses, it must reflect the world that we inhabit.

All ASCO schools colleges are committed to diversity. They have now added diversity into their mission statements. They are incorporating the sensitivity of culture into their curriculum.

Data is being kept on the recruitment success and faculty hires. These are but a few of the baby steps being taken. BUT an ongoing effort must continue and accelerate to grasp the concept that all people are unique and special, especially in delivering Optometry’s calling to be of service to our fellow beings.

George E. Foster, O.D. — Dean — Northeastern State University College of Optometry
Since in the last twenty years the emigration of peoples throughout the world has expanded significantly, we now find in our mainstream American culture a diverse ethnic and cultural population. Professionals of all disciplines have had to adapt.

I believe that the way diversity has impacted optometry is principally in terms of language skills. Communication becomes the means by which symptoms are understood, diagnostic tests are evaluated, and therapies are instituted and explained. Health care providers can no longer rely solely on interpreters as the sheen numbers of people who speak Spanish, Vietnamese, Chinese, and other languages increase.

Optometrists must also be cognizant of cultural health practices. When these deeply held beliefs are not understood or integrated into the chosen therapy, then the therapy is more likely to fail. The key to understanding is education, and it will be a challenge for the private practitioner to uncover these beliefs independently. Again, this is where the schools and colleges of optometry, by aligning with public health institutions, can best serve the education of new optometrists and to offer continuing education to licensed practitioners in these areas. Both new and experienced practitioners will thus receive the communication tools needed to best serve the ever-expanding diversity of their patients.

Terrence Knisely O.D., Ph.D.
The New England College of Optometry

Looking ahead to the future, I hope to see:

- Integration of public health issues and cultural differences regarding health care and its impact.
- Continued attention and awareness of developing inter-personal skills on sensitivities and communication particularly for cultures common to a particular area or region.
- Expansion of the educational curriculum to include an international experience in a developing country. Working with an underserved population will enhance one’s sensitivities and understanding of culture differences within a community and will expedite the provision of effective patient care.
- Development of more widespread language skills, particularly Spanish, among practitioners. The Spanish speaking population is the fastest growing minority in the U.S.

Bina J. Patel O.D., F.A.A.O., Associate Professor
International Director, Center for International Advancement of Optometry
The New England College of Optometry

Learning to appreciate and expand our knowledge in issues of diversity is providing opportunities for growth and intellectual development among students, faculty, and administration at our optometric institutions. It is also expanding our opportunity to better serve our communities. Embracing this opportunity to teach, learn, create an environment that values, respects, and appreciates racial, gender, and ethnic diversity is a win for everyone. It is imperative that we encourage optometric students to value the diverse patients that help them achieve clinical competency. The reward is reciprocal respect culminating in a higher level of self-awareness and self-respect.

The next 20 years will present a complex mix of racial, ethnic, gender, and generational challenges and opportunities. New consumers (students or patients) will have new demands for their dollar. They will require environments and programs that are flexible, while acknowledging and respecting their life and cultural differences. Not only will the face of America continue to change, but our experiences will be shaped through travel and technology that interface with diverse cultures. Leaders in optometric education must take ownership of programs that establish sound infrastructures that universally address and support these experiences.

Millicent L. Knight, O.D.
Professional Affairs Consultant, Vistakon, Johnson & Johnson Vision Care, Inc.
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**CooperVision, Inc.**

The contact lens unit of The Cooper Companies, Inc. (NYSE: COO), said today that in keeping with its long-term commitment to the rapidly growing contact lens market in Southern Asia, it has established marketing, distribution and administrative operations in Malaysia and Singapore. The CooperVision office will be located in Singapore.


**Volk Optical**

To meet the needs of the company’s growing global customer base, Volk Optical, a leader in aspheric optics, has appointed Tim Warrell to the newly created position of Marketing and Customer Service Manager.

Warrell will meet customer needs for optical products and service in the United States and abroad. Volk offers a complete line of diagnostic, therapeutic, and surgical ophthalmic lenses, equipment, and accessories. The company continues to keep pace with advances in the industry worldwide, most recently expanding its offerings to include new lenses for 25-gauge vitrectomy procedures and an AutoClaveSterilizable (ACS™) line.

Volk Optical is an innovator in the design and manufacture of diagnostic, therapeutic, and surgical ophthalmic lenses, equipment,

(Continued on page 102)
For me, every day in optometric education is "my best day." It is a rare day when I’m not faced with some new (and often unexpected) challenge or reward. Perhaps this is because my role as an educator is diverse and continually changing. In fact that is probably why so many are drawn to a career in education.

Didactic teaching and academic administration are primarily what I do. Although I have been teaching the same courses for many years, they never fail to challenge and reward me each time I teach them. The challenge is to impart knowledge in the most effective way possible and the reward is to see the students’ eagerness to learn and their enthusiasm when they understand. Each day that a challenge is met and a reward is received is "my best day."

Another aspect of what I teach that contributes to "my best day" is the fundamental nature of the subject matter (clinical refraction, phorometry and case analysis). Since these subjects help to form the foundation for so many subsequent courses and for the students’ patient care experiences, the stakes are quite high for student learning. This of course presents its own challenges and rewards.

My role in academic administration provides numerous challenges and rewards. Perhaps the most challenging — and maybe not so rewarding at times — is the development of first, second and third year didactic class schedules for each academic term. The great challenge here is to bring many campus constituencies together to develop schedules that do not conflict with the diverse and often complex faculty assignments, and that are consistent with classroom and laboratory availability. There have been times, although rare, when I have scheduled two classes in the same room at the same time. This is the not so rewarding part. When everything works, however, the rewards are high.

Another important aspect of my administrative role is to assist with the development of assignments for both full-time and part-time faculty members. The challenge here is to match the needs of the academic program with the desires and interests of each faculty member. With respect to junior faculty members in particular, I look for teaching opportunities that are of interest to them and that will help to develop their teaching skills. In addition to didactic teaching, the needs of the clinical program, the scholarship interests of each faculty member, and the administrative opportunities for the faculty must all be considered in the development of assignments for each academic year. The challenges are great but so are the rewards.

Perhaps one of my most significant (and recent) challenges was to chair a committee charged with conducting a self-study of the institution for accreditation renewal. The completion of this very important endeavor required nearly 16 months. The coordination of those involved in the self-study process and the preparation of the self-study report presented very unique challenges and rewards. The day that the self-study report was completed was clearly "my best day."

The ultimate reward I receive as an educator is when my students walk across the stage during commencement and receive their degrees as Doctors of Optometry. This annual event always renews my reasons for choosing optometric education as a career. I never fail to be impressed with the maturation of my students that takes place during the four-year professional program. To see them graduate as well-educated and confident professionals is most certainly "my best day in optometric education."

Dr. Brookman is professor and associate dean for academic affairs at the Southern California College of Optometry.
There is much cultural diversity in the online world. Never before have there been so many resources available to learn about distant peoples and nations. However, there are some great technology divides as well. Of people living in North America, 68% are connected to the internet. Compare this to Africa, where only 2.5% of people are connected. (http://www.internetworldstats.com/)

The Center for the Study of Cultural Diversity in Health Care (http://cdh.med.wisc.edu/) notes that by the year 2050:
- The non-Hispanic white population will decrease from 75 percent to 50 percent of the total population.
- The Hispanic population will increase from 9 percent to 25 percent.
- The Asian population will increase from 3 percent to 8 percent.
- The African American population will increase from 12 percent to 14 percent.

These diverse cultures will eventually be reflected not only in the patients we serve but also in the optometry students we teach and eventually in the makeup of our optometric profession. But how do we start our journey towards cultural competence? One way is to utilize the internet not only to breach communication barriers, but also to learn all we can about those we serve and those who will be our future colleagues.

If you go to http://www.ggalanti.com/articles.html you will find an impressive number of articles on various cultures and how they view health care. These articles include "Cultural Competence and Pediatric Care" and "How to Do Ethnographic Research" as well as articles on the similarities and differences of cultures that are as diverse as the Hmong and Mexican Americans. Other articles you may wish to review include "Cultural Diversity, Alternative Medicine, and Folk Medicine" by David J. Hufford, Ph.D. (available at http://www.temple.edu/isllc/newfolk/medicine.html). And finally, for quick snapshots of various cultures and how they view healthcare you may wish to visit The Cross Cultural Health Care Program at http://www.xculture.org/index.cfm.

Some of the patient education materials that we distribute are now available in other languages, predominantly Spanish. You may even want to spend the time to have your case history forms translated into different languages. If you keep the layout and check-offs identical to your English version, you can match them up side by side to determine the patient’s chief complaint or Review of Systems information, even if you don’t know the language.

Speaking another language is certainly one method to bridge the cultural gap. The web is full of resources for learning other languages or polishing up on a language you learned previously. From language software available at http://www.transparent.com to finding a language tutor in your area, you’re sure to find some online help. Net Learn Languages found at http://www.nll.co.uk can even assign you a personal native speaker of your desired language who can teach you over the internet.

Ever find a great reference for your latest project but discover that the abstract is in Russian? Unless you have some well-versed colleagues, you better start searching for your “Learn Russian in a Weekend” tapes! Another solution may be to check out BabelFish.

BabelFish technology can translate speech from one language to another. There are a host of translation services, many of which are free, which can be located at http://www.babelfish.org. Alta Vista has its own version at http://babelfish.altavista.com that allows you to simply cut and paste text, select which language you want translated, and presto! You can even enter the URL of a web page and have the entire page translated.
CIBA Vision, a Novartis Company, recognizes that diversity is created by individuals and groups from a broad spectrum of demographic and philosophical differences. We have over 6,500 employees and provide lenses and lens care in more than 70 countries. We accept and value individual and group differences without prejudice, in a climate of mutual respect and tolerance and we greatly appreciate the contributions of individuals from different backgrounds.

We are proud to sponsor this special issue of *Optometric Education* on "Cultural Awareness in Optometric Teaching and Patient Care." CIBA Vision has a long history of partnering with ASCO and the schools and colleges of optometry to improve the quality of educational programs. In 1994, CIBA Vision initiated and sponsored the Total Quality Education Grant Program (TQE), which gave grants to improve programs at a number of schools. Recently, CIBA Vision created and funded the Each One Reach One program to promote the career of optometry and to increase the number of applicants to the schools, an issue identified as one of ASCO's strategic objectives. This program provides career information materials for practicing optometrists to use in recruiting prospective optometry students.

CIBA Vision extends support to ASCO for its efforts to promote diversity and to understand the impact of culture on optometric teaching and patient care.

We sincerely thank Dr. Elizabeth Hoppe, editor of *Optometric Education*, and the authors of the articles in this special issue for their work on this important topic for optometry.

Suzanne H. Nylander, O.D., F.A.A.O.
Manager, Academic Development
North America Professional Services
CIBA Vision, a Novartis Company
Culture and Communication

Enid-Mai Jones, M.Ed.

It has become a cliché to say that the world is shrinking or becoming a "global village" or that "America is a melting pot." Rapid advancements in transportation and communication, political unrest and recent migrations have brought the people of the world closer together in a physical sense and have increased human interaction. The make-up of the American population continues to change as a result of immigration patterns and significant increases among racially, ethnically, culturally and linguistically diverse populations already residing in the United States.

The United States is experiencing a shift in demographic trends, resulting in an increase in cultural diversity. Demographers predict that the next two decades will bring racial and ethnic minority population to a numerical majority in the United States. Primary care organizations and federal, state and local governments must implement systemic change in order to meet the health and mental health needs of this increasingly diverse population. The reality is that African Americans, American Indians, Alaska Natives, Asian Americans, Pacific Islanders, and Hispanic Americans accounted for 30 percent of the population in 2000. These population groups are projected to account for about 40 percent of the population by 2025.

As professionals working in or preparing to work in this global and diverse environment, we must realize that success in part depends on our ability to understand the dynamics of culture and how it shapes our ability to communicate effectively. It is important to understand intercultural communication and how it is affected by culture. Intercultural communication refers to the influence of cultural variability and diversity on interpersonally oriented communication outcomes. Differences in communication and social style, world view, customs, expectations, rules, roles, and myths illustrate a few of the elements that explain how culture shapes the communication process.

As human beings, we are greatly influenced by our "culture." Culture is the holistic interrelation of a group's identity, beliefs, values, activities, rules, customs, communication patterns, and institutions. As people we have learned intriguing ways of acting and thinking that significantly organize our world. Culture is a powerful vehicle for socialization. It influences how we adapt and learn; it includes customs, habits, language, expectations, and roles.

First, culture teaches significant rules, rituals, and procedures. It defines our attitude towards time, how to dress, what is polite or expected. The process of learning the rules and rituals of our culture is called socialization, which refers to developing a sense of proper and improper behavior and modes of communicating. These are important because they establish boundary-setting, inclusion and self-worth. These modes of communicating define human development within the context of any one specific culture.

Secondly, culture reinforces values. Good and evil, the meaning of truth, and a core understanding of the world are taught in a cultural context. Culture teaches us what is beautiful or ugly, sexy or unappealing. Third, culture teaches us about relationships with others. These relationships formed in culture generate a dynamic of roles and expectations. For example, the optometrist may be seen as a figure of high authority and therefore may not be questioned even when the patient lacks understanding. Culture shapes our perceptions and affects the human tendency to categorize the roles of others.

Communication is central to our experience. It is through communication that we learn who we are, and what the world around us is like. Communication permits us to express our thoughts and feelings to others, and to satisfy our emotional and material needs. Through communication, we explore the world around us, and establish bonds, networks, and relationships with other people. Our culture impacts our personalities, perceptions, values, behaviors, language, time and space concept, nonverbal communication, and interaction with others. In large part, our identity as both individual personalities and as cultural beings is shaped through communication with other people. The cultural background of the communicator influences almost every detail and pattern of his and her communication activities.

When we communicate with individuals from a different cultural group, we are engaged in intercultural communication. Intercultural communica-
Intercultural communication recognizes how culture pervades what we are, how we act, how we think, and how we talk and listen. Intercultural communication involves understanding the influence of culture and interpersonal relationship attributes as they affect intercultural communication and perception of differences. These factors influence two people as they build a communication climate from which they find commonality, reduce uncertainty and anxiety, and provide a context basis for continued communication. Failure to consider the cultural context can lead to misunderstanding and miscommunication. We must be aware that interpretations of the verbal and nonverbal messages are influenced by both the recipients' cultural background and ours.

A significant element of intercultural communication is the silent language of nonverbal communication. The term nonverbal communication is commonly used to describe all human communication events that transcend spoken or written words. Nonverbal communication patterns are highly culture-bound. Thus nonverbal communication involves not only the actions but the cultural interpretations of those actions in relation to the verbal communication uttered simultaneously. Nonverbal messages such as space, gestures, postures, body movement, eye behavior/movement, greetings, time and facial expressions may complement, contradict, repeat or accentuate, regulate or negate the verbal message. Each culture perceives nonverbal behaviors, converting them for communication value as defined by our respective culture. For example, our culture governs how close we stand while talking with another person, how we use (or avoid) eye contact; it affects how we express (or suppress) powerful emotions such as joy, disapproval, and anger. Although some nonverbal forms — such as smiles and frowns — are universal gestures, the ways in which they are used - and, therefore, what they mean — are not.

Successful intercultural communication requires enthusiasm and a willingness to overcome cultural barriers. It is a two-way process. Thus understanding the relationship between culture and communication leads the intercultural communicator to try to avoid overreaction and to probe deeper into what is happening during the intercultural encounter. It is important to operate with a flexible world-view and patience, and to be able to respond to changing situations. Living and working in a diverse environment means that we have to develop and display empathy. Display of empathy requires that we not only put ourselves in someone else’s place but that we focus and diligently listen in order to understand each other’s point of view. A culturally-fluent approach to communication means working over time to understand the ways communication varies across cultures, and applying these understandings in order to enhance intercultural relationships and interactions.

References

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Southern California College of Optometry

The Southern California College of Optometry (SCCO) invites nominations and applications for the position of President. Established in 1904, SCCO is a private, independent and fully accredited four-year professional college granting the Doctor of Optometry degree. SCCO enjoys an outstanding reputation for its dynamic and progressive optometric educational program; its extensive and unequalled outreach clinical program; and its well-earned financial strength.

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Please send your nominations or your application to:
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EOE
Cultural Competency and Optometric Education

LeVelle B. Jenkins, O.D., F.A.A.O.

Abstract

The standards for Culturally and Linguistically Appropriate Services (CLAS) in health care were issued by the Office of Minority Health (OMH) in response to the rapid increase in diversity in the United States and the need for all people entering the health care system to receive equitable and effective treatment in a culturally and linguistically appropriate way. The EYECARE model is designed to give optometric institutions, organizations, and practitioners a template for incorporating cultural competence into their prospective areas of eye care delivery while adhering to the CLAS standards. The acronym EYECARE stands for Evaluate, Yield, Explore, Communicate, Acknowledge, Re-evaluate, and Execute.

Key Words: EYECARE model, CLAS standards

Introduction

The United States is rapidly becoming more diverse. This increase in diversity is attributed to significant increases among racially, culturally and linguistically diverse individuals already residing in the United States and to recent trends in immigration patterns. As the U.S. population becomes more diverse, optometrists, optometry students, and others involved in eye care delivery will encounter individuals from many different cultural and linguistic backgrounds. It is imperative that optometrists and optometry students understand and respond with sensitivity to the needs and preferences that culturally and linguistically different individuals bring to the eye care system because culture and language are vital factors in how health services are rendered and received.

The standards for Culturally and Linguistically Appropriate Services (CLAS) in health care are the final report for the Cultural Competence Research Project, sponsored by the U.S. Department of Health and Human Services Office of Minority Health and the Agency for Health Care Research and Quality (AHRQ).

There are 14 CLAS standards that are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organization Support for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations.

- CLAS mandates are current federal requirements for all recipients of federal funds (Standards 4, 5, 6, 7).
- CLAS guidelines are activities recommended by OMH for adoption as mandates by federal, state, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, 13).
- CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).1 (Appendix A)

The collective set of the CLAS standards are intended to educate and facilitate required and recommended practices as they relate to cultural and linguistic services in health care. Cultural and linguistic competence (according to CLAS definitions) refers to a set of congruent behaviors and attitudes that come together in a system, agency, or professional organization that enables effective work in cross cultural situations. Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, values, beliefs, and institutions of racial, ethnic, religious or social groups. Competence implies having the ability to function as an individual or an organization within the context of cultural beliefs, needs and behaviors presented by patients/consumers and their communities.2

The CLAS standards should be of particular interest to schools and colleges of optometry because these institutions educate a diverse student body to deliver quality comprehensive eye care to a diverse population. Optometry students receive a large part of their education from externships, many of which include sites in Indian Health communities and VA hospitals. In addition, a good proportion of the schools and colleges of optometry are located in communities with ethnic diversity. Furthermore, the faculty members of the optometric educational institutions are in most cases a culturally homogeneous group (1.7% African American, 4.5% Hispanic, 10.5% Asian, 0.9% American Indian, 1% Foreign National, 0.5% other and 81% Caucasian) who are teaching a very heterogeneous student body. It is reasonable that the CLAS standards be incorporated into optometric education.
The EYECARE Model for Cultural Competence

The EYECARE model is designed to give optometric institutions, organizations, and practitioners a template for incorporating cultural competence into their prospective areas of eye care delivery. The acronym EYECARE stands for Evaluate, Yield, Explore, Communicate, Acknowledge, Re-evaluate, and Execute. The standards for culturally and linguistically appropriate services (CLAS) can easily be incorporated into the framework of the EYECARE model to ensure compliance with the regulations while establishing guidelines for providing competent care as it relates to culture and linguistics. While exploring a cultural group's health-related beliefs and values, health care organizations should develop collaborative partnerships with the community. The partnership will allow community members to be active participants in determining its needs. It also gives the health care organization direct access to potential employees within that community. This allows for the fulfillment of CLAS standards 1-2 and 11-12. Standards 4-7 fit within the communication component of the model. Acknowledgement and acceptance of the co-existence between western and folk or traditional medicine satisfies standard one. The re-evaluation and restructuring of policies and procedures and the execution of a proactive, culturally sensitive plan that values diversity, respects cultural values, and promotes quality eye care allows for compliance with standards 8-10 and 2, 3, 13-14, respectively.

Additionally, the patient is at the center of the model with bi-directional arrows leading to the community (which includes factors such as the patient’s family, health care beliefs, neighborhoods, religion, communication styles, behavioral norms, etc.) and the organization (which includes employees, students, faculty, administrators, etc.). There must be a reciprocal relationship between the organization’s culture and the patient’s culture, with frequent modifications, in order to achieve cultural competence. The process is dynamic in nature and continuously evolves with each encounter. (Figure 1)

The Anatomy of the EYECARE Model

Evaluate
Evaluate the beliefs, biases, prejudices and assumptions of organizations, teaching institutions, professionals, students and employees. This process involves the recognition of one’s biases, prejudices, and assumptions about individuals who are different. Without being aware of the influence of one’s own cultural values, there is risk that one may engage in cultural imposition. Cultural imposition is the tendency to impose one’s beliefs, values and patterns of behavior upon another culture.

Yield
Yield to and surrender all preconceived prejudices and biases toward different cultures. Optometrists, optometric organizations, and optometric educational institutions must be willing to come to terms with and set aside past experiences, learned behaviors, and stereotypes about different cultural groups. The desire to be flexible and open must be present and one must respect differences while focusing on similarities. If eye care professionals want to create a future of rendering culturally responsive care, it will have to be driven by desire. Desire is the fuel necessary to draw one into a personal journey towards cultural competence.

Explore
Exploring a cultural group’s health-related beliefs and values can lead to understanding their world view. Patients’ world views will explain how they interpret their illness and how their world view guides their thinking, doing, and being. Treatment efficacy is another issue to address in the process of obtaining cultural knowledge. This involves obtaining knowledge in such areas as “bio-cultural ecology”—biological variations, disease and health conditions and ethnic pharmacology. Ethnic pharmacology is the study of variations in drug metabolism among ethnic groups. For example, Zhou, Koshakji, Silberstein, et al. demonstrated that Chinese subjects are more sensitive to the cardiovascular effects of propranolol than Caucasian subjects. There are several factors that are involved in determining responses to a specific drug in ethnic groups. These factors include genetic, environmental, structural, and cultural variation in ethnic groups.

During this educational process, it is important to be aware of intra-cultural variations. There are more differences within cultures than across cultures. An individual is a unique blend of the diversity found within each culture, a unique accumulation of life experiences, and the process of acculturation to other cultures. Therefore, everyone needs a cultural assessment, not just people who look like they need one.

Communicate
Assessment of the patient’s linguistic needs is an important aspect of becoming culturally competent. Optometrists must assess patients’ communication styles to learn about cultural-specific cues that are used. Understanding these communication cues can assist the provider in explaining procedures and instructions. One must also consider
the different dialects within a particular language. Using a bilingual staff member or a formally trained medical interpreter is necessary to facilitate accurate communication during the patient-staff interaction and the patient-doctor interaction. The use of untrained interpreters, friends, or family members may pose a problem due to their lack of knowledge regarding medical terminology and ocular and systemic disease entities. Written and oral information should be presented in the patient's preferred language and the preferred language should be documented in the patient's demographic information. The use of children as interpreters should be discouraged.

Acknowledgment

Acknowledgment and accept that traditional western medicine and alternative or folk medicine can co-exist. Provider bias and prejudice can directly influence the interaction between the patient and the provider, the provider's delivery of care, and the way in which patients perceive care. Individuals and organizations must acknowledge and respect other cultures because the patient's cultural beliefs and practices will impact eye care outcomes. An example of this can be found in the Cuban culture's practice of Santeria. A patient who is experiencing a decrease in vision may attribute this as punishment from the Orisha (Saint), Obatala, the father of all human beings and the source of energy, wisdom, purity, and peace. This individual may offer as propitiation white pigeons, white canaries, female goats, plums or yam puree. The eye care provider should acknowledge the patient's beliefs and when possible, incorporate these beliefs into the traditional western medical treatment plan.

Multiple encounters with many individuals from a specific culture will be more indicative of that culture than a few sporadic encounters. These encounters can lead to cultural sensitivity, which is a heightened awareness of the specific needs of each patient within a cultural group, and can be manifested by a provider's ability to accurately interpret and respond to non-verbal or other cultural cues or in the way in which health care organizations provide information to their patients. This sensitivity can lead to the behavioral adaptations needed for cultural competence.

Reevaluate

The process of becoming culturally competent requires optometrists, optometric educational institutions, and optometric organizations to re-evaluate and restructure current policies, procedures, vision statements and mission statements to be more inclusive and respectful of all cultures. Administrators must foster a climate in which optometrists, students, and staff understand that the provider-patient encounter includes the interaction of three cultural systems—the culture of the providers, the culture of the patient, and the culture of the organization. A trans-cultural administration should be a creative and knowledgeable process of assessing, planning, and making decisions and policies that will facilitate the provision of educational and clinical services. It should take into account the cultural caring values, beliefs, symbols, references, and life ways of people of diverse and similar cultures for beneficial or satisfying outcomes.

Organizational policies must be culturally sensitive, appropriate, and recognize the rights of the individuals and families. Organizational leaders must assess the physical environment of care to determine barriers and potentially negative messages. What message does the organization send through its physical surroundings? How does the entryway present the culture of the organization to the public? Is the entrance warm and inviting? Is the signage prominent? Is it clear where the patient should go to give or receive information? Leininger developed a cultural care model to conduct an organizational assessment that includes factors such as environmental context, language and ethnography, technology, religious/philosophical, kinship/social factors, cultural values, political/legal, economics, and education of the organization.

Execute

Optometrists, optometric organizations, and optometric educational institutions must execute a proactive, culturally sensitive plan for addressing health care issues in culturally diverse communities. The plan must value diversity, respect cultural values and promote quality eye care. These organizations must create an inclusive workplace reaching out beyond the organization by encouraging members of the workforce to become active in the community and to participate in state and federal programs, working with poor and with diverse cultural groups. An inclusive workplace goes beyond the golden rule of treating others as you wish to be treated yourself. Instead, such a workplace is receiver oriented and involves treating others as they wish to be treated.

Cultural Competency as a Continuum

Campinha-Bacote suggests that individuals move through a four-stage cognitive process of becoming competent. The stages are: unconscious incompetence, conscious incompetence, conscious competence and unconscious competence. "Unconscious incompetence is not being aware that one is lacking cultural knowledge. There is no awareness on the part of the individual that cultural differences exist between themselves and the patient. Conscious incompetence is the awareness that one is lacking knowledge about another culture. Individuals may recognize this incompetence by attending workshops on cultural diversity, reading articles or books on the topic, or having direct cross-cultural experiences with patients from culturally diverse backgrounds. They know that culture plays an important role in eye care delivery, but do not know how to effectively use this knowledge. Conscious competence is the intentional act of learning about the patient's culture, verifying generalizations and providing culturally responsive therapeutic interventions. Unconscious competence is the ability of the doctor to spontaneously provide culturally responsive care to patients from diverse cultural backgrounds."

Jenkins proposes that as one moves through this cognitive process, there is a change in one's affect from apathetic to empathetic to sympathetic to committed. There is also a corresponding change in one's skill level or ability to interact cross-culturally with sensitivity and precision. The individual moves along a continuum, starting off as being unskilled and moving to learning skills, becoming moderately skilled, and ultimately becoming highly skilled. The overall effect of the cross cultural encounter is the individual's behavior moves from destructive to neutral to constructive. (Appendix B)

Some specific steps that optometry schools can take to instill cultural competence among students and faculty include:

1. Cultural Competency Workshops
   a. An initial assessment should be done to determine the culture of the individual school. This assessment
is used to determine the level of cultural competence/incompetence and the workshop can be tailored to address specific concerns. Each school should have a diversity caucus with members from the faculty, staff, and student body who will work with the cultural competency trainer and aid in the development and implementation of an organizational action plan.

b. The workshops should include the basic components of diversity training—knowledge, awareness, skills, and action. The workshops can be held during faculty retreats and/or during national conferences. The most effective workshops are one to two days in length and utilize both didactic and experiential teaching techniques. The workshops should be interactive and attended by the deans and presidents, as well as faculty, students and staff. The student’s workshops can also be separate from the others.

c. At the conclusion of the workshop, everyone should construct an individual action plan for implementing at least one learning tool from the workshop. An organizational action plan should be developed by the group to address the specific concerns as outlined in the initial assessment along with a timeline for implementation.

a. Include language in mission and vision statements that articulates the principles, rationale, and values for providing linguistically and culturally competent optometric care.

b. Develop policies, procedures, and fiscal planning to ensure the provision of language access and interpretative services.

c. Provide resources and develop policies to support ongoing in-service training and professional development in cultural and linguistic competence at all levels.

d. Implement specific policies and procedures that integrate cultural and linguistic competence into each core function of the teaching institution.

e. Develop a strategic plan to recruit, hire, and maintain a diverse and culturally and linguistically competent workforce.

f. Develop a strategic plan to recruit, admit, retain, and hire students from ethnically diverse cultural groups.

3. Coursework/Curricula
a. Incorporate multicultural eye health-related lectures and case studies into the breadth and scope of each optometric didactic and clinical course.

b. Offer expert academic or practice guest lecturers periodically to discuss multicultural issues such as health care disparities, homelessness, the importance of language access from the patient’s point of view, etc.

c. Develop and incorporate a curriculum that all students must enroll in that discusses health beliefs and practices, concept of pain, time, gender roles, religious beliefs, child-rearing practices, and communication styles of, at the very least, the culturally and ethnically diverse patients in the service area.

4. Practice-Based Strategies
a. Offer externships in multicultural eye and health care.

b. Develop case studies with a cultural and linguistic context.

5. Research
a. Encourage and support dissertations or theses on multicultural health and cultural and linguistic competency.

b. Participate in faculty research projects that focus on multicultural eye health and cultural and linguistic competency.

c. Fund an Endowed Chair in the school or college of optometry for multicultural health and cultural competency.

6. Fostering an Environment that Values Multicultural Students
a. Ensure that the school has dedicated staff and resources to provide an environment that values multicultural students.

b. Create and/or support multicultural student organizations and student-faculty committees.

c. Provide the students with a range of learning opportunities to participate in community-based participatory action research projects and initiatives on multicultural health.

d. Foster among the faculty and preceptors an understanding of cultural beliefs and values of minority students enrolled in the schools as it relates to learning styles, gender roles, and communication, both verbal and non-verbal.

e. Display artwork and pictures created by students or local residents that depict local cultures.

Key success factors for the incorporation of cultural and linguistic competence into all aspects of optometric education and clinical training programs include:

1. Solid and authentic institutional commitment.

2. Resource commitment.

3. Willingness to change policies and practices.

4. Administration and Faculty Champions.

5. Shared vision and “buy in” from faculty, staff, and students.

6. Community engagement, involvement, and collaboration.

7. Safe and supportive environment for discussion and change.

8. Patience, persistence, and realistic expectations.

Conclusion
The standards for CLAS are proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the needs of those who are culturally diverse. The standards are intended to be inclusive of all cultures and not limited to any particular group or subset of groups; however they are specifically designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.

The CLAS standards are primarily directed at health care organizations in general, but can also be utilized by optometric educational institutions, professional organizations, and practitioners. In addition, CLAS should be utilized by policymakers at the federal, state, and local level, accreditation and credentialing agencies, purchasers of health benefits, patients, advocates of eye care, and educators. The EYECARE model is an excellent tool to use for incorporating cultural competence in patient care, policies and procedures, and curriculum development. This model can assist in the dialogue between providers and cultural groups when assessing and meeting the needs of these groups. CLAS can easily be incorporated into the framework of the EYECARE model to assist optometrists in establishing guidelines for providing competent care.
as it relates to culture and linguistics. The EYECARE model demonstrates the need for understanding different cultures and the value of diversity.

Finally, schools and colleges of optometry can encourage cultural competency in their students, faculty, and staff by conducting workshops; incorporating inclusion dialogue in their mission statements and policy and procedure manuals; establishing a curriculum that interweaves cultural competency training in didactic and clinical courses; encouraging and supporting research that focuses on multicultural eye health and cultural and linguistic competency; and fostering an environment that values multicultural students, faculty and staff.

Note: Sections of this article appeared previously in an article written by the author for the American Optometric Association’s journal, *Optometry.* “Developing Cultural Competency in Optometric Care,” appeared in the August 2005 (Vol. 76, 8) issue of the AOA Journal.

References

Appendix A: The National Standards for Culturally and Linguistically Appropriate Services

1) Health Care Organizations should ensure that patients/consumers receive from all staff members, effective, understandable and respectful care in a manner compatible with their cultural health beliefs and practices in their preferred language.
2) Health Care Organizations should be strategic and proactive in the recruitment, retention and promotion of a diverse staff at all levels and leadership that is demonstrative of the demographics of the service area.
3) Health Care Organizations should ensure that all staff at all levels and across all disciplines, receive on-going education and training in culturally and linguistically appropriate service delivery.
4) Health Care Organizations must offer and provide language assistance services, at no cost, to all patients with limited English proficiency (LEP) in a timely manner, at all points of contact, during all hours of operation.
5) Health Care Organizations must notify the patient in his/her preferred language both verbal offers and written notices of their right to receive language assistance services.
6) Health Care Organizations must assure that the language assistance is provided by an interpreter or bilingual staff and not family and friends of the patient unless at the patients’ request.
7) Health Care Organizations must make available easily understood patient related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
8) Health Care Organizations should have a written strategic plan for providing culturally and linguistically appropriate services.
9) Health Care Organizations should conduct initial and on-going self assessments of all CLAS-related activities.
10) Health Care Organizations should ensure that the data on the individual patient’s race, ethnicity, and spoken and written language are collected in the health records and periodically updated.
11) Health Care Organizations should maintain current demographic, cultural, and epidemiological profile and needs assessment of the community to accurately plan for the implantation of CLAS related activities.
12) Health Care Organizations should develop collaborative partnerships to facilitate community involvement in the planning of CLAS-related activities.
13) Health Care Organizations should ensure that conflict and resolution processes are culturally and linguistically sensitive.
14) Health Care Organizations are encouraged to make available to the public their progress and successes in implementing the CLAS standards.

Appendix B: The Four Stages of Becoming Culturally Competent*

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<th>Skills</th>
<th>Overall Effect</th>
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*Campinha-Bacote (See Reference 5)
Chief Academic Officer Survey on Teaching Cultural Competency in Optometric Education

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Beth Schultz, O.D., M.S., F.A.A.O.


Abstract

Background: An educational movement by medicine, nursing, dentistry and pharmacy to institute formalized programs on cultural competency has been gaining momentum in the United States. These elite members of the health care educational community have recognized that culture influences patient care outcomes. Since optometrists are patriots within the health care delivery team it is crucial for us to take our place in the movement. Some schools presently offer courses on diversity training and cultural awareness.

Methods: To learn more about existing curricula in diversity training and cultural awareness, members of the Chief Academic Officers (CAO's) of the Association of Schools and Colleges of Optometry were surveyed. This web-based zoomerang™ survey, conducted in November of 2004, inquired about level and types of training on cultural competence within the respective institutions.

Results: 35% of institutions provide cultural competency training for clinical faculty; 53% of institutions provide cultural competency training for students. The delivery vehicle for training varied between lecture and workshop or a combination of the two.

Conclusion: Optometry is just beginning to create formal cultural diversity training as part of its curriculum. ASCO and its member institutions have embraced concepts of diversity and multiculturalism in optometric education and in the profession. Clearly, from the results of the survey much more is needed to bring the issue of cultural competence to the forefront of optometric education.

Key Words: cultural competency, diversity, faculty development

Background

Optometry is a dynamic, ever-changing profession. Our optometric schools and colleges and their associated eye health care facilities are becoming more diverse in terms of student body and patient populations respectively. Addressing cultural issues in our institutions is quickly being recognized as an opportunity for optometric educators to contribute to the development and attainment of cultural competency. Cultural competency is defined as "A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations." Ultimately, attainment of cultural competency throughout optometric educational institutions will aid in improving eye health care outcomes within and beyond their clinical education programs.

The United States is the third most populated country in the world and is presently growing. Not only is the U.S. population increasing in number, but its diversity is increasing exponentially. As the U.S. expands, the population is becoming more diverse partly due to an increase in immigration. Yet unanswered questions remain:

1. Are we teaching this diverse body of students, faculty and staff to be culturally sensitive and aware when caring for patients, and interacting with other staff, faculty and students? And, 2. above all, why is this important to our profession within the health care system?

Medical education has included topics related to diversity on several levels. The Liaison Committee of Medical Education (LCME) has included an accreditation standard, which requires that all students develop "an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness." Medical schools for years have incorporated some type of diversity training into residency programs and subsequently into undergraduate medical education as well as faculty development. Recently, they have also begun to look at the effectiveness of such training.

Other health professions have followed suit, including nursing, dentistry and pharmacy.
ty of teaching the understanding of diverse cultures and belief systems. As a member of this healthcare community, optometry must investigate the need for such education and cultivate programs to foster a change in knowledge and beliefs on culture in our future graduates. Essentially, optometric education must target a change in knowledge, attitudes, and beliefs through symposia and workshops. These formal programs should eventually translate into a change in behaviors by faculty and students. This ultimate translation will become a key feature of medical care in the future given our growing diversity. This visionary approach corresponds to the Medical Outcomes Study (MOS), which was a comprehensive approach to the assessment of health. In particular, the study was designed to evaluate the impact of chronic disease on patient functioning and well-being and to determine if the key features of medical care are associated with more favorable patient outcomes. A formal optometric educational program focused on cultural competency would directly influence our national and global health care initiative to produce more favorable patient outcomes throughout all cultures.

Optometry is just beginning to create formal cultural diversity training as part of its curriculum. ASCO and its member institutions have embraced the concepts of diversity and multiculturalism in optometric education and in the profession. ASCO bases its diversity program on several assumptions including: (1) Greater diversity among health professionals is associated with improved access to care for our diverse society, greater patient choice and satisfaction, better patient-provider communication, and better educational experiences for all students, which will prepare them for the diverse communities they will serve in practice, (2) Diversity is good for optometric education and the profession, and (3) It is the right thing to do. To this end, the Intercultural Sensitivity Education for Educators (ISEE) research group began its initial study of how to bring the issue of cultural competency into the schools and colleges of optometry.

Methods

To learn more about the existing curricula in diversity training and cultural awareness topics, the Chief Academic Officers of the schools and colleges of optometry in the U.S. and Puerto Rico were surveyed. This survey was conducted in November 2004 and inquired about the level and types of training on cultural competency within their respective institutions. Surveys were conducted using the web-based program zoomerang. A copy of the survey questions is included in Appendix A.

Results

There were 17 responses, for a response rate of 100%. Results are summarized in Figures 1 through 3. Six institutions (35%) provide cultural competency training for their clinical faculty. Of the six positive responses, the preferred modality is training via workshops. Only one school presented faculty training solely via a lecture format. One respondent indicated that a four-hour workshop is the only form of faculty training, and three schools utilize a combination of lectures and workshops. One school provides a workshop and an online diversity awareness program. The logistics of the training programs are similar. The lectures are all reported as one-hour sessions. Most workshops are 2 hours in length. The maximum number of hours spent in workshops was reported as 10-15 hours per year.

Different types of content experts provided materials covered during cultural competency faculty training programs. In three of the schools, a faculty member provides the training. Two schools include a guest speaker or guest organization along with a faculty member. One responder indicated that the vice president of human resources provides the training.

In addition to the faculty development programs held at six institutions, there are separate programs for the student populations. Nine institutions (53%) provide cultural competency training for their students. This is most often accomplished through lectures, with eight of the nine positive responders indicating that some lecture time is used. Two schools combine the lecture with workshops and only one school uses solely a workshop format.

The logistics of the student training programs are varied. The amount of time devoted to lectures on the topic of cultural competency ranges from 1 hour to 10 hours. The workshops are either 1 or 2 hours in duration.

Placement of the student training programs within curricula was similar. The majority of the lectures on cultural competency occur in the third year of the program (n=5, 63%), followed by
the first year (n=4, 50%), second year (n=2, 25%), and fourth year (n=1, 13%). Three of the four workshops on cultural competency occur in the first year, with the remaining workshop presented in the third year.

Discussion

A majority of schools provide some type of training for students, while relatively few include training for faculty. It is clear from these data that much more is needed to bring this issue to the forefront of optometric education. In 2000 the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) put forth standards for the culturally and linguistically appropriate services (CLAS) that serve as a “means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers.” Currently these standards apply to health care organizations; however individual practitioners and health professional schools are encouraged to comply.

Inequalities in health care have been well documented in the literature. However, the hypothesis that provider behavior and beliefs contribute to this disparity is largely a new and unexplored entity. The theory that altering the beliefs and practices of faculty has been studied in medicine and was found to have a profound impact on not only the student but on the institution as well.

To this end, the ISEE group has focused on the design of a faculty development program that strives to alter attitudes and behaviors and which may also be correlated with improvements in health care outcomes. Teaching and attaining cultural competence is an ongoing process that begins with recognizing one’s biases as they relate to others who are ethnically or linguistically different than us. It is believed that by training clinical faculty through a series of symposia that utilize a lecture and role-play format, the impact will be widespread and will also reach students and ultimately positively affect patient health outcomes.

From a clinical perspective, improving health disparities involves creating a better understanding among providers of the critical aspects of cultural competence including the theories of health beliefs and the application of health literacy to the practice of eye care. It is critical that optometric educational institutions, organizations, faculty, students, practitioners and staff members understand and respond with sensitivity to the needs and preferences that culturally and linguistically different individuals bring to the eye care system.

This survey of the chief academic officers was a critical first step towards the optometric initiative to cultivate cultural understanding and sensitivity. The CAO survey results describe the programs that are currently available in our optometric educational facilities and answer our original questions: Are we teaching this diverse body of students, faculty and staff to be culturally sensitive and aware when caring for patients, and interacting with other staff, faculty and students? Yes, we are teaching the majority of students but only the minority of faculty and staff are being exposed to training in cultural competence. And, above all, why is this important to our profession within the health care system? The importance is highlighted through multifactorial variables. First, through example set by the existing practice models within schools of medicine, nursing, dentistry and pharmacy. Secondly through the assessment of the survey results, which reveal variability in program modality (lecture vs. workshop format). This demonstrates a call for consistency in program structural format among all schools and colleges of Optometry. Finally we view the importance of this topic to our profession when considering the gestalt of optometrists as essential health providers of eye care within the medical field.

Since optometrists are at the forefront of a patient’s entry to preventative and therapeutic medical care we must streamline a universal program on cultural competence to reflect our “hands on” clinical realm. In examining the outcomes of the survey that only four schools provide a workshop format for faculty and three schools provide a workshop format for students, the survey exposes a critical necessity for promoting clinical case-based workshops. By utilizing a hands-on approach workshop format, integration of information that has been presented will be ingrained into a best-practices behavior model. This approach is a stepping-stone to a future appraisal of global eye health care outcomes. The future schema of studying global health outcomes is supported by a report of experiences using patient-based Health-Related Quality-of-Life Assessments (HRQOL) in routine patient care. The report by Meyer et al. was used to monitor patient care in a busy dialysis clinic. The report suggests that patient-based assessment can improve individual treatment regimens and can contribute to the epidemiology of treatment. Eventually we can transfer this global health outcome assessment concept found in primary medicine to global eye health outcome assessment in optometric primary eye health care by utilizing patient-based assessment in the routine eye exam. These future goals are given a more substantial foundation through conducting and
analyzing the CAO survey. Given the survey results, the next stage of development will be to prepare case/patient based workshops for faculty development to bring the field of optometry a step closer to the global initiative of a patient-based assessment that appears to improve treatment outcomes.

References


Appendix A

Chief Academic Officers Survey

1. Please select your institution from the drop down menu.

2. Please provide us with the name and contact information of the person completing the survey. Please note: This information is for follow up purposes only. Results of the survey will be reported only by aggregate, and not by individual institution responses.

3. Do you have cultural competence training for your clinical faculty?

4. If YES, what type(s) of training have you had for clinical faculty? If NO, please proceed to question #6.

5. Who is responsible for training your clinical faculty in cultural competence?

6. Do you provide training in cultural competence for your students?

7. If YES, what type(s) of training have you had for students? If NO, you have finished the survey. Thanks for participating!

8. In which year(s) of the program do lectures on cultural competence occur?

9. n which year(s) of the program do workshops on cultural competence occur?

10. Please provide us with the contact information for the faculty member(s) responsible for teaching students about cultural competence.

11. Do you have any additional comments you would like to share about the inclusion of cultural competence in the optometric curriculum?
Intercultural Sensitivity: Educating Educators (ISEE)—Training Optometric Faculty to Educate Students

The Intercultural Sensitivity: Educating Educators (ISEE) Research Group

Yaniglos, O.D., F.A.A.O.
Carlson, O.D., F.A.A.O.; Aurora Denial, O.D., F.A.A.O.; Elizabeth Hoppe, O.D., M.P.H., Dr.P.H., F.A.A.O.; Levelle B. Jenkins, O.D., F.A.A.O.; Kimberly Optometric Faculty to Educate Students (ISEE)—Training

Abstract

Increasing cultural and linguistic diversity in the United States is a contributing factor in the growing disparities within our health care delivery system, especially those related to certain high morbidity conditions such as glaucoma and diabetic eye disease that disproportionately affect minority populations. This situation is compounded by the relatively low numbers of minority faculty in our training institutions, thus leading to an inherently limited response to the problem in the near term. This paper describes the first phase of an inter-institutional program of development, sponsored by the Association of Schools and Colleges of Optometry, and designed to increase awareness of the problem among faculty and staff in our optometric educational institutions. It is intended that this program would lead to improved knowledge, attitudes, and behaviors within the intracultural domain and that measurable improvements in health care outcomes will emerge in future evaluation processes. Outcomes of the current workshop series at three collaborating optometric institutions did demonstrate significant positive differences in these parameters among participants.

Key Words: Intercultural competency, linguistic diversity, health disparities, health care outcomes

Introduction

As immigration continues to affect the make-up of the U.S. population, optometrists, optometry students, and others will deliver eye care to individuals from increasingly diverse racial, ethnic, cultural and linguistic backgrounds. Increasing diversity is known to contribute to disparities in the health care and eye care delivered. Health disparities are important in eye care because they may cause permanent vision loss in underserved populations. People from differing racial, ethnic, cultural and linguistic backgrounds suffer disproportionately from systemic diseases such as diabetes, hypertension, cardiovascular disease, as well as ocular manifestations of systemic diseases like diabetic retinopathy, hypertensive retinopathy, and glaucoma.1

The impact of health disparities in terms of access to care, follow-up and compliance is particularly significant in African-American and Hispanic populations that have higher prevalence rates of these problems. For example, African-Americans are twice as likely, compared to Caucasians, to suffer continuing vision impairment due to unoperated cataracts; Hispanics over 40 years of age have a 20% rate of binocular vision loss due to this same treatment disparity.2 Glauc maritalm accounts for 19% of irreversible blindness in African-Americans,3 who are three times more likely to have this disease than Caucasian patients.4 Yet African-Americans are eight times more likely to remain undiagnosed,5 and are treated by medicine6 and surgery7 only half as often as Caucasians.

Diabetic eye disease is also more prevalent in minority populations because of higher rates of hyperglycemia (hemoglobin A1c >8%) affecting 50% of black women and 45% of Mexican-American men.8 Inadequate diabetes management in these groups leads to greater diabetic eye disease, which is multiplied by an added disparity in fewer annual ophthalmic examinations and less timely interventions creating much higher risk of blinding eye disease.

Adding substantially to the problem of health disparities is the fact that academic health care training programs often do not have correspondingly diverse faculty. There is significant potential for cultural misunderstanding because many programs rely heavily upon underserved minority populations for a great deal of their teaching case load. This cultural mismatch contributes to health disparities by affecting the quality of the health outcomes and by the subsequent perpetuation of less than optimal clinical teaching outcomes for the next generation of optometrists. While minority student recruitment is gradually changing faculty compositions for the better, it will take some time before academic clinical teaching programs will be sufficiently diverse to better enable culturally competent delivery of care. Even as we do see greater diversity in our faculty, there will always be a substantial need to address the features of culturally competent care in the development of all clinical educators.
Thus, in order to change the cultural environment of an optometry school, and ultimately the profession at large, it is necessary to focus upon the faculty. The faculty serves as a stabilizing and determining force within any academic institution. While the student body turns over every four years, the faculty remains to serve as role models for each successive cohort of students. Optometry faculties have demonstrated a desire to increase their knowledge of and ability in cross-cultural issues and physician trainees have identified this domain as an important area of their professional development as practitioners. If an institution’s faculty transforms their own personal attitudes, beliefs and behaviors with respect to culture as a value system, it will have a greater impact for future generations of students. Thus, faculty development in this area is a logical approach. Cultural competency (CC) represents a new frontier for optometry and can potentially reduce disparities in health care among our nation’s growing minority populations because culture and linguistics play a critical role in how optometrists deliver care and how patients perceive and receive the care they are rendered. By removing barriers to more effective communication, culturally and linguistically appropriate care greatly increases the likelihood that better care will be delivered that results in better patient compliance and more favorable health outcomes.

The Intercultural Sensitivity Education for Educators (ISEE) Research Group was formed in 2004 by optometric faculty from four colleges, i.e., New England College of Optometry (NECO), Pennsylvania College of Optometry (PCO), The Ohio State University College of Optometry (OSU) and University of Houston College of Optometry (UHCO). The ISEE group recognizes that optometric institutions are becoming more multicultural in terms of both the student and patient populations. This cultural diversity presents an ideal opportunity for educators to contribute to the development of cultural awareness by improving the knowledge, beliefs, attitudes and, ultimately, behaviors of faculty and staff in dealing with local cultural differences. ISEE’s purpose has been to promote faculty awareness of intercultural and linguistic issues by offering faculty training and to conduct measurement of outcomes of this training. In addition, it is the longer term goal of ISEE to use faculty development to improve care that is delivered to multi-cultural patients in our teaching clinics. It is hoped that, ultimately, we may be able to demonstrate improved health outcomes that may be attributable to the effect of these inputs.

Methods

Through the work of the ISEE Research Group, mini-grants were approved by the Association of Schools and Colleges of Optometry for training workshops at three optometry colleges located in major metropolitan cities—NECO (Boston); UHCO (Houston); NECO (Philadelphia). Each of these colleges conducted a development symposium for their faculty and staff. The development programs consisted of lectures and small group interaction on the subject of cultural competency. Each site employed one national content expert in culturally competent vision care, LeVelle B. Jenkins, O.D., who presented elements of a cultural competency curriculum that was tailored to the vision care profession. This presentation was entitled, “Developing Cultural Competency in Optometric Care.” Participants were also introduced to the National Standards for Cultural and Linguistically Appropriate Services (CLAS Standards) and the EYECARE model for cultural sensitivity. Two of the three sites also utilized a second content expert who addressed cultural competency in a more general sense. In addition to lectures, there was significant audience participation activity at each site, including the use of role-playing at one site (UHCO).

There was a short satisfaction survey conducted at each site after the program; however the main outcome measure consisted of a 43-item Eyecare Cultural Competency Survey comprised of four domains: knowledge, attitudes, beliefs, and behaviors.

The Eyecare Cultural Competency Survey is being developed using standardized psychometric techniques in order to use this instrument for future research projects and for the standardized measurement of outcomes from educational interventions. The survey used in this project was developed by first reviewing a variety of published instruments that have been used in peer-reviewed research. Items from the published instruments were grouped into the four domains to be evaluated: knowledge, attitudes, beliefs, and behaviors. Items that were not related to the four domains were dropped from the process. Items that were relevant to the testing areas were further evaluated for redundancy, clarity, and the relationship to the curriculum content planned for the symposia to further curate the list of possible survey questions. Items that were specific to other health disciplines (e.g., prenatal care, behavioral health) were dropped from the potential survey questions, resulting in a list of 163 items across the four domains.

Several members of the ISEE Working Group reviewed the complete domain of possible items to edit, modify, re-write, and eliminate questions until a final group of approximately 50 items was selected. The reduced survey instrument was then evaluated by three non-optometrist staff members at one of the host institutions. The three evaluators represented a diverse group.

Table 1: Sample Questions from Questionnaire Used

| Knowledge: “I am knowledgeable about the impact of family dynamics on health care decisions.” |
| (Answer Choices: very knowledgeable, knowledgeable, somewhat knowledgeable or not knowledgeable) |

| Attitude: “I hold diversity as one of my personal values.” |
| (Answer Choices: Strongly agree, agree, disagree or strongly disagree) |

| Behavior: “I tolerate bias and prejudice in the workplace.” |
| (Answer Choices: Frequently, sometimes, occasionally or never) |

| Beliefs: “I believe that older patients are not open to change.” |
| (Answer Choices: Strongly agree, agree, disagree or strongly disagree) |
in terms of age, gender, educational background, cultural background, and ethnicity. They were asked to make further suggestions to enhance the clarity of the items and to evaluate the items for confusing terms or redundant concepts. The final version of the survey instrument was generated after this review, resulting in the selection of 43 items, with 10 items related to the participant's knowledge, 10 items evaluating attitudes, 12 items examining beliefs, and 11 items describing behaviors. The final survey is undergoing analysis for validity and reliability to ensure that it attains appropriate psychometric properties.

This survey was given before each workshop and again at a point 2-4 months after the program. Sample questions in each of the four domains are given in Table 1.

Survey information was collected anonymously using a code matching system to enable paired comparison of pre- and post-workshop surveys. All results were entered into an Excel spreadsheet for analysis. Each participant's responses were averaged across the 43 questions asked and also using the subset questions within each of the four domains evaluated. Paired Student's t-test comparison analysis was performed on the available pairs of pre- and post-workshop data. Unpaired t-tests were performed between all pre-workshop data and those post-workshop data sets that were available.

Results

The short workshop satisfaction survey that was taken immediately at the conclusion of each workshop indicated that 77% of those participating felt they had a greater awareness of cultural sensitivity issues. Greater than 50% said they were encouraged based on the workshop to try to render more culturally sensitive patient care.

Not every participant answered every survey item, both in the pre-symposium version and in the post-symposium version. In some cases respondents selected different items to answer in the two administrations. In order to control for this missing data, an average score was calculated for each of the four domains, and for the entire instrument.

Ninety-four individuals at the three institutions completed a pre-workshop survey of the major outcome measures exemplified in Table 1. There was an overall participation rate of 39% in both the pre- and post-workshop surveys. Participation in both surveys at individual institutions ranged from 26-50%. Results of the major outcome survey are shown in Figure 1 and indicate that post-surveys taken in the two-four months after the workshop demonstrated a greater perception of improvement in all domains of cultural competency measured. The statistical significance indices for each comparison are shown in Table 2. Unpaired t-test comparison of all pre-workshop results with the paired pre-workshop demonstrated no significant differences in any category of data (p>0.382), which is consistent with set/subset nature of these two groups. Unpaired t-test comparison of all pre-workshop results with all post-

<table>
<thead>
<tr>
<th>Category</th>
<th>Knowledge</th>
<th>Attitude</th>
<th>Behavior</th>
<th>Beliefs</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Pre vs Paired Pre</td>
<td>0.375</td>
<td>0.331</td>
<td>0.348</td>
<td>0.295</td>
<td>0.382</td>
</tr>
<tr>
<td>Unpaired Pre-vs Post</td>
<td>0.013</td>
<td>0.009</td>
<td>0.015</td>
<td>0.009</td>
<td>0.011</td>
</tr>
<tr>
<td>Paired comparison</td>
<td>0.007</td>
<td>0.006</td>
<td>0.011</td>
<td>0.005</td>
<td>0.005</td>
</tr>
</tbody>
</table>

Figure 1: Comparison of pre- and post-Workshop Results
workshop results demonstrated a high level of significance (p<0.011) and an even more obvious difference in the comparison of paired data sets (p<0.005).

Discussion

The survey items designed to measure potential changes in symposium participants' behaviors relied on a self-report of a variety of specific actions. For example, respondents were asked whether they use consent forms, health education materials, and other relevant information to accommodate the cultural and linguistic needs of the populations in their service area. Another survey item asked if the respondent has attempted to learn and use key words and colloquialisms of the languages used by patients. Because of the short time between the educational intervention and the administration of the post-symposium survey, it is possible that intended changes in behavior have not yet taken place. It will be important to evaluate whether long-lasting effects remain in place over time, or if there are additional changes in reported behaviors.

The measurement instrument is based on self-reporting and may not accurately represent a translation of the materials presented in the symposia into the optometric classrooms and teaching clinics. Ultimately the role-modeling of appropriate, culturally sensitive communications in the clinical teaching environment will be the true measure of success. Improved interactions between faculty, staff, and students of differing cultural backgrounds may also be an additional benefit from this type of educational intervention.

What is most important is that the workshops were well received by participants at all sites. Participation was active regardless of location and a majority of participants indicated that, as a result of the workshop, they had gained a greater sense of cultural sensitivity awareness and wanted to apply this to their everyday practice. Since there was a measurable improvement in "culturally sensitive" responses on the large survey after a two-four month period after the workshop, there is some hope that this method of faculty development will have a favorable future impact.

Of course, it is critically important to provide reinforcement opportunities to consolidate any gains from a training session. Thus, the Association of Schools and Colleges of Optometry (ASCO) has awarded the ISEE Study Group another faculty development grant to conduct additional workshop activities, including enhanced role playing opportunities. These programs will take place in 2006.

It is also necessary to measure the effect of any intervention, not only in terms of participant opinion, but also by outcomes assessment. While this is much more difficult, it is hoped that by working with eye problems of high prevalence in underserved populations it may be possible to produce an effective model for the measurement of health care outcomes in response to cultural sensitivity training inputs.

The short workshop satisfaction survey that was taken immediately at the conclusion of each workshop indicated that 77% of those participating felt they had a greater awareness of cultural sensitivity issues.

Conclusion

The results of this study show a change in the levels of knowledge, awareness, beliefs, and behaviors of optometric faculty and staff in the important area of cultural sensitivity and cultural differences. The measured change is demonstrated in the short-term, approximately two to four months post-intervention. The change is based on a self-administered questionnaire. Further research is needed to evaluate both the long-term results and the application of the materials into the optometric educational process and in the provision of culturally appropriate patient care. A second series of symposia is currently being planned.

References

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Assessing Cultural Competency in Optometric Faculty

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Nancy Carlson, O.D., F.A.A.O.


Abstract

**Purpose:** Cultural competency can be thought of as a special type of communication that practitioners use to effectively care for a diverse group of patients. As the U.S. population becomes more diverse, optometrists will need to communicate with individuals from many different cultures. Since the faculty of any optometric institution interact with generations of students and future practitioners, it is essential that the faculty model culturally competent patient care. The purpose of this pilot study is to establish the faculty's knowledge of cultural competency and to evaluate their responsiveness to training.

**Methods:** Twenty-six faculty members participated in a cultural competency symposium. The faculty was surveyed before the start of the training and four months post-training.

**Results:** The results from this pilot study indicate that the faculty had a high level of desire to move along the cultural competency continuum. As a result of this cultural desire, the majority of the faculty were responsive to the training and increased along the spectrum.

**Key Words:** Cultural competency, diversity, faculty development

**Introduction**

Providing a high level of excellence in patient care should be a priority for all optometrists. One essential component of providing excellent health care is effective communication between doctor and patient. Communication in the clinical setting has been defined as the process of influencing patient behavior producing changes in knowledge, attitudes and skills required to maintain and improve health. Cultural competency can be thought of as a special type of communication that practitioners use to effectively care for a diverse group of patients. This special type of communication involves the practitioner integrating his/her recommendations with the patient's values, which may be influenced by the patient's cultural background.

Culture and transculture may relate to race, ethnicity, primary language, gender, age, country of origin, sexual identity, disability status, or a variety of other characteristics. In establishing a good patient rapport the literature most often refers to language and ethnicity but the other factors may also be important. Betancourt defines culture as "an integrated pattern of learned beliefs and behaviors that can be shared among groups and includes thoughts, styles of communicating, ways of interacting, views of roles and relationships, values, practices, and customs." Betancourt further states that both patients and practitioners are influenced by multiple cultures.

As the U.S. population becomes more diverse, optometrists will need to communicate with individuals from many different cultures. The U.S. Census reports that by the year 2035 ethnic and racial minorities will constitute 40% of the population. Health disparities have often been linked to cultural differences between patients and practitioners, patient health status and outcomes of care.

The New England College of Optometry's (NECO) clinical education is provided through a culturally, economically and racially diverse network of community health centers in the greater Boston area. The community health centers are located in neighborhoods of under-served populations. During their training, students are exposed to a wide variety of ethnicities and cultural groups. As a result of this diverse network, clinical faculty practicing in these settings are required to be proficient in communicating with a diverse group of patients.

As optometric educators, we are constantly striving to teach students how to better communicate with patients. The New England College of Optometry is fortunate to have many clinical optometric faculty members who have demonstrated expertise in patient communication. However, few if any, have had formal training in cultural competency.

The faculty within an institution serves as a stabilizing and determining force. While a student body turns over every four years, the members of the faculty remain to serve as role models for each successive cohort of students and future practitioners. It is important that the faculty model cultures and transcultures which may be influenced by the patient's cultural background.
In November 2004, The New England Eye Institute, the clinical teaching affiliate of The New England College of Optometry, presented a four-hour, cultural competency symposium. The symposium presented the RESPECT model of patient care and consisted of lecture, case examples, role playing and small group discussion. The RESPECT model was developed by the Diversity Curriculum Task Force in the Department of Medicine at Boston Medical Center. RESPECT is an acronym for a list of essential components that, if used, will optimize health care encounters for both the patient and the practitioner. The elements of the RESPECT model may be addressed in any order and at any time during a patient encounter. The authors strive to provide their patients with a comfortable and shame-free environment for health care in which the patient can freely express his/her needs, fears, and ideas about his/her health. The authors of the RESPECT model stress the importance of the practitioner becoming self-aware, examining his/her beliefs and values and how his/her culture affects his/her clinical encounters.

### Table 1: RESPECT Model

<table>
<thead>
<tr>
<th>Boston University Diversity Curriculum Task Force</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Respect:</strong> Show respect for the patient verbally and non-verbally</td>
</tr>
<tr>
<td><strong>Explanatory:</strong> Elicit the patient's explanatory model of health</td>
</tr>
<tr>
<td><strong>Social and Spiritual Context:</strong> Elicit the patient's social and spiritual beliefs that may help the patient cope with his illness or may conflict with medical regimens</td>
</tr>
<tr>
<td><strong>Power:</strong> Share the power with the patient</td>
</tr>
<tr>
<td><strong>Empathy:</strong> Demonstrate empathy for the patient</td>
</tr>
<tr>
<td><strong>Concerns:</strong> What underlying concerns and fears does the patient have?</td>
</tr>
<tr>
<td><strong>Trust:</strong> Assess the patient's level of trust and improve it if needed</td>
</tr>
</tbody>
</table>

### Table 2: Overall Score Summary

<table>
<thead>
<tr>
<th></th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum score</td>
<td>60</td>
<td>61</td>
</tr>
<tr>
<td>Maximum score</td>
<td>85</td>
<td>100</td>
</tr>
<tr>
<td>Mean score</td>
<td>68.7</td>
<td>73.4</td>
</tr>
<tr>
<td>Median score</td>
<td>68</td>
<td>72</td>
</tr>
<tr>
<td>Mode</td>
<td>68</td>
<td>80</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>5.41</td>
<td>8.95</td>
</tr>
</tbody>
</table>

The purpose of this pilot study is to establish the faculty's knowledge of cultural competency and to evaluate their responsiveness to training.

### Methods

Twenty-six faculty members participated in the study. The faculty represented between one and thirty years of clinical experience with an average of seventeen years. The majority of the faculty practice in neighborhood health centers in the greater Boston area. The faculty was surveyed before the start of the symposium and then again four months after the symposium. A four-month interval was chosen to allow faculty the opportunity to incorporate concepts presented at the symposium into their practices.

The survey instrument used was the Inventory for Assessing the Process of Cultural Competence Among Health Care Professionals - Revised (IAPCC-R). The assessment tool consists of five cultural domains: desire, awareness, knowledge, skill and encounters. Surveys were scored using the IAPCC-R Scoring Key and assigned to corresponding category ranges. Content validity and reliability has been established by several different studies. Descriptive statistics and paired t-test were used to analyze the data.

### Results

The response rate for the pre-survey was 100% (26 out of 26). The response rate for the post-survey was 92% (24 out of 26). The IAPCC-R has a possible range of scores from 25 to 100 points. The baseline scores ranged from 60 points to 85 points, with a mean value of 68.7, median 68, mode 68, and standard deviation of 5.4. The post-survey scores ranged from 61 points to 100, with a mean value of 73.4, median of 72, mode of 80 and a standard deviation of 8.95. Table 2 illustrates the pre-survey and post-survey scores. The distribution of overall scores in the various category ranges is shown in Table 3.

A paired t-test was conducted to test for differences in the pre- and post-test scores for both the overall score and ten subsection scores. The subsection scores (Table 4) were defined as cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire.
Table 3: Distribution of Category Ranges

<table>
<thead>
<tr>
<th>Category Range</th>
<th>Number (Percentage) Pre-test</th>
<th>Number (Percentage) Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culturally Proficient</td>
<td>0</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Scores 91-100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Culturally Competent</td>
<td>3 (11.5%)</td>
<td>9 (37%)</td>
</tr>
<tr>
<td>Scores 75-90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Culturally Aware</td>
<td>23 (88.5%)</td>
<td>14 (58%)</td>
</tr>
<tr>
<td>Scores 51-74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Culturally Incompetent</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Scores 25-50</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Statistically significant differences were found between the pre-test and post-test values for the overall score (p=0.003837), cultural awareness (p=0.0077877), knowledge of other cultures (p=0.009699), and skill (p=0.00211), showing a higher level of cultural competency following the training session. Interestingly, no difference was found for the subsection scores for cultural desire (p=0.19) or encounters (p=0.15).

Discussion

The modeling of culturally sensitive communication between patient and doctor is essential in the educational process of students. Experiential learning is a process by which concrete experiences and reflection upon those experiences cause modification or further definition of concepts.7 By observing culturally sensitive patient care students will be exposed to the skills, knowledge base and attitudes that are needed to care for a diverse group of patients. Therefore it is vital that the faculty value cultural competency and demonstrate appropriate knowledge and skills to the students.

There are many definitions and models of cultural competency. Campina-Bacote describes cultural competency as an ongoing continuum in which health care professionals "see themselves as becoming culturally competent rather than being culturally competent."8 Cultural desire is depicted as the force that stimulates the process of cultural competency.8 Cultural competency is the integration of cultural desire, awareness, knowledge, skill and encounters, which leads to the ongoing process of cultural competency.

Cultural desire involves the concept of caring and includes the motivation of the health care provider to want to enter into the process of becoming culturally competent.8 The pre-survey

Table 4: Subsection Score Summaries

<table>
<thead>
<tr>
<th></th>
<th>&quot;Desire&quot;</th>
<th>&quot;Desire&quot;</th>
<th>&quot;Aware&quot;</th>
<th>&quot;Aware&quot;</th>
<th>&quot;Knowledge&quot;</th>
<th>&quot;Knowledge&quot;</th>
<th>&quot;Skill&quot;</th>
<th>&quot;Skill&quot;</th>
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<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
<td>Pre-test</td>
<td>Post-test</td>
<td>Pre-test</td>
<td>Post-test</td>
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<td>Post-test</td>
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<td>Minimum score</td>
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<td>10.0</td>
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<td>15.0</td>
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<td>1.82</td>
<td>1.89</td>
<td>1.97</td>
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<tr>
<td>Paired t-test value</td>
<td>No Difference (p=0.19)</td>
<td>Statistically Significant (p=0.01)</td>
<td>Statistically Significant (p=0.01)</td>
<td>Statistically Significant (p=0.00)</td>
<td>No Difference (p=0.15)</td>
<td></td>
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</tbody>
</table>
results demonstrate that the majority of clinical faculty initially scored in the high range of cultural desire. The post-survey results of cultural desire did not reveal a statistically significant difference. This lack of difference may indicate that the attendees were self-selecting for a high level of desire to learn more about other cultures and that the training session did not result in an increase among this already elevated group. Alternately, the faculty may have scored high in cultural desire because of years of experience dealing with diverse groups of patients.

Cultural encounters are a measure of the frequency of actual face-to-face interaction with clients from different cultures. Cultural encounters may not have changed over the four-month period from the start of the training session. This is consistent with the stability of the clientele that most of the faculty is interacting with.

Cultural knowledge, skill and awareness did show a statistically significant difference between pre- and post-survey. These concepts deal with knowledge base, skills in collecting data and performing a culturally based physical assessment and self-reflection of one's own cultural background. The faculty benefited in these areas from the training.

Baseline data showed that no faculty members who participated initially scored in the "culturally proficient" range. The majority were found to be "culturally aware," which suggests that they are open to becoming more proficient in dealing with culture as a value system. The post-survey results indicate that the faculty was responsive to the information presented at the symposium. This is not a surprise since the majority of faculty scored high in the area of cultural desire.

The optometric literature has a scarcity of information in the area of cultural competency. Although this pilot study contains a small number of subjects (n = 26), each faculty member has the possibility of influencing hundreds of students over the course of his/her career. This study has stimulated a number of questions that will need to be investigated if the profession of optometry is to keep up with other health professions. Future studies will need to explore: the best model of cultural competency, the best mode of delivery of information, the most effective number of interventions, the length of time it takes to change ingrained patterns of behavior, and the effects on patient outcomes.

Conclusion

The results from this pilot study indicate that the participants had a high level of desire to move along the cultural competency continuum. As a result of this cultural desire the majority of the faculty responded to the training and moved along the spectrum. Since the faculty interact with generations of students and future practitioners, it is essential that they role model culturally competent patient care. As optometrists, we are continually expanding our knowledge base. Cultural desire is a necessary force to motivate self-initiated learning in cultural competency.

While the results of this study are promising, the long-term retention and benefits from training remain unknown. Additionally, the potential impact on patient care and ultimately on patient health outcomes remains uncertain.

Acknowledgments

We would like to thank Carol Mostow, Roger Wilson O.D., and Kristen Brown, O.D., for their participation and leadership in the organization of the cultural competency symposium.

References

National Coalition Building Institute: A Symposium and Series of Workshops at The Ohio State University College of Optometry

Barbara A. Fink, O.D., Ph.D., F.A.A.O.

Abstract

As part of its efforts to enhance diversity and multiculturalism, The Ohio State University College of Optometry applied for and received a grant from the Association of Schools and Colleges of Optometry (ASCO) to put on a symposium and a series of workshops developed by the National Coalition Building Institute (NCBI). Ms. Cherie Brown, founder and executive director of NCBI, provided a two-hour kick-off symposium, “Optometrists as Leaders in a Diverse Community.” It included the Ten Principles of Coalition Building, as well as a preview of some of the exercises that make up the workshops, “Building Community by Welcoming Diversity.”

Key Words: multiculturalism, diversity, prejudice reduction, National Coalition Building Institute (NCBI)

On September 27, 2005, The Ohio State University College of Optometry used a grant from the Association of Schools and Colleges of Optometry (ASCO) to provide members of the faculty, staff, and students with a diversity/multicultural symposium. This launched a series of workshops, “Building Community by Welcoming Diversity,” that promote a climate that is free from discriminating language and actions, encourage open and honest communication, improve self-awareness, permit the understanding of differences, and celebrate differences. The keynote speaker for the symposium was Ms. Cherie Brown, founder and executive director of the National Coalition Building Institute (NCBI).

National Coalition Building Institute (NCBI)

NCBI is an international leadership network that combats all forms of racism and discrimination worldwide. It was founded in 1984 in Washington, D.C., as a nonprofit leadership training organization. It is dedicated to ending the mistreatment of every group, whether it stems from nationality, race, class, gender, religion, sexual orientation, age, physical ability, job, or life circumstances. It is one of the leading diversity training organizations, and it has chapters in 50 cities worldwide. In addition, there are over 70 NCBI campus affiliates and 30 U.S. organizational affiliates. NCBI-trained leaders work in teams to provide a resource for combating prejudice in their communities.

Ms. Brown’s work has been featured on ABC Evening News, National Public Radio, Christian Science Monitor World News, and in the Washington Post and Fortune Magazine, as well as in other newspapers and magazines. In 1999, the work of NCBI was designated a “best practice for racial reconciliation” by President Clinton’s Initiative on Race. The U.S. Department of Education chose NCBI’s work on race and gender issues on college campuses as one of only five organizations to receive a designation of “best practice.” Ms. Brown has worked with the United States Congress, Public Broadcasting Service, U.S. Department of Education, W.K. Kellogg Foundation, The Teamsters Union, AFL-CIO, NAACP, National Organization of Women, and many other groups to welcome diversity and train leaders in a diverse community. She has directed training programs throughout the world. She has a Master’s in Counseling and Consulting Psychology from Harvard University and is author of several publications, including Healing into Action: A Leadership Guide for Creating Diverse Communities.

Optometrists as Leaders in a Diverse Community

The title of the symposium was “Optometrists as Leaders in a Diverse Community.” Ms. Brown encouraged putting principles into practice. Leadership is needed in all professions, including optometry, to combat all forms of racism and discrimination. Through the symposium, Ms. Brown demonstrated how members of the faculty, staff, and students could become leaders for a diverse society. She encouraged the taking of principled and courageous stands to fuel momentum for community change.

The symposium concentrated on ten principles that form the foundation of NCBI philosophy.

(1) Guilt is the glue that holds prejudice in place. Putting blame on groups of people for past prejudicial behavior, or trying to make groups of people feel guilty for past wrongdoings of that group, is unproductive. Confrontational methods create
defensiveness and a resistance to dialog and change. When people feel bad about themselves, they cannot make constructive changes. Treating people with dignity and respect provides the environment needed for positive change.

(2) Every person counts and every issue counts. NCBI addresses a wide range of diversity issues, including race, ethnicity, gender, social class, age, sexual orientation, religion, disability, job, and life circumstances. This includes issues of majority groups as well.

(3) Welcoming diversity is more than a lack of poor treatment of different groups. Each individual belongs to many groups, based on gender, race, religion, national origin, and so forth. Recalling that every group counts is important in welcoming diversity.

(4) Ask questions, take risks, and make mistakes. Individuals must recognize the misinformation they have learned about other people and other groups in order to move forward. They must permit others to make mistakes about their groups so that others can learn from them.

(5) Treating everyone the same may be unintentionally oppressive. Each person should be treated as a unique individual. Treating everyone the same disregards the differences that make people unique.

(6) We don't change minds; we change hearts. In order to shift attitudes, we must hear personal stories. When people hear stories about the incidences of prejudicial treatment and bigotry experienced by others, they are moved and shift their attitudes. They become more committed to ending prejudice when they realize the impact it can have on a person's life.

(7) Listening is not the same as agreement. Listening must occur to begin dialog and communication. A person making a bigoted remark is frequently pleading for someone to listen to him/her. The remark is most likely the result of past influences that resulted in stereotyping by the person. That person needs to be treated with respect even when he or she is openly expressing prejudices. Listening is the first step in changing attitudes.

(8) Taking leadership on diversity issues requires the skill of taking courage. Leaders need to end silence and speak out against all forms of oppression. Politeness, like guilt, also holds prejudices in place.

(9) Having close authentic, personal relationships with people of diverse backgrounds is the core for building diverse communities and overcoming prejudices. We need "kitchen relationships" with people who are different from us, not just "living room relationships." We need to have close relationships with diverse people so that we can be honest and truthful, make mistakes and take risks, and go beyond cautionous and political correctness.

(10) Skill training empowers people to be able to shift oppressive jokes, comments and slurs. Everyone has the capacity to lead the workplace in welcoming and valuing diversity. Teams of people empowered with these skills bring about institutional change. NCBI provides participants with practical skills for changing prejudicial behavior.

Ms. Brown previewed some of the exercises that the faculty, staff, and students were to experience in the NCBI workshops. These included exercises to acknowledge group identification, an exercise on listening, and role playing to shift another's attitudes.

The duration of the symposium was 1 hour and 45 minutes. Clinics, classes, and laboratories were cancelled so that people could attend the symposium. There were approximately 250 people in attendance; most of the members of the faculty, staff, graduate students, and students participated in the symposium, with the exception of fourth year students who were away on externships. Evaluation forms were distributed to participants in the symposium as they entered the auditorium. They were asked to complete the evaluation forms at the end of the symposium and hand them to members of the Diversity Enhancement Committee as they exited the auditorium. Table I is a summary of the responses to each of the questions.

NCBI Workshop: Building Community by Welcoming Diversity

Four workshops were planned for the 2005-2006 school year. The first workshop, "Building Community by Welcoming Diversity," presented by facilitators of The Ohio State University chapter of NCBI, took place immediately following the symposium. It is based on the Prejudice Reduction Workshop Model that was developed by Cherie Brown. The workshops are protected by copyright and the sole property of NCBI. Workshops were provided throughout the school year so that all members of the faculty, staff, students, and graduate students would have an opportunity to continue with diversity and cultural competence training. About 20 to 30 people have participated in each workshop, and it is valuable to have a mix of people from different backgrounds who represent faculty, staff, and students. Breakfast, lunch, and a snack are provided at all the workshops. Participants wear nametags with their first name. Comfortable seating is arranged in semi-circles, directed toward the front of the room. Two large flip charts are used to emphasize main points throughout the workshop.

"Building Community by Welcoming Diversity" is a full-day workshop, and participants must attend for the entire day. It is an interactive, participatory program designed to promote awareness and increase sensitivity to the many similarities and differences among individuals and groups in our society. Participants are arranged into small groups and pairs throughout the day to take part in incremental exercises and then brought together in the large group for summarization and evaluation. The objectives of the workshops, as stated in The Ohio State University chapter NCBI brochures, are to help participants to:

1. celebrate their similarities and differences;
2. identify the misinformation that they have learned about other groups;
3. recognize the internalized negative feelings and behaviors that they direct towards members of their own groups;
4. claim pride in their own group identities;
5. learn about the personal impact of discrimination through the telling of stories; and
6. gain empowerment by learning concrete tools for effectively interrupting prejudicial remarks, jokes, slurs, and behaviors.

The types, order, and purposes of the exercises that took place for the
College of Optometry will be summarized here. These descriptions indicate how the workshops have been experienced by members of the faculty, staff, and students of the College, but they are not necessarily what might take place in all NCBI one-day prejudice-reduction workshops.

Introductions
The workshops begin with introductions. Participants are asked to stand up (if they are able to) and state their name, their position, and something special about themselves (such as a hobby, favorite fruit, or favorite color). Facilitators then present the two workshop working agreements: (1) participants may share with the whole group information only about themselves (and not about partners from working in pairs); and (2) participants may not repeat outside of the workshop any information that individuals share. Facilitators ask for a show of hands from all participants to demonstrate acceptance of these two agreements.

Up/Down Exercise
The first exercise of the workshop is called “Up/Down.” The purpose of this exercise is to demonstrate the similarities and differences among the people in the group. People either stand or raise their hand when the facilitator calls out the name of a group to which they belong. Everyone applauds them. Groups that are mentioned include: birth order (oldest child, middle child, youngest child, only child, twin), place of birth, ethnic/cultural groups (e.g., German, Russian, African or Black), religion, economic background (had enough, more than enough, or less than enough when growing up), age (in 10-year increments), and gender. Some fun categories, such as “chocolate-lovers,” might be used, and participants are asked for additional categories. After facilitators go through several groups for each category, they ask, “Which group did I leave out?” Sexual orientation is also used as a category for the up/down exercises; however, it is introduced by mentioning that some people who identify as gay, lesbian, bisexual, or transgender (GLBT) might not want to stand, and that is fine. The facilitators ask for people to stand who have friends, family, or other people they care about who are GLBT. The up/downs continue with disabilities and private identities, such as alcoholic or victim of sexual abuse.

Paired Introductions
The second exercise of the workshop involves working in pairs. Participants introduce themselves to their partners by sharing all the groups to which they belong, such as: “I am White, blonde, German-Irish, American, female, heterosexual, Catholic, middle class, middle-aged, married, working mother, associate professor.” The purpose of this exercise is to identify that we think about some of these groups more than others; however, every group is important in thinking about welcoming diversity. Also, prejudices can be experienced because of membership in each of the groups.

NCBI Theory
NCBI workshop theory is discussed at this point, including the founding principles. The concept of leadership oppression is mentioned, in which leaders are unfairly blamed for things over which they have no control just because they are in leadership positions. NCBI teaches leaders to respond to leadership attacks. It emphasizes that leaders deserve encouragement and support so that effective changes can be made to improve attitudes and communities.

First Thoughts
The third exercise is called “First Thoughts.” The purpose of this exercise is to look at stereotypes that we have learned about groups other than the ones to which we belong. The facilitators draw a picture of a record on the flip charts, and participants are invited to suggest all the influences that make up a person’s record. These include: parents, other relatives, peers, friends, teachers, colleagues, religious leaders, media (movies, newspapers, television, etc.), political leaders, and so forth. These records, including prejudices, surface when a person is feeling threatened. It is emphasized that people are more than their records.

Prior to beginning this exercise, there is a discussion about taking risks and making mistakes. Few people really enjoy making mistakes, and many are not very forgiving in allowing others to make mistakes about their groups. In order for the First Thoughts exercise to work, people must be willing to make mistakes about other groups. The facilitators have the participants shout, “I love taking risks. I love making mistakes!” They then have participants shout, “I welcome you to take risks and make mistakes about me and my group!”

Each participant selects a new partner. They choose a group to which neither of them belongs. For example, if both partners are male, they might select the group “female.” The group could be more specific, such as “African-American working mothers.” One partner mentions the name of the group, as well as variations on the name (such as “women,” “females,” “girls,” “chicks,” “ladies,” “mothers,” “wives,” and so forth), varying the tone of voice each time the group name is stated. The other partner says the first uncensored thing that pops into his/her mind. After about 10 variations of this, the partners switch and repeat the exercise. Participants might find themselves censoring their first thoughts, and sometimes their minds might go blank. They might realize that they really don’t know a lot about the group they have selected-or that many of their first thought are stereotypes of that group. After both partners complete the exercise, participants are invited to share their first thoughts with the full group, reminding them to share only for themselves and not for their partners. Participants who are members of the group selected for the first thoughts exercise are then invited to share their feelings on hearing the first thoughts. Participants should not become defensive, feel guilty, or feel uncomfortable with this exercise, and they are reminded that they are more than their records.

Internalized Oppression
After a short break, facilitators call participants back through the use of percussion instruments. The purpose of the next exercise is to look at less-than-positive feelings that people have about some of the groups to which they belong. This is called internalized oppression, and it can be the result of discrimination and taking stereotypes out against members of our own groups. Participants select a new partner. They select a group to which both of them belong. Using finger pointing, emotion, and body language, participants are invited to express what they cannot stand about that group. For example, “What I can’t stand about you working mothers is that you don’t take care of your children and you aren’t committed to your careers.” Some people find this exercise to be more difficult...
than the First Thoughts exercise; however, some people find it very easy to come up with things they cannot tolerate about their own groups. Some people are taught never to talk about negative feelings towards their own groups in public. This exercise should teach participants that many of the things we do not like about our own groups are the result of internalization of what people from outside our groups have said about us. It identifies stereotypes and struggles of each group.

Pride
Participants are sent back to work with the same partner. This time they think of the things that make them feel good about, or proud of, their group. They will make statements such as "What I am most proud of about working mothers is that they are excellent multi-taskers, they have such full, interesting lives, and they are enlightened." After participants complete this exercise, they are again asked to share for themselves only what they are proud of about their own groups. There is a discussion about pride—that true pride welcomes diversity. Pride is a sense of self-dignity and self-worth, but it does not present one's own group as better than another's group.

This exercise concludes with an activity designed to have participants think about groups to which they belong but of which they are not completely proud. For example, a person might not be fully proud of being over 40 years old. Facilitators have participants leap into the air, shouting, "It's great to be X (e.g., over 40 years old)!

Discussion About Names
Participants have lunch together to continue personal sharing. After lunch, there is a discussion about names and the importance of pronouncing other peoples' names correctly. People with difficult-to-pronounce names volunteer to pronounce their names, and the other participants repeat their names and welcome them.

Caucuses
The purpose of the caucuses exercise is to have participants think about different ways people have experienced discrimination and to begin to think about how to end discrimination. People are invited to think about groups to which they belong that have experienced some form of discrimination. The facilitators record groups on a flip chart. The list of possible caucuses might include: women, Catholics, GLBT, Black, single parents, over sixty, short, and so forth. Participants are asked to select a caucus to which they belong, and the number of participants interested in each caucus is recorded to determine the final caucuses.

Participants meet with other members of their caucus. There should be at least two people for each caucus. Facilitators might pair with individuals in order to represent groups or issues that should be addressed at the workshop. Caucuses are provided with a marker and newspaper to record their answers to the following question: "What do you never again want people to say, think, or do toward your group?" After several minutes, each caucus presents its responses to the full group. Following the presentations, there is a full-group discussion about what people learned from the caucuses.

Speak-Outs
Throughout the workshop, facilitators are vigilant for participants who seem at-ease speaking about incidences of prejudice or discrimination. If there are particular issues that should be addressed at the workshop, facilitators look for individuals who are likely to be able to share a personal story concerning these issues. Three or four people are asked by the facilitators to present to the group an instance in which they experienced discrimination or prejudicial behaviors. At least one of the people is from a group that is not typically thought of as suffering from discrimination, such as white men. People are usually approached about the speak-outs during lunch or during the caucus exercise. The participants are asked in private about whether they would be willing to do a speak-out. If they are not interested, willing, or able, then they are not coerced. The speak-outs frequently become very emotional; therefore, the facilitators prepare the participants for this possibility.

The facilitator offers his/her hand to the person who is sharing an incidence of discrimination in case the participant needs such support. The participant then tells a story about a time he/she experienced racism, sexism, homophobia, bullying, or any other type of discriminatory behavior. Following the speak-out, the facilitator provides the participant with the opportunity to say the least polite thing he/she would like to say to the prejudiced persons, allowing the participant to vent. The facilitator then asks the participant if there is anything else he/she needs to say or to hear from the group to feel pleased for having shared the story. The speak-out raps up when the facilitator asks for a show of hands from the other participants, demonstrating that they will increase their commitment to eliminating such types of discrimination. The speak-outs are usually the most memorable and dramatic part of the workshop. They emphasize to the participants that everyone has a story and has experienced incidences of discrimination.

Role Plays
One of the final exercises of the workshop is role plays. The purpose of this exercise is to train participants how to shift others' attitudes when they hear oppressive jokes, comments, or slurs. There are three ineffective responses to such comments: (1) ignoring the comment and changing the subject; (2) expressing anger or indignation, resulting in defensiveness; or (3) letting the wrongdoer know he/she was offensive but providing no additional input. The ineffective responses are demonstrated by the facilitators so that participants can realize they are not helpful.

Participants get together in pairs to come up with examples of oppressive jokes, comments, or slurs. Facilitators list the comments on the flip charts. One of the participants is selected to play the role of the bigot; another volunteer practices effective strategies to shift attitudes. Effective responses involve maintaining an even tone, listening, moving closer to the offender, and treating the other person with respect. The response should not be patronizing. The attitude-shifter is trying to get the offender to speak-out, to try to understand if there is an underlying reason for making inappropriate comments. Effective techniques to reduce defensiveness and continue conversation include use of the following phrases: "Tell me more," "I can tell you're upset," "How does that make you feel?" "Help me to understand what you mean by that." "What questions" are less likely to result in a defensive response than "why questions." For example, the question "Why did you say that?" is likely to elicit a defensive response, while "What do you mean?" might encourage the other person to think about what he/she said.

Participants are cautioned that attitudes will probably not be shifted by
one interaction; however, use of this model can enable change of attitude in another person. Participants need to learn to listen to the hurt underneath the prejudicial comments and remember they are listening to a record. Listening is not the same as agreeing, and the participant needs to think well of the person while eliciting a speak-out from him/her. Past hurts are opportunities for prejudice to enter, but the role playing exercise enables participants to take advantage of opportunities in which they can act as agents of change. Finally, participants are cautioned that there are incidences in which it might be better to ignore prejudicial comments, such as when the offender is very angry, a stranger, or with a group of people.

Closing

To close the workshop, participants and facilitators form a circle. Participants are invited to share a personal highlight of the workshop. People frequently share something they learned from the day or something that touched them emotionally. Facilitators ask participants to share any personal goals they have to welcome diversity. Participants are asked to complete evaluation forms.

Impact of the NCBI Symposium and Workshops

Both the symposium, “Optometrists as Leaders in a Diverse Community,” and the workshops, “Building Community by Welcoming Diversity,” have been very well-received by the members of the faculty, staff, and students at The Ohio State University College of Optometry. Both received excellent evaluations.

As seen in Table 1, the ten goals of the symposium received average scores ranging between 4.17 and 4.68 on a scale of 1 to 5, with 5 being excellent. There was excellent participation at the symposium, with most members of the faculty, staff, students, and graduate students in attendance for the two-hour presentation and exercises. Examples of comments from the evaluation forms are listed below:

“I thought the part about shifting a person’s attitude was excellent. It teaches listening skills that I think will be very important in handling not only everyday situations, but also conflicts with patients in clinic and in practice.”

“I think that there should be classes in medical/optometry schools that we are required to attend. Seminar classes like these teach us how to communicate with patients and people in general.”

“I have been to a lot of diversity workshops and have never really found them useful. This workshop was the first one that seemed to show something different. I appreciated hearing what she had to say.”

“Every issue intended to be presented was presented with clarity. The speaker was open and eager to present issues that are sometimes difficult to discuss. Very good seminar!!”

Table 2 shows the results of the evaluations of the first two NCBI workshops. Seven areas received evaluations of “excellent,” “good,” or “fair.” A fourth category, “needs improvement,” was also included on the evaluation forms; however, it was not marked on any of the evaluation forms. The evaluation forms for the workshops also asked participants to rate on a scale of 1 to 5 (1=poor, 2=below average, 3=average, 4=good, and 5=excellent) the applicability of the workshop to life and overall satisfaction with the workshop. The mean score for “applicability to your life” was 4.57, and the mean score for “overall satisfaction with the workshop” was 4.81. The evaluation forms also allowed participants to pro-

### Table 1: Summary of Symposium Evaluation Scores

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<th>Symposium Goals</th>
<th>Number of Responses for Each Score</th>
<th>Average Score</th>
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<tr>
<td>Identification of the purpose and objectives of the symposium</td>
<td>1 = poor  2 = below average  3 = average  4 = good  5 = excellent</td>
<td>Average Score</td>
</tr>
<tr>
<td>Organization and clarity of the presentation</td>
<td>0  0  9  45  79  4.53</td>
<td></td>
</tr>
<tr>
<td>Quality of information presented</td>
<td>0  0  2  40  91  4.67</td>
<td></td>
</tr>
<tr>
<td>Increased awareness that diversity means that every group counts and every issue counts</td>
<td>0  0  8  41  84  4.57</td>
<td></td>
</tr>
<tr>
<td>Improvement in ability to identify incidences of discrimination in your community</td>
<td>0  1  30  53  49  4.13</td>
<td></td>
</tr>
<tr>
<td>Increased awareness of how to practice skills of listening</td>
<td>0  3  13  52  65  4.35</td>
<td></td>
</tr>
<tr>
<td>Resolve to build authentic relationships across group lines</td>
<td>0  1  20  61  51  4.22</td>
<td></td>
</tr>
<tr>
<td>Increased awareness of how to shift another’s attitude and interrupt prejudicial jokes, remarks, and slurs</td>
<td>0  3  16  52  62  4.30</td>
<td></td>
</tr>
<tr>
<td>Eagerness to take on diversity issues and build inclusive environments in your community</td>
<td>0  4  26  47  56  4.17</td>
<td></td>
</tr>
<tr>
<td>Overall satisfaction with symposium</td>
<td>0  0  10  49  74  4.48</td>
<td></td>
</tr>
</tbody>
</table>
vide written responses to 6 questions:

1) What information did you learn about yourself? 2) What information did you learn about others? 3) What skills did you learn? 4) Give one example of how you will use your skills in your life/workplace. 5) What were some things the leaders did or said during the workshop that were particularly helpful or meaningful to you? 6) What would have made the workshop experience more powerful or effective for you? Many participants indicated that they plan to use the skills they learned when they returned to the workplace and their everyday lives, particularly those skills concerned with listening and shifting attitudes. Other important lessons from the workshop included: realizing the long-term impact of offensive comments, appreciating differences, and recognizing discrimination and stereotyping.

Testimonials from the workshop include:

"We spend so much time being professional with each other. The workshop was a great opportunity just to be people for a day — proud, embarrassed, strong, and vulnerable. I came away from it with a greater appreciation of who my co-workers were." 

"The workshop helped me realize 'my identity'. A wholesome experience."

"After attending the workshop I spent several days thinking about my own issues. I felt that the NCBI workshop was valuable in helping me do some self-evaluation. I would recommend them."

"This experience taught me that anyone can be a victim of mistreatment in our society (not just the 'typical' minorities). Wonderful! I feel like I can relate to others better now."

"I very much appreciated the opportunity to attend the NCBI workshop. The participants' attitude was nowhere near one of blame or guilt. To the contrary, I felt safe, and better yet, productive, all day. I have attended sessions on this topic before. Today I learned more than in any of the others, and never once felt as if I was wasting my time. Thank you Diversity Committee!"

"This was a profound experience for me that will influence my perspective and relationships in many ways. There was nothing dogmatic or pushy about the workshop's approach. I felt validated and supported in being more open to individual needs, and had the opportunity to develop new ideas for being authentic and respectful in my work. An invaluable experience!"

"Please accept my sincere thank you for breaking the code of silence and hence isolation. Participation in such a workshop is really the only way to allow the process of healing to begin and to help colleagues emerge from isolation."

Five people (including faculty, staff, and one student) attended a three-day NCBI Train-the-Trainer Workshop at Ohio University in Athens, Ohio on September 16-18, 2005. This three-day workshop prepared participants to become NCBI facilitators. Participants meet in small groups and receive individual coaching in leading the various components of two programs: the NCBI Prejudice Reduction Workshop and the NCBI Controversial Issues Process, which provides training in conflict resolution. NCBI also offers a five-day Leadership Training Institute to prepare participants to provide leadership to end discrimination, reduce intergroup conflict, and build multi-group coalitions. Participants receive training to establish NCBI chapters in their communities. Contact information for the organization is provided in Table 3.

Table 3: Contact Information

<table>
<thead>
<tr>
<th>National Coalition Building Institute</th>
<th>1120 Connecticut Avenue, NW Suite 450 Washington, D.C. 20036 Telephone: 202-785-9400 e-mail: <a href="mailto:ncbiinc@aol.com">ncbiinc@aol.com</a></th>
</tr>
</thead>
</table>

The NCBI web site contains additional information about the organization and its efforts: www.ncbi.org.

Conclusions

The NCBI symposium, "Optometrists as Leaders in a Diverse Community," provided education for approximately 250 members of the faculty, staff, graduate students, and students of the College of Optometry at The Ohio State University. It was well-received, as is evidenced by the scores and comments from the evaluation forms. So far, about 60 members of the faculty and staff, as well as two graduate students, have participated in the NCBI workshop, "Building Community by Welcoming Diversity." Scores and comments from the workshops also reflect well on the quality of the workshops. Students in the professional curriculum are currently being provided with additional workshops in cultural competence by Dr. LeVelle Jenkins, a member of the regular faculty at The Ohio State University and author of the EYECARE Model of cultural competency in optometric care.

References

Industry News
(Continued from page 73)

and accessories. The company is based in Mentor, Ohio, and has representatives and distributors around the world. To order or obtain more information about Volk products, visit www.volk.com, phone Volk at 1-800-345-8655 (+1 440-942-6161 outside the United States), or contact your Authorized Volk Distributor.

ViSTAKON, Division of Johnson & Johnson Vision Care, Inc.

Richard Clompus, O.D. has joined Vistakon in the newly created role of Director, Professional Development. Dr. Clompus will be responsible for managing Vistakon’s professional development programs for current practitioners. Dr. Clompus brings over 26 years experience in the vision care industry. Most recently he was Vice President, Professional Affairs for The Spectacle Lens Group of Johnson & Johnson Vision Care, Inc.

Before joining Johnson and Johnson Vision Care, Inc., Dr. Clompus managed his own primary care optometric practice, where he provided comprehensive family eye care, contact lens and low vision rehabilitation services. He has been a clinical faculty member of The Eye Institute at the Pennsylvania College of Optometry.

Dr. Clompus is a member of the American Optometric Association, Virginia Optometric Association, American Academy of Optometry, and a charter member of the Contact Lens Section of the American Optometric Association. Dr. Clompus holds a Doctorate in Optometry from the Pennsylvania College of Optometry.

Transitions Optical

More than 1,000 industry professionals from North and South America gathered at the Royal Pacific Resort, Universal Studios, in Orlando, Fla. for the 10th annual Transitions Academy, themed “Leadership in Action - Making It Happen.”

Transitions Academy was developed as an educational event for independent optical laboratories to share cross-cultural experiences and learn business-building strategies. Over the past 10 years, Transitions Academy has grown significantly to become one of the optical industry’s leading educational forums.

“We have always considered education leadership integral to industry leadership and Transitions Academy helps us fulfill our continuing commitment to support our optical industry partners,” said Dawn West, Transitions’ events manager. For more information about the company and Transitions Lenses, the first to earn the American Optometric Association’s Seal of Acceptance for Ultraviolet Absorbers/Blockers, visit transitions.com or contact Transitions Optical Customer Service at (800) 848-1506 (U.S.) or (877) 254-2590 (Canada).

Allergan

Allergan introduced ALPHAGAN® P (brimonidine tartrate opthalmic solution) 0.1%, which is a new formulation of the original ALPHAGAN® 0.2% and ALPHAGAN® P 0.15%, a leading brand in the glaucoma market. ALPHAGAN® P 0.1% is indicated for lowering intraocular pressure (IOP) in patients with open-angle glaucoma or ocular hypertension. The availability of ALPHAGAN® P 0.1% is in the latest advance in the ALPHAGAN® franchise, which is currently the third-largest selling glaucoma franchise in the world, and underscores Allergan’s commitment to providing eye care specialists and patients with advanced medicines that have optimal safety and efficacy.

This new formulation was designed to ensure that patients receive maximal therapeutic efficacy while reducing drug exposure. ALPHAGAN® P 0.1% ophthalmic solution offers the lowest effective dose of brimonidine (0.1%), which significantly reduces patient exposure to the drug.

Results from a 12-month clinical trial show that IOP reductions with new ALPHAGAN® P 0.1% ophthalmic solution were clinically equivalent to the original ALPHAGAN® 0.2%. The difference in mean IOP reductions between ALPHAGAN® P 0.1% and ALPHAGAN® 0.2% ophthalmic solutions was < 1 mm Hg at all follow-up time points over 12 months. With ALPHAGAN® P 0.1%, the drug concentration has been decreased by 50 percent from the original product, ALPHAGAN® 0.2%, without sacrificing efficacy. Full prescribing information for ALPHAGAN® P 0.1% is attached and can be found at www.Allergan.com.

Compulink

Compulink held its annual university meeting in April. This meeting offers the opportunity to further knowledge on the Compulink Advantage software and network with other university colleagues. If you are interested in attending the annual university meeting, or to see what their new software can do for your University, please give Compulink a call at (800) 456-4522. All are welcome!

Essilor of America/Varilux

February 1 was the deadline for third and fourth year optometry students to participate in the 2006 Varilux Student Grant Award Program. Interested students submitted a 2,000 word case report on patients fit with Varilux lenses to their school’s clinical staff. The winning student at each school will receive $1,000 and will be entered into the national judging. The national award winner and faculty advisor will each receive an all-expense paid trip for two to Optometry’s Meeting™. For more information, contact Dr. Rod Tahran at (800) ESSILOR, ext 5170 or rtahran@essilorausa.com or Danne Ventura at (800) ESSILOR, ext 7369 or dventura@essilorausa.com.
IN REVIEW


This is a multi-authored book on the practice management aspects of optometry. The authors are the practice management educators at the schools and colleges of optometry. As stated in the preface, this is a “unique achievement” in optometry, since it is the collaboration and cooperative work of all the practice management educators, and never before have “all the educators in a subject area worked together to provide a common textbook” on a particular topic.

Business Aspects of Optometry is divided into six sections: practice options, business organizations, insurance, starting a practice, practice administration, and financial aspects of practice. The second edition has added sections about insurance, contracts, taxes, financial planning, and record keeping, as well as changes to update the chapters from the previous edition.

This book is an impressive collaborative work of great importance to the profession of optometry. If students are only taught the technical aspects of taking care of patients (e.g., ophthalmoscopy, retinoscopy, biomicroscopy, etc.), then they may be astute clinicians, but lost in the business world. This book will help prepare students to thrive and survive financially after they graduate. Topics such as starting a practice, negotiation, obtaining a business loan, organizing an office, selecting and managing an office staff, record keeping, use of computers, patient communications, tax reporting, and marketing, are of direct and practical use to readers.

I recommend this book to all students of optometry and practicing optometrists. Congratulations to the full set of collaborating authors for their unique contribution to optometry.

Guest Reviewer: Dr. Henry Ettinger New York, NY


Essentials of Clinical Binocular Vision is a text that optometric practitioners have needed for some time. As many practitioners use handbook type texts (i.e., Wills Eye Manual) to reference diagnosis and treatment options for pathology presentations, no such text has been available for binocular vision diagnosis. This text is a terrific tool for students and optometric practitioners to utilize as the starting point for the care of binocular vision patients.

This book is extremely easy to read and reference. The first ten chapters have a consistent layout describing general information, common symptoms and signs, possible differential diagnosis, necessary work-up procedures, treatment options, and appropriate follow-up care. These ten chapters deal with the most common binocular vision disorders seen in primary care practices. Suggestions for thorough case history questions and the lists of symptoms often presenting with each condition are strengths of the book. These aid a practitioner in making a tentative diagnosis from the case history and leading the examination in the right direction from that point forward. The lists of differential diagnoses are also superb. They are especially helpful in the strabismic deviations with a suspected pathological etiology. The treatment sections are also very “real life” and can be implemented in any primary care practice.

Chapters are broken up to deal with soft binocular vision disorders (vergence and ocular motor dysfunction), accommodative disorders, strabismus and amblyopia. In the strabismus chapters photographs of many of the deviations are presented and tips regarding co-management of patients requiring referrals for tertiary care are given.

Step-by-step instructions are provided regarding determination of the proper spectacle prescription for many diagnoses. Many practitioners shy away from treatment of binocular vision disorders for fear of determining the wrong Rx. This text provides prescribing steps for soft binocular vision disorders such as convergence excess, as well as strabismic deviations with refractive etiology and pathologic etiologies (e.g., thyroid eye disease, paralytic strabismus, etc.).

Essentials of Clinical Binocular Vision includes tips for the primary care practitioner to implement basic vision therapy. It includes the breakdown of the binocular vision work-up, how to structure an orthoptic appointment, and explanations of basic vision therapy techniques for the primary care practitioner to use.

As an optometrist who sees many patients with binocular vision disorders, I highly recommend Essentials of Clinical Binocular Vision as a pocket guide to aid the most experienced clinician as well as a new or primary care practitioner who needs a helping hand every now and then and then in the area of binocular vision.

Guest Reviewer: Dr. Valerie Kattoff Associate Professor of Optometry Illinois College of Optometry
I thank my parents for my brown eyes. But today, I thank my eye doctor for my blue ones.

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