

# JOURNAL OF OPTOMETRIC EDUCATION

Volume 3, Number 1  
Spring, 1977



# JOURNAL OF OPTOMETRIC EDUCATION

Official Publication of the Association of Schools & Colleges of Optometry

## TABLE OF CONTENTS

Volume 3, Number 1      Spring, 1977

<b>Association Activities and Board Briefs</b>	<b>4</b>
A synopsis of actions and recommendations of the most recent Board of Directors meetings.	
<b>The Journal Looks at the Veterans Administration</b>	<b>6</b>
An Interview with Mr. David Danielson, AOA Washington Office An Interview with Dr. Kenneth Myers, VA Central Office JOE Highlights ASCO/AOA Joint Project Team Report	
<b>Richard Averill on ASCO, Education and the Profession</b>	<b>20</b>
Mr. Richard Averill, long time Washington Office Director, comments on issues as he prepares to head the entire AOA staff operation.	
<b>A Survey of Attitudes of Optometry Instructors</b>	<b>22</b>
by Lester E. Janoff, O.D., M.S.Ed. Dr. Janoff surveys optometric educators on a number of behavioral attitudes.	
<b>Twenty-Five Years Later – The University of Houston College of Optometry</b>	<b>28</b>
While the university celebrates its Golden Anniversary, the college celebrates its Silver with a brand new building.	
<b>Departments</b>	
Book Review	25
Editorial	3
Classifieds	27
Abstracts	26
Front Cover design by Roger Kranz	

The **JOURNAL OF OPTOMETRIC EDUCATION** is published by the Association of Schools and Colleges of Optometry (ASCO). **Managing Editor:** Louis A. Ebersold. **Associate Editor:** Barbara B. Shea. **Art Director:** Roger Kranz. **Editorial Assistant:** Cassie Jablonski. Business and editorial offices are located at 1730 M Street, N.W., Suite 210, Washington, D.C. 20036. **Subscriptions:** JOE is published quarterly and distributed at no charge to dues-paying members of ASCO. Individual subscriptions are available at \$10.00 per year. \$15.00 per year to foreign subscribers. Postage paid for a non-profit, tax-exempt organization at Washington, D.C. Copyright ©1977 by The Association of Schools and Colleges of Optometry. Advertising rates are available upon request.

# EDITORIAL

## Chester H. Pheiffer

No one can dispute the fact that the Veterans Administration operates the world's largest hospital/clinical system. The VA's Department of Medicine and Surgery (DM&S) runs 171 hospitals, 206 outpatient clinics, 89 nursing homes, 18 domiciliaries and many other special programs and centers. Last year the VA hospitals provided treatment for 1.3 million hospitalized patients and logged 16 million outpatient visits. Each VA hospital provides a plethora of special medical services which could make it a model of institutional health care delivery. But doubts remain . . .

The relationship that exists between VA hospital/clinics and the country's medical and associated health schools has done much to change the present educational programs of these schools. Benefits for both the VA hospitals and the schools from these teaching affiliations are obvious. Most professional and associated health professional schools, with one glaring exception, have long been permitted (accepted) in these training hospitals/clinics. Optometry is that exception—remaining out of the fold not by choice, but by administrative fiat.

The teaching affiliation programs started on a large scale after 1946, when General Omar Bradley became the administrator of the agency. He established "Deans' Committees" at these newly affiliated hospitals and these in turn produced a measurable improvement in the patient care quality. In keeping with the VA's professed desire to have health care second to none, the VA's DM&S is now currently affiliated

with over 92 medical schools, 57 dental schools, 314 nursing schools, 45 schools of pharmacy and over 850 of their allied professional or supporting health schools.

The Congress continues to legislate public laws which delineate the VA's importance as a training facility for this country's health professionals. In 1972, the VA Medical School Assistance and Health Manpower Training Act established new programs of grants to non-profit universities, colleges and institutions which were then or were to become affiliated with the VA. These grants were to be given to help them expand and improve their facilities for training health care professionals with the end in view of enhancing the care of the VA's patients.

However, the role of optometry in this network of hospital affiliations is almost non-existent. In 1975, the New England College of Optometry applied for grants under this grant program and in 1976, Southern California College of Optometry did also. Both of these applications were approved but a moratorium was placed on the funding. In sharp contrast to the comparatively large numbers of ophthalmologists supported by the program, there are only nine full-time, twenty-two part-time, and under forty attending/consulting optometrists who are employed by the VA.

Affiliations other than under the grant program have surfaced in recent years, notably at Alabama, Berkeley, Southern California, Illinois, NEWENCO, Ohio State and Indiana. Benefits from these teaching affiliations are obvious. The

hospital receives experienced staff support, while the schools are able to offer greater inter-professional exposure than their own school clinics could possibly provide.

It has long been felt that the Deans' Committees at the various hospitals, as well as the hospital directors, have needed a directive from the DM&S to encourage the fostering of optometric affiliations. Now they have such a directive. Dr. Myers and Mr. Danielson both describe its promise in separate interviews in this issue. P.L. 94-581 established both an Optometric Service within the DM&S and a new pay structure for VA O.D.'s. In essence, this legislation gives moral support from the Congress to optometry. The Service has the potential to develop optometric services for the VA patients to the fullest. Through Congressional mandate the VA has the responsibility to help train *all* health professionals. Optometry represents the largest independent health profession following physicians, dentists and nurses. It is more than obvious that the VA has a duty to help in the training of future practitioners of optometry and, more importantly, to provide proper health care to the veteran which has not been fully realized.

If ever there existed a climate more conducive to gaining academic affiliations, I have not lived through it. But taking advantage of the law still depends on local decisions. The VA Central Office should send out the word. Congress has made its wishes known and continued discrimination should not be tolerated.



This issue of the **Journal of Optometric Education** will highlight and abstract the minutes from the Board of Directors' quarterly meetings in Portland, December, 1976; and Houston, March, 1977.

## **Board of Directors Meeting, Portland, Oregon, December, 1976**

The Board of Directors were invited to meet on the campus of Pacific University, Forest Grove, Oregon. During his President's report, Dr. Wallis stated that the ASCO position on the new HEW initiative on Health Manpower Credentialing had been transmitted to the HEW committee. The President also reported that no response had been received to a letter directed to the Missouri Optometric Association requesting clarification of issues raised in a recent AOA news article.

Dr. Wallis, reporting for the Executive Committee on actions and recommendations to the Board, introduced a working document on seven areas of concentration/functional elements for the Association's future program planning. Dr. Wallis also reported that the Executive Committee was considering reducing the number of full scale Board meetings from the present four to two for the upcoming year. Several Board members mentioned that concerns had been raised by the American Academy of Optometry on the scheduling of outside meetings in conflict with Academy programs.

The Executive Director reported that no formal response had been received from the letter transmitted to the National Academy of Sciences Institute of Medicine concerning AOA's position statement on primary health care. Dr. Ebersold reported that applications for

membership on the National Health Council had been completed and submitted and that dues would be around \$300 per year.

The subject of the Veterans Administration and the newly enacted legislation was raised. Dr. Kenneth Myers, Director of Optometry in the Veterans Administration, provided some information on future programming in the VA. Following general discussion, the Board adopted a resolution urging member institutions who experienced discrimination in regard to academic affiliations, to raise objections at the local level through all appropriate means.

Dr. Eskridge provided a progress report on the teaching manual being prepared by a subcommittee of the Council on Academic Affairs. He reported that the manual would be available some time early in 1977.

Dr. Michael Heiberger briefly related attempts to establish compatible dates for the National Board of Examiners in Optometry test. He also reported on a financial aid survey being conducted by ASCO and an HEW contractor, Audits and Surveys, Incorporated.

A discussion on designation of health manpower shortage areas in optometry was held. The Board adopted a resolution stating that the profession had established a reasonable and appropriate level of optomet-

ric manpower per population at a level of 14.3 optometrists per 100,000 population, and based on this benchmark figure, when the number of available optometrists per population falls below 80 percent of the level, a shortage of optometric manpower exists.

Dr. Jerry Strickland discussed the joint task force on new academic facilities and the decision of the AOA not to renew the project teams' mandate. The Board did, however, endorse an informal arrangement between AOA and ASCO to provide one resource person to each developing school project when requested by the AOA President.

Discussion was held on the current activities of the American Optometric Foundation and the Board went on record instructing the President to request the ASCO Trustees to the American Optometric Foundation to initiate an internal evaluation of the AOF's programs and finances.

Dr. Hopping reported on meetings that he had attended for the Association. He had been asked to attend the Association of American Medical Colleges meeting in San Francisco.

The Board adopted a resolution praising the American Optometric Association, its staff, councils and leadership for their initiative in the sponsorship of the special conference on education held in Mississippi. The Board also thanked the AOA through the liaison trustee, Dr. Jack Von Bokern, for the AOA's assistance in funding the financial comparison study through the National Center for Higher Education management systems.

After lengthy consideration and discussion, the Board moved to adopt the statement of priorities and purposes developed by the Executive Committee and instructed the Executive Committee to study and implement the new program as effectively

# ies & Board Briefs

as possible making efficient use of the limited financial resources of the Association. In addition, the Board approved the ASCO budget for the fiscal year 1976-77.

The Board voted unanimously to adopt a set of guidelines on industrial relations developed by a committee chaired by Dr. Willard Bleything.

Dr. Rosenbloom provided the Board with the particulars of a faculty development plan and the Board voted to officially recognize the program but added that the administration of the program be the responsibility of interested institutions.

The Board also asked the President to consult with the Canadian schools concerning appropriate affiliation and report back to the Board in March.

## **Board of Directors Meeting, Houston, Texas, March, 1977**

The Board of Directors reaffirmed its confidence in the Executive Director and resolved to continue to operate an independent National Office in Washington, DC. Dr. Pheiffer was introduced and briefly discussed the activities of the coming weekend revolving around the dedication of the new \$10 million College of Optometry building on the University of Houston Central Campus, followed by a four day International Symposium on Vision Research. Both events were part of the University's half century celebration.

Dr. Wallis, as part of his President's report, stated that negotiations with the Chief Medical Director of the Veterans Administration had been proceeding as directed by the Association. Dr. Wallis asked Dr. Peters to comment in more detail on the recently completed project team report and

recommendations to the Veterans Administration. During discussions with Dr. Chase, Dr. Wallis reported that there was mutual agreement concerning reporting requirements in the field, hiring and personnel practices, and utilizing the joint project team study before announcing any new policy decisions. Dr. Peters was thanked for his work on behalf of the Association.

Dr. Wallis also reported that he had met with the Chairman of the House Appropriations Subcommittee on Health, Congressman Flood, along with Deans and Presidents of other independent health professions schools in the Philadelphia area.

Updated reports on efforts to establish new schools and colleges of Optometry in different regions and states were heard.

Dr. Heiberger reported on the use of the Medical College Admission Test by schools of Podiatry. Dr. Heiberger was of the opinion that the ASCO Board need take no action at this time. Dr. Heiberger also brought the Board up to date on activities and plans for the Council on Student Affairs. Dr. Heiberger reported no progress on a study to determine examination dates for the National Board of Examiners in Optometry.

Dr. Edwin Marshall, ASCO Liaison from the National Optometric Association, was recognized in order to present comments that were to be made by Dr. Will Kelley, President of the National Optometric Association. Dr. Kelley had become ill on his trip to Houston and was unavailable to speak to the Board.

Several *Constitution and Bylaws* changes were read into the record by Dr. Wallis at the recommendation of the Executive Committee. This was done in order to bring the changes to the attention of the Board within the Constitutionally prescribed limits. The amendments were technical in nature and made important changes in the procedure for termination of membership for failure to pay dues.

The American Optometric Foundation was discussed by Dr. Heath, one of the ASCO representatives to the AOF Board of Trustees. The Board decided to call for a financial status report of the Foundation and an accounting to be made by the AOF at the ASCO Annual Meeting in Toronto. Various fund raising efforts for the Association were discussed during this portion of the meeting.

Dr. Peters introduced the topic of the joint project team report on the Veterans Administration. The Board unanimously endorsed the report of the joint project team on the VA as transmitted and published on March 1, 1977. In a related event, the President reconstituted the ASCO portion of the joint project team in order to make timely response on any issues related to the VA which were presented to ASCO for critical review.

A resolution commending the many years of service to the profession of Mr. J. Harold Bailey was read and unanimously approved.

Dr. Peters reported that ASCO had been accepted into membership in the National Health Council.

# EDITOR'S MESSAGE

This issue of the Journal of Optometric Education focuses on Optometry and the Veterans Administration. In the waning days of the 94th Congress, legislation was enacted that, among other things, upgraded optometry to a full service within the VA hierarchy. The legislative changes also shifted salary and personnel questions out of the Civil Service system and into a special category, especially for physicians, dentists and nurses, known as Title 38. The importance of gaining full service status within the VA is carefully outlined in three separate articles in this issue.

Two of the articles are interviews with people closely associated with the effort to gain the legislation and those responsible for carrying out its mandate in the future. Mr. David Danielson, Associate Director of the National Health Division in the Washington Office of the American Optometric Association describes the legislation and how it was accomplished. Dr. Kenneth Myers, Director of Optometry in the Veterans Admin-

istration, looks at the new law and sketches out the responsibilities for the VA for the future of improved eye/vision care.

The third element in this package is a special National Office report summarizing and abstracting from a major paper presented to the Veterans Administration by a joint project team of the American Optometric Association and the Association of Schools and Colleges of Optometry. The paper entitled "A Report to the Department of Medicine and Surgery of the Veterans Administration For the Development of a Program of Optometric Service" was published and transmitted on March 1, 1977, and was subsequently endorsed by both the American Optometric Association and the ASCO Board of Directors.

In addition to summarizing the background and rationale of the paper, the detailed professional recommendations of the project team are carried in their entirety.

## INTERVIEW: From the Outside

### AOA's Danielson on the V.A. Legislation

**ASCO:** How did the new optometry provisions in P.L. 94-581 originate?

**Danielson:** Well, there were several ingredients which had to be present before we could attempt what eventually transpired in P.L. 94-581. As early as 1971, the AOA testified before the 92nd Congress as to the need for a Director of Optometry—but it wasn't until the 93rd Congress that the legislation (S. 59) creating such a position was signed into law as P.L. 93-82.

In 1975, the AOA testified on behalf of better salaries and the creation of an independent Optometric Service at the Senate hearings on the recruitment and pay problems for VA physicians. The Senate found that the VA seemed to have trouble recruiting not only physicians, but other health care practitioners as well, because certain VA salaries were non-competitive. One of the out-

comes of this was that physician assistants and dental technicians were given a new, more competitive salary ladder.

**ASCO:** What was the VA Civil Service O.D. career salary like?

**Danielson:** Under the Civil Service schedule, VA O.D.'s were limited to GS-9 and GS-11, which works out to about \$14,000 to \$22,000 a year, and most O.D.'s earned about \$19,000 after 15 years of service.

**ASCO:** That's not much of a salary ladder.

**Danielson:** No, it's not. That fact was brought out in our testimony before the Senate Veterans Affairs Committee in 1975.

**ASCO:** What was the outcome of those Senate hearings?

**Danielson:** The Congress called for a General Accounting Office study of physicians' and dentists' pay in the federal system, as well as allied health profession salary situations. The Presi-

dent signed this bill, and the Veterans Administration Physicians and Dentists Pay Comparability Act of 1975 became P.L. 94-123.

**ASCO:** Then P.L. 94-123 laid the ground work for P.L. 94-581?

**Danielson:** In a remote way, yes. You see, in May of 1976 we went to the Senate Subcommittee on Health and Hospitals to offer input for S. 2908—the Veterans Omnibus Health Care Act of 1976. We hoped to get language in the Committee Report due in March, 1977. As it turned out the Subcommittee staff became interested in our presentation and asked us to submit further suggestions.

**ASCO:** Is this when you made the decision to introduce amendments to S. 2908?

**Danielson:** Well, our initial reaction was to get the best language we could for the GAO Study. But after talking with Subcommittee members, we got the strong impression that we had sup-

*David S. Danielson, B.S., is Associate Director of the National Health Division in the American Optometric Association's Washington Office.*

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By David O. Harrington, A.B., M.D., F.A.C.S. 1976, 4th edition, 413 pages plus FM I-XVIII, 6¾" x 9¾", 421 illustrations and 9 plates with 5 in color. Price, \$25.00.

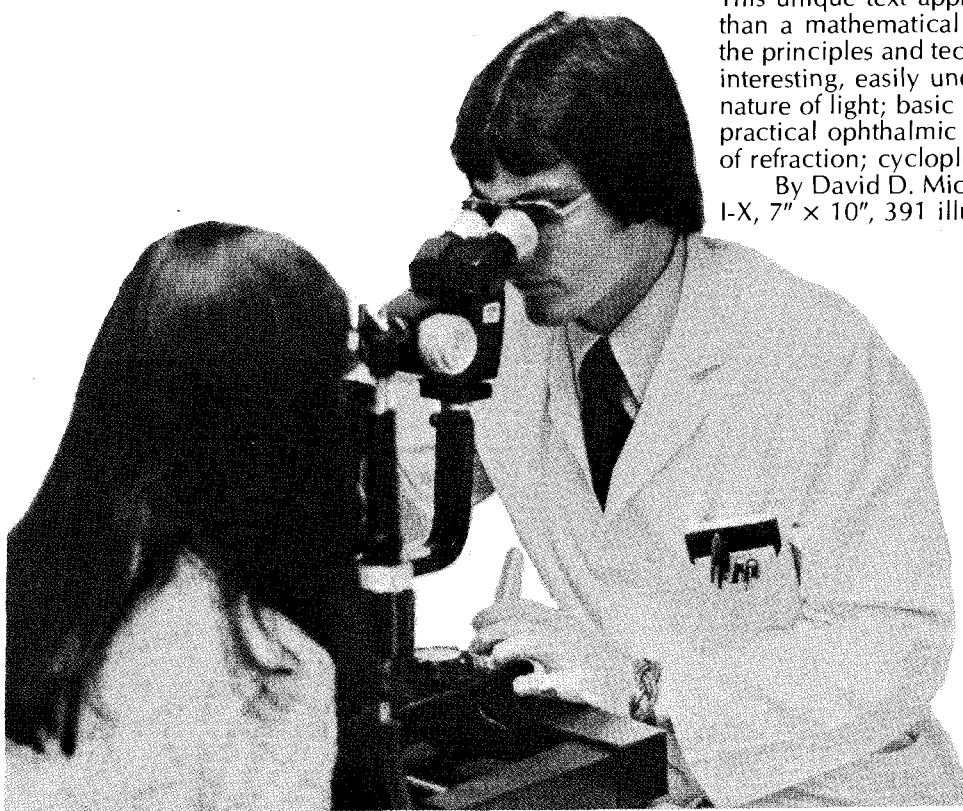
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By Arthur H. Keeney, M.D., D.Sc.; with 5 contributors. September, 1976. 2nd edition, 322 pages plus FM I-XIV, 7" x 10", 200 illustrations. Price, \$21.50.

## **VISUAL OPTICS AND REFRACTION: A Clinical Approach.**

This unique text approaches optics from a clinical, rather than a mathematical viewpoint, and accurately describes the principles and techniques of refraction. Presented in an interesting, easily understood manner, topics include: the nature of light; basic optics; lens optics; cylindrical lenses; practical ophthalmic optics; physiologic optics; principles of refraction; cycloplegics; and more!

By David D. Michaels, M.D. 1975, 518 pages plus FM I-X, 7" x 10", 391 illustrations. Price, \$29.50.



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Photo by Bruce Raudy

port for an optometric pay system comparable to that for VA physicians and dentists. We then spent a few days researching and writing a rather involved amendment, complete with supporting arguments which we offered the Subcommittee.

**ASCO:** What did you propose?

**Danielson:** In our amendment, we asked for removal of VA O.D.'s from Title 5 of the U.S. Code (Civil Service) placing them instead in Title 38 of the Code under the professional personnel program of the Department of Medicine and Surgery. We also called for upgrading the Director of Optometry to Director of Optometric Service.

**ASCO:** Could you explain what this means?

**Danielson:** As I mentioned earlier, VA optometrists were paid and administered under the Civil Service regulations and pay structures found in Title 5 of the Code. In this 5 USC regulations, optometrists were locked into pay

levels GS-9 to GS-11. We requested our own pay system in the Department of Medicine and Surgery of the VA, just as the physicians, dentists and nurses did back in 1946.

**ASCO:** What is the basis for this Title 38 pay system? How is it unique?

**Danielson:** In the Department of Medicine and Surgery, physicians, dentists, nurses (and now optometrists) and a few other health professionals, are paid according to their professional qualifications and abilities. The popular term for this method within the VA is the "rank-in-the-man" system. Basically, it means physicians appoint and evaluate physicians, dentists appoint and evaluate dentists and so on, without regard for Civil Service personnel guidelines. Further, salaries are based solely on qualifications and not job descriptions. The Civil Service job classifications had held optometrists' salaries down for twenty years.

**ASCO:** This sounds like a kind of peer

review system.

**Danielson:** You're absolutely right. Now, VA O.D.'s have the same pay and personnel systems—Title 38—as do physicians, dentists and nurses.

**ASCO:** OK, we've touched on the history of optometry's involvement in the VA's Department of Medicine and Surgery. Now, we'd like to know exactly what P.L. 94-581 provides for Optometry.

**Danielson:** Well, distilled down to essential ingredients, P.L. 94-581 does two things: (1) it establishes a clinical salary table for VA optometrists which, if fully utilized by the VA, will be competitive with the salary levels of O.D.'s practicing in HMO's and the universities and (2) it establishes an Optometric Service within the DM&S, as well as a Director of this Service.

Now let me back up to this new salary schedule. In their report on S. 2908, the basis for P.L. 94-581, the Senate Committee recognized that the VA employed too few optometrists (less than 1/10 the number a similar sized HMO would employ), and in citing reasons for this said "... most importantly, non-competitive salaries, particularly at the mid and advanced career levels..." We now have in 38 USC 4107, 5 clinical pay grades for optometrists. These grades range from Associate Grade, equivalent to GS-11, to Chief Grade which is about a GS-15, or in dollar amounts, around \$38,000.

**ASCO:** What about the Optometric Service?

**Danielson:** The Senate Committee identified another barrier preventing the hiring of optometrists. This was the absence of an Optometric Service and a Director of this Optometric Service, "... responsible to the Chief Medical Director for the operation of his or her Service." The Senate Committee felt this new law would "... coordinate recruiting and retention efforts and enhance professional status of these personnel."

**ASCO:** But exactly what is the significance of an Optometric Service?

**Danielson:** For the VA optometric program to grow and render high quality care, it must have sufficient organizational and professional autonomy to design, evaluate and administer its own programs. The Director of the Service must have the administrative discretion necessary to expand and deliver his services—in this case—optometric services to the VA patients.



**ASCO:** We have an analogous situation with our state university affiliated member institutions which enjoy full independent professional status with academic deans who report to their vice-president for health affairs.

**Danielson:** That's a good point. And, as you know, the VA desires optometric teaching affiliations. We feel P.L. 94-581 will put optometry in a similar position within the VA so that continued educational affiliations can develop.

**ASCO:** How is P.L. 94-581 working thus far? Have you seen an increase in optometry's professional status, and are more O.D.'s being hired?

**Danielson:** Well, I certainly can't speak for the VA, but I am aware that the Department is having problems implementing the law.

**ASCO:** Do you care to elaborate?

**Danielson:** It's no secret agencies move in ponderous ways. Until new equitable optometric qualification standards and administrative regulations are established which meet the intent of

### It's no secret agencies move in ponderous ways.

Congress, I can't see any immediate improvements being made.

**ASCO:** What about better pay—will the VA O.D.'s get a raise?

**Danielson:** I don't really know the answer to that. But I do know the VA O.D.'s currently employed are still under Civil Service, and are being paid at about the level of the new "Associate Grade". And that's the bottom of the five new grades. Whether they will get

a raise and the amount of that raise is dependent on how the new qualification standards are written. If they turn out to be a rehash of the Civil Service standards, I don't expect any real progress will result, and the VA will continue to employ very few optometrists.

I know this doesn't sound very promising, but you must remember this is a new program. It has the possibility of becoming an outstanding example of sound optometric patient care if it is handled properly. In a way, this sets a precedence of sorts because optometry in the VA now has, by federal statute, independent status—a Service—just as do physicians, dentists and nurses.

#### Veterans' Administration Clinical Optometrist Schedule

Chief grade .....	\$31,309 Minimum to \$40,705 Maximum*
Senior grade .....	\$26,861 Minimum to \$34,916 Maximum
Intermediate grade .....	\$22,906 Minimum to \$29,782 Maximum
Full grade .....	\$19,386 Minimum to \$25,200 Maximum
Associate grade .....	\$16,255 Minimum to \$21,133 Maximum

\*Basic pay is limited by 5USC5308 to the rate for level V of the Executive Schedule which is, as of October 1976, \$39,600.

## INTERVIEW: From the Inside

# VA's Myers on the Growth of Optometry



*Editor's Note: Kenneth J. Myers, Ph.D., O.D., is Director of Optometry in the Department of Medicine and Surgery at the Veterans Administration, Washington, D.C. Dr. Myers discussed issues of importance to both the VA and the profession with ASCO's Executive Director, Dr. Louis A. Ebersold.*

**ASCO:** As you start your third year as Director of Optometry for the Veterans Administration, what observations can you make regarding trends in optometry?

**Myers:** I think I can clearly say, Lou that there has been a consistent development over the last 20 years toward increased employment and utilization of optometrists within the Department of Medicine and Surgery. The other day I was going through our legal files and found the first amendment to Title 38 of the U.S. Code, the codification of federal laws effecting optometry which occurred in P.L.

Photo by Bruce Reedy

85-56 in 1957. This law amended Section 4104 of 38 USC to specifically mention optometrists in regard to appointment of staff within the Department of Medicine and Surgery.

Later, Public Law 85-462 further amended Title 38's Section 4015 to include definite qualifications for appointment as VA optometrist. At that time, VA optometrists were first required to be licensed to practice optometry in one of the states, territories, or commonwealths of the United States or in the District of Columbia. Public Law 85-857 then changed this to read "be licensed to practice optometry in a state".

In 1960 Public Law 86-598, the "Veterans Eye Care Act", defined the services of an optometrist as being "medical services". Other administrative changes have also occurred in the past 20 years. For example, several years ago the VA eyeglass prescription form was rewritten to require the signature of an "ophthalmologist or optometrist" instead of only an ophthalmologist.

More recently, P.L. 93-82 of August 1973, created the office of the Director of Optometry via Section 4103 of Title 38 and it was to that office I was appointed in September 1974. Now, of course, continuing in this trend, Congress has, via P.L. 94-581, further amplified and expanded the future role of doctors of optometry within the VA.

**ASCO:** What do you perceive to be the benefits to Veterans patients from the optometric sections of P.L. 94-581?

**Myers:** Well, Lou, I can answer that very simply. The VA is unique among all federal and HMO health care programs for employing so few optometrists. As you know, the Armed Forces employ about three optometry officers for every ophthalmology officer and similar and higher ratios hold in HMO's like the Kaiser groups. Of course, in private practice the ratio of optometrists to physicians specializing in the care of the eye is 2 to 1 or, to those actually board certified in ophthalmology, 3 to 1. In contrast, the VA employs few optometrists. On a FTE ratio basis we employ five or six ophthalmologists for every optometrist; an inverse ratio.

Now the first question that comes to mind is why this ratio is reversed. I believe there are three reasons for this: (1) Since 1946, our VA hospitals have been affiliated with medical schools, dental schools, nursing schools and other schools of health and, as a natural consequence, departments of ophthalmology. These affiliations have cer-

tainly benefited our hospitals and resulted in ophthalmology residents, faculty, and staff providing medical/surgical eye care.

(2) The VA population consists primarily of men approximately 50 years of age who suffer from many chronic diseases. This, coupled with eligibility restrictions on who may receive eyeglasses, has resulted in our eye clinics seeing a much higher percentage of ocular disease and injury than the typical private practitioner. While an average of five percent of private eye patients usually require referral to a physician for further medical or surgical treatment, our eye clinics find 15 to 20 percent of their eye patients require medical or surgical treatment.

(3) Finally, and I think most importantly, the VA has not been able to offer competitive salaries for optometrists. It is this latter issue that P.L. 94-581 primarily addresses. Even though we have more ophthalmologists than optometrists, we need still more ophthalmologists and even more optometrists. Thus, while the VA may not require ratios

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similar to the HMO's and the Armed Forces, it does, in my opinion, need many more optometrists, perhaps enough to produce a one-to-one ratio.

**ASCO:** Could you briefly give us the essential characteristics of P.L. 94-581 as it pertains to salary and other professional aspects?

**Myers:** Well, as you know, P.L. 94-581 has removed VA optometrists from the Civil Service 5 USC personnel system, and placed them under the Title 38 personnel system used for physicians, dentists and nurses since 1946 within the VA. This has resulted in a new separate optometric salary table consisting of five clinical optometric grades. These are equivalent, in dollars, to Civil Service grades GS-11 through GS-15.

There are several important advantages to this new system. First, optometrists will now be appointed, evaluated, and promoted by hospital Professional Standards Boards containing optometrists and physicians. These boards recommend appointment grade and salary

solely based upon the professional qualifications of the optometrist and not, as in Civil Service, upon an additional job description. As you know, the Civil Service system sets an optometrist's grade by two factors: a grade according to his professional qualifications and a grade according to the position or job description held. Only the lower of those two grades is then offered.

Thus, the clear advantage to the new P.L. 94-581 system is that VA optometrists will now be paid solely upon the basis of professional clinical qualifications as are VA physicians, dentists and nurses. As a result, only better qualified optometrists will be promoted and retained thus improving patient care. Within the agency this philosophy is "rank-in-the-man" since one's true patient care qualifications are inherent to background, training, and service and not the actual position held. The VA recognizes that two clinicians, each serving in the same position under the same conditions and with similar responsibilities, may vary greatly in their clinical competency and skill and should, thereby, receive different salary grades as recognition that a clinician gains in professional competency with years of experience and training and should be duly rewarded on such a basis.

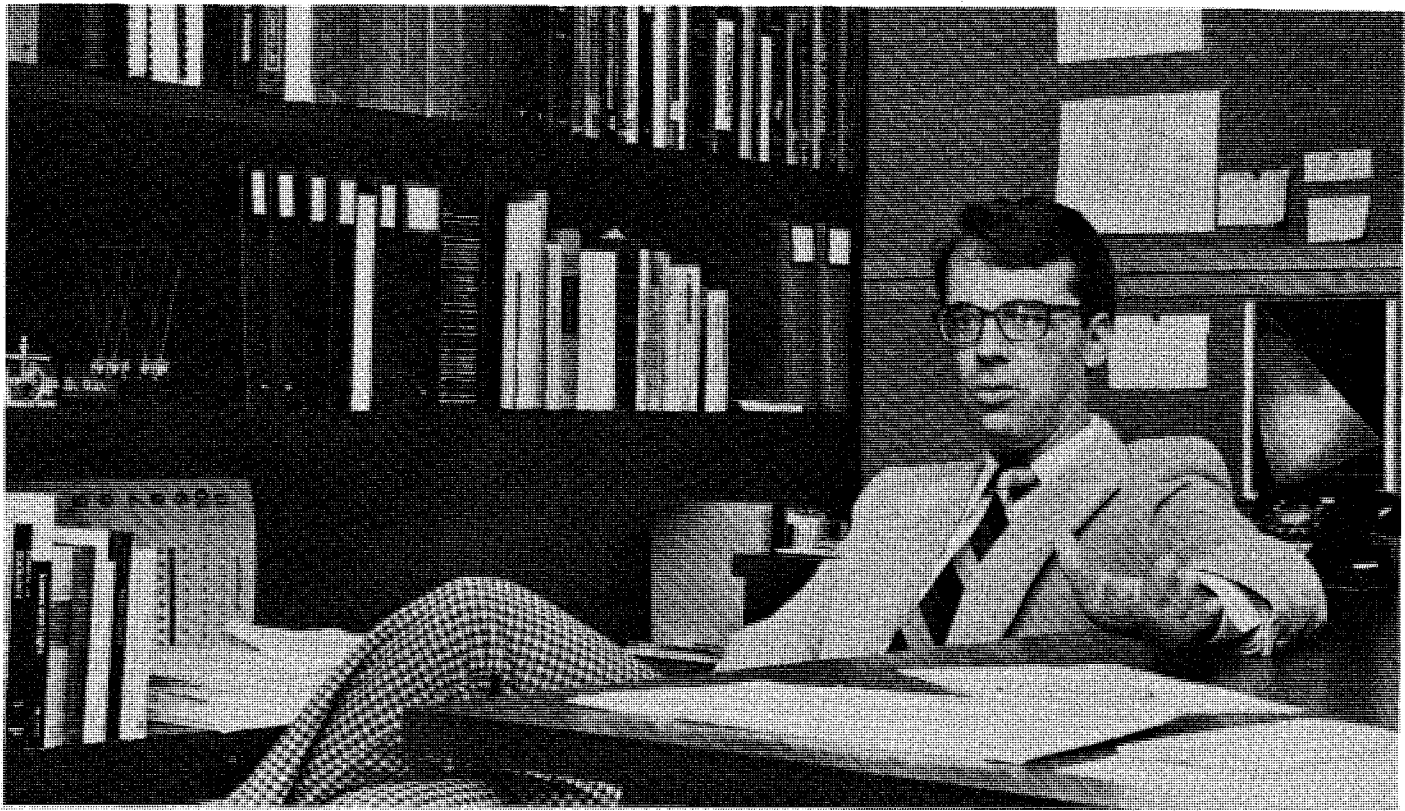
**ASCO:** Does this mean that VA optometrists will be paid on the same scale as VA physicians and dentists, for example?

**Myers:** No, it does not necessarily mean that. As you know, physicians and dentists have these same five clinical salary grades; however, they are eligible for bonuses and have somewhat different qualification standards. It does mean the appointment evaluation, and promotion procedures will be the same for optometrists as they are now for physicians and dentists.

**ASCO:** What type salaries do you envision resulting?

**Myers:** The actual optometry qualification standards have not yet been written. These are the standards the Professional Standards Board will use to evaluate staff optometrists. However, since the Title 38 system is clearly a "rank-in-the-man" system, whatever these standards are they will be based on clinical optometric professional competency and not, except for the top grade of "Chief", upon administrative or other position duties as formerly done by the Civil Service.

It is my hope that optometrists enter-



ing the VA right out of school will stay in the agency and be able to look forward to receiving advancement from the first to the third grade as long as they perform satisfactorily. I anticipate the top two grades will be reserved for clinical optometrists who are responsible for medium- or large-size hospital or outpatient optometric clinics. This would be similar to the career paths for VA physicians and dentists where the "Chief" grade is reserved for the chief of service.

**ASCO:** What other features does P.L. 94-581 have for VA optometrists?

**Myers:** The administrative position of optometry has been improved. The office created by P.L. 94-82 which I hold, "Director of Optometry", has been upgraded to "Director of Optometric Service". When this position was created, there were questions within the agency concerning to whom it should report. Initially, optometry was assigned to the Prosthetics Division of Surgical Service which, in turn, reported to the Deputy Director of Surgical Service for Prosthetics. Approximately a year later, it was reassigned directly to the Director of Surgical Service.

As a result of P.L. 94-581, the Director of Optometric Service will now report to an Assistant Chief Medical Director (ACMD). This means the optometry director will report on the same administrative level as do the directors of other

professional services; for example, directors of medicine, surgery, nursing, pharmacy, etc. Another way of looking at it would be to say that the Director of Optometric Service will report within the VA similar to the manner in which the dean of an optometry school reports within a university health science center. The ACMD, in turn, reports to the Chief Medical Director.

**ASCO:** What is your overall assessment of where optometry stands in the VA at this time?

**Myers:** I am encouraged by the progress of the last 20 years. Today there is a great criticism of government bureaucracy and government medicine. I have been uniformly impressed, however, with the sincerity and dedication of the professional staff within the DM&S even though red tape is a stumbling block to be struggled with on a day-to-day basis.

Optometry has been to date, a somewhat undeveloped VA resource. One of the most useful functions I have performed at the VA, I believe, has been to inform its officials about those patient care services which optometry can provide.

It is clear the VA has been listening and, more importantly, has made a sincere commitment to upgrading the medical and optometric eye care rendered eligible veteran patients. To that end, I believe VA officials now plan to fully utilize optometry by capitalizing

upon the latitude offered by P.L. 94-581. It will permit them to offer competitive salaries and recruit more optometrists who will be allowed to provide patient care in a fully professional manner.

**ASCO:** Tell me something about the optometric residencies and student programs recently developed.

**Myers:** If you recall from an earlier article, the VA has played a major role in providing training for physicians, dentists, nurses and other health care providers and has had a major impact upon the education of many other health care professionals. Through its programs which began in 1946 when affiliations with medical schools were first initiated, the VA has today become a vast national educational resource.

Now, P.L. 94-581 will hopefully improve optometric care in the same way the 1946 bill improved medical and dental care, by encouraging as many colleges of optometry as possible to affiliate with VA hospitals and outpatient clinics. We are developing one year residencies for graduates and student rotation residencies of several months. At present, we have three optometric residencies with several more in the final planning stages and seven optometric student rotations now in operation with several more of these also planned.

**ASCO:** As a result of the recent law do

you expect to employ more optometrists?

**Myers:** Well, I certainly hope so, Lou. These things are hard to predict, of course, as you know. One should keep in mind that the law does not dictate to VA hospitals that they hire optometrists. It simply allows a hospital to offer competitive salaries if it wishes to employ optometrists.

I did forget to mention how non-competitive I felt the former Civil Service optometric salaries were. The average salary in private practice is now \$35,000 per year which includes the younger, less experienced practitioners, as well as older practitioners practicing part-time. If I recall correctly, the average annual earnings for an optometrist in the prime of his career is over \$40,000.

Although it is true that private practice generally pays better than other systems, we should also note that the salary rate HMO's provide optometrists is about 70 percent the rate of physicians. This amounts to starting salaries of from \$18,000 to \$21,000 with prospects of earning approximately \$35,000 to \$40,000 after years of service. While not competing with the HMO's or private practice, the schools and colleges do provide for faculty salaries that generally start around \$15,000 for someone recently graduated upwards to the low or middle \$30,000 range for full professors. The Armed Forces, considered to pay the lowest salaries, are still able to pay career optometrists into the low \$30,000 range.

Thus, when you realize that in 1976 the average full-time VA optometrist with 15 years of service earned only \$18,000, you understand why there are so few full-time VA optometrists. In fact, many HMO's start young optometrists at a salary above what our staff is earning after 15 years of service.

**ASCO:** In summary then what would be your prognosis for VA optometry?

**Myers:** I would give it a healthy and favorable prognosis if P.L. 94-581 is fully implemented, and that is primarily my responsibility. I believe optometry can and will make a highly worthwhile contribution to VA patient care which will become increasingly recognized by the agency's top officials. I further believe that the VA is now committed to a strong Optometry Service. Not out of an inherent love for optometry, but because optometry can render a vitally needed form of patient care. I think it will, therefore, continue to develop optometric training affiliations while



increasing the numbers of staff optometrists.

I also see an excellent opportunity for furthering present cordial relationships between VA ophthalmology and optometry and, of equal importance, between VA optometrists and physicians, as well as other providers of health care. Dr. Peters has, I believe, correctly raised the point that optometrists often devote all their time to considering how optometry and ophthalmology should interrelate while ignoring the fact that for many patients it is the referral from optometry to another physician or health care provider that is of equal importance.

The data gathered from our newly developed optometry clinics support this. While a high percentage of referrals are made to ophthalmology, a sizable percentage, in some cases 30 percent to 50 percent, are made to other physicians or patient care services. At the same time, I believe optometry will play an increasingly important role in providing documentation and evaluation services for other physicians and professional staff within our hospitals. As one example, several of our optometry clinics now provide internists with sequential fundus photographs of diabetic patients, as well as grading of hypertensive patients. As the Optometry Service grows in size and scope, I think we will see an increased number of referrals to and from VA optometry clinics.

**ASCO:** One last question—what role do you feel optometry will play in pro-

viding primary vision care within the VA?

**Myers:** Well, I think we can look to what is already being done in the Birmingham Hospital Optometry Service and the Los Angeles Outpatient Optometry Clinic. At each, patients having an eye or vision complaint not due to obvious medical condition or trauma are referred to the optometry clinic for triage. Complete optometric workups are provided with referrals made, as necessary, to the other hospital services.

In a similar manner, ward physicians refer patients to the optometry clinic when there is a question concerning the patient's vision. These clinics mimic the triage systems used by military hospitals and HMO's and thereby allow ophthalmologists, as but one example, to devote more of their time to medical or surgical therapy. By ensuring that optometry provides triage, general examinations, and complete optometric diagnosis and therapy, a very efficient, cost effective and high quality eye care system has resulted. By adding the number

**ASCO:** Thank you for providing us with the above information.

**Myers:** It is completely my pleasure, Lou. On behalf of the VA, allow me to thank you for this opportunity to convey to your members what we are doing to improve optometric patient care. I would also like to express appreciation for the fine support ASCO has given the VA and to say I look forward to continuing cooperation between your member institution and our hospitals.



# The Joint Project Team Looks at Critical Issues For Optometry in the V.A.

In response to recent legislation authorizing the development of a full-fledged optometry program within the Department of Medicine and Surgery (DM&S) in the Veterans Administration, a joint project team of the American Optometric Association and the Association of Schools and Colleges of Optometry was created.

The Joint Project Team developed and presented to the DM&S a statement indicating how the profession felt optometric service might best be further developed for the benefit of the veteran patient. Since 1946, DM&S in the VA has been responsible for the quality of health care available to the veteran. Historically speaking, professional organizations, primarily medicine and lately dentistry and nursing, have contributed their suggestions toward the end of supplying qualified service within the Veterans Administration and utilizing VA facilities for training purposes.

This Joint Project Team report represents optometry's views on delivery and training issues, qualifications and standards for personnel selection and organizational relationships for optometrists in the VA.

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It may help to begin at the beginning with a look at the need for eye/vision services within the VA by reviewing the nature of the veteran population. Of the nearly thirty-nine million Americans that have served in the Armed Forces since the Revolutionary War, it is estimated that 29,459,000 were still alive at the end of 1975. And of course, the nation's veteran population continues to increase. Almost 90% of the nation's veterans alive today served in the military during periods of armed conflict or war.

The oldest living American veterans are those who fought during the Spanish American War in 1898. The youngest, of course, are the Viet Nam veter-

ans. The average age of these men and women on June 30, 1975, was 45.9 years of age. It is now estimated that almost 45% of the population of the United States are potential beneficiaries provided for under provisions of various veterans laws. At the end of fiscal year 1975 there were also 3.8 million dependents of deceased veterans.

In order to learn more about the type of U.S. veteran who seeks health care from VA hospitals/clinics, the School of Community and Allied Health Resources at the University of Alabama in Birmingham, conducted an eighteen month VA-sponsored investigation. The authors studied the patient population in the Birmingham VA Hospital which is affiliated with the University of Alabama and in the Montgomery VA Hospital which is not affiliated with a medical center. An interesting revelation of the study was the frequency of hospitalization during the last ten years in the two hospitals.

Through the various statistics which have been amassed concerning the veteran population, it is possible to predict some of the major health problems which they will face. It is important to

**TABLE 1**  
**Frequency of Hospitalization**  
**During Last Ten Years**

	Zero	1-2	3-4	5-8	9-12	over 12
<b>Birmingham</b>	38.1%	32.3%	11.6%	9.0%	5.8%	3.2%
<b>Montgomery</b>	32.2%	20.3%	23.7%	15.3%	8.5%	0%
<b>Average</b>	35.15%	26.3%	17.65%	12.15%	7.15%	1.6%

note once again that the veteran population is older than the general population, i.e. 78% of all veterans seeking care at VA hospitals are over the age of forty. Through knowledge of the major health problems which this population will face, it is possible to predict the vision needs of the veteran patient.

When the National Center for Health Statistics published a list of chronic afflictions which caused limitation in activity of older persons in 1969, it was not surprising to find that heart conditions, arthritis and rheumatism and orthopedic impairments were listed as the three top chronic health problems. However, the fourth leading cause was somewhat of a surprise, that being visual impairments, which led a long category of chronic disorders.

Utilizing the technique proposed by Dr. Jack Daubs in *"Epidemiological Considerations In Predicting Regional Vision Health Care Needs"*,<sup>1</sup> it can be predicted what the vision needs of veteran patients might be. Dr. Daubs states "the probability of a person having a visual defect is increased with age, therefore, as with death rates, the rates of vision defects of the young cannot be compared with rates of vision defects among the old". On that premise, a table can be constructed which predicts the number of vision examinations that will be needed by the nation's 29.459 million veterans across the country on a yearly basis. The resulting numbers represent the total number of visual examinations annually required for the U.S. Veteran. These figures project that out of 29,459,000 veterans, 11,596,000, or about four out of ten, need vision care each year.

Various studies have been made on vision defects to be found among veteran patients. In 1976, examinations were made by R.N. Kleinstein, and R.D. Newcomb<sup>2</sup>, in which they examined almost 1,500 optometry service records which had been collected over a two and one-half year period of time at the Birmingham VA Hospital. These records indicated that over 70% of the pa-

tients which had been examined required spectacles or changes in their current prescriptions in order to maximize their vision performance. Almost half of the patients had not received any vision care within the prior three years of their examination by the optometry service and 12.4% indicated that they had never received complete visual analysis.

Further, in 1976, Newcomb<sup>3</sup> examined a random sampling of veteran patients who were visually asymptomatic when arriving at the VA hospital in Birmingham. Newcomb found that over half of them needed either prescription lenses which they would be obtaining for the first time, or needed a significant change in their present prescription.

In 1975, Dr. Kenneth J. Myers<sup>4</sup> found a substantial difference between the ocular disease/injury rate among veteran patients as compared to the general population nationally. While noting the difficulty in finding exact data on visual impairments because the definition is rarely consistent from one study to another, Dr. Myers<sup>5</sup> projected that from 41,448 to 54,912 veterans are legally blind, from 127,908 to 130,004 are unable to read newsprint and from 373,867 to 663,828 have impaired sight.

A rather astonishing statistic was reported by Dr. G. Selvin<sup>6</sup> in 1977 in a report from the Los Angeles VA Outpatient Clinic. Dr. Selvin noted that 31.54% of his patient population had ocular disease. "Even though the ophthalmology outpatient clinic is operating at full capacity", he reported "there are still a great deal of previously unscreened eye problems existing among our patients." He stated that of the 329 patients screened during a one month period, 323 required some type of vision therapy.

From the foregoing it can readily be seen that there exists a large need for vision/eye services among the veteran patient population. Since, as we have noted, it is possible to predict that one

out of every two veterans now entering a VA hospital or clinic has a vision problem that is correctable within the scope of optometric practice, it is obvious that optometry should function as a member of an interdisciplinary team to meet the health needs of these veterans.

The report, taking these facts into consideration, then turns its attention to a protocol of optometry service in the VA. The following classifications are generally considered services which an optometrist can provide: **1.)** ambulatory clinical services, **2.)** triage for asymptomatic ambulatory patients, **3.)** triage for ambulatory patients with visual symptoms, and **4.)** consultation and documentation for house staff for inpatients.

In the first of these, ambulatory clinical optometric services, the veteran patient would be given a comprehensive eye/vision examination when presenting himself to the optometric service. Treatment for the patient would include prescriptions for visual aids and/or referral for treatment beyond the scope of optometric service. Table 2 shows the optometric service outcomes which are predictable for an ambulatory clinic.

The statistics that are presented in Table 2 indicate major vision problems, chief among them being restricted or impaired vision at the reading distance (near), another being blurred vision at distance.

In the former group, significant improvement was obtained from 91% of the patients and in the latter group 64% obtained significant improvement. The statistics presented also show that 36% of this population had either ocular manifestation of systemic disease or ocular disease. Half of these patients were considered requiring referral to other health professionals in the hospital.

Another area in which optometrists could provide services to veterans with predictable outcome would be triage for asymptomatic ambulatory patients. In this area, the VA optometrist would be used to identify those veterans who might have a vision problem which was either unknown or unrecognized by the veteran himself. A high degree of these problems makes such a service extremely desirable. These services will identify those who are in need of vision care and those who require a referral to other services for diagnosis and treatment.

The obvious need for triage for ambulatory patients with visual symptoms is that such a service can direct the patient to the most appropriate care as needed thus conserving valuable health



manpower resources which can be more useful elsewhere. There is a very high rate of confirmation of the tentative diagnosis for these ambulatory patients which indicates that this service is an effective utilization of optometrists.

Optometry should, of course, be utilized by the house staff of the VA hospitals and clinics to provide consultation and documentation regarding vision problems. In this manner optometric services can interrelate with a large number of other services to the ultimate benefit of the veteran patient.

The preceding paragraphs suggest the predictable outcome if optometry were to intervene in the health care services provided to the veteran patients. These are projections for the future, however. At this time let us turn to the existing programs with their opinions for development in the future.

At the present time, the VA is making inadequate use of optometry. Larger numbers of optometrists are needed to care for the ever increasing number of veterans that have unmet vision needs, while those optometrists that the VA does employ are not used to the full extent that their knowledge and skill could permit. In 1976, there were only nine full time optometrists, 22 part time optometrists, and 33 attending/consulting optometrists in the VA. There were also only seven affiliated training programs for optometry students in 1976, as well as only three accredited residency positions for optometry graduates. The statistics show that while there are 550 optometry officers vs 220 ophthalmology officers in the Armed Forces

**Through the various statistics which have been amassed concerning the veteran population, it is possible to predict some of the major health problems which they will face.**

hospitals and clinics, the VA employs 100 full-time equivalent ophthalmologists, but only 17 FTE optometrists.

It has been pointed out that optometry in 1976 faces the same problems that were faced by physicians in 1946 under the Civil Service Commission. At this time, the Civil Service Commission does not even have a list of eligible practitioners, and the present salary structure is such that optometrists are not applying to the VA or accepting appointments. Additionally, a random sampling of VA optometrists throughout the United States indicated that there were very few protocol statements on a local level for optometric services with the result that quality and scope of vision care services are variable throughout the agency. There is an imperative need for national guidelines regarding salaries, lines of responsibility and some type of uniform organizational structure if comprehensive vision care is to become a reality.

In the manpower training area, there are 188 residents in ophthalmology who are receiving all or part of their

training by virtue of 141 full-time residency positions in VA facilities. Additionally, there are 33 full-time, 52 part-time and 90 attending/consulting ophthalmologists. In fiscal year 1976, the VA spent approximately \$8 million for ophthalmological training, services and supplies, while at about the same time spending only \$300 thousand for all optometric training, services and supplies.

There are a number of options, however, for development of optometric services within the VA. Each of the twelve accredited schools and colleges of optometry in the country is near enough to a VA hospital or clinic to provide a valuable affiliation. These affiliations would provide the same type benefits related to optometric services. Such affiliations would enhance training opportunities, but more importantly, improve the quality of vision care services provided the veteran patient.

Further opportunities for optometric service development lie in the three Blind Rehabilitation Centers which the VA runs, with a fourth center to be constructed in 1978. Though two of these centers have optometric consultants, their programs could be expanded. Each of these facilities also presents a unique opportunity for the use of the optometry service to provide vision care for these veterans, as well as to provide special training for the professional optometry student.

### Optometric Services—A Protocol

It is painfully obvious that there are not only an inadequate number of optometrists in the VA, but those who

**Table 2**

Presenting Condition	Number	Refractive Correction				Special	Referral
		No Rx	Rx > 20/40	Rx < 20/40	No Improv.	Low Vis. Aid	Other Service
1. Visual Acuity (Distance)							
a. Normal (20/15 - 20/25)	250	105	145				
b. Restricted (20/30 - 20/50)	468		413	23	32		
c. Impaired (20/60 - 20/150)	210		136	55	7	3	
d. Legal Blind (20/200 - 20/1000)	68		27	24	16	1	
e. No Useful Vision — Total Blind	13				13		
2. Visual Acuity (Near)							
a. Less than 20/40 near	691		583	72	26	10	
3. Binocular Coordination							
a. Signif. heterophoria	49		49				
b. Strabismus	47	46					1
4. Organic Problem — Ocular disease or ocular manifestation of systemic disease	372	186					186

\*Based on random sample of 650 of 2900 patient charts VAH Bham, which allows for a sampling error of 2.7. Comparable data obtained VAOC LA.

\*\*Numbers do not add to 1000 because more than one condition may be present for each veteran.

are present are being utilized well below their maximum potential. It is, therefore, important for the VA to begin to develop service protocols for staff optometrists to allow them to maximize their level of knowledge and skills in providing services to the veteran patient.

For the most part, optometrists serving veterans in the VA facilities had had to function without any kind of formal statements of duties, functions, responsibilities or limitations. Further, opportunity for the training of optometrists in VA facilities is a recent occurrence, and because of the lack of such programs and the lack of clear Central Office direction, each new program has had to conform to the interests and concerns of local facility administrators. This has led to fluctuations when the administrations changed, and of course, variations in the protocols which were negotiated in this manner.

The proper protocol for the services of an optometrist should be related to his knowledge and skills, and, therefore, his educational qualifications. The laws regulating the practice of optometry must be considered, as well as the availability of other related services, including the equipment available in a facility to carry out the optometric procedures; all considered in light of the needs of the various veteran patients.

With the passage of P.L. 94-182, Congress mandated a study of the services of optometrists as they related to the needs of cataract and aphakic patients. The study, administered and prepared by the Bureau of Health Manpower in the Health Resources Administration, was submitted to Congress in July, 1976. There were four optometrists, three ophthalmologists, and two public representatives who provided professional consultation for the report. Though primarily aimed at patients with cataract and aphakia, many of the conclusions of this study apply to the establishment of a proper protocol for optometry within the VA. This published report was entitled "Report to Congress: Reimbursement Under Part B of Medicare for Certain Services Provided by Optometrists".

In the aforementioned report the Institute of Medicine of the National Academy of Sciences defines an optometrist as the "health professional that performs eye examinations to determine the presence of visual, ocular or neurological abnormalities, and prescribes lenses, other optical aids, or therapy, such as eye exercises to enable maximum vision. Optometrists are trained to

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recognize disease conditions of the eye and ocular manifestations of other diseases, and to refer patients with these conditions to the appropriate health professionals."

The HEW report goes on to state that the definition, as well as available data on the uses of optometric services underscores the role of the optometrist as a provider of primary health care services. The role for the optometrist, then, is to function as the main contact within the health care system for individuals with visual problems, to include certain of those who have conditions that would need referral to other health practitioners.

The HEW study came to some other reasonable conclusions. The study group found that the services that an optometrist performs correspond in many areas to those services currently reimbursable under Part B of the provisions of Medicare when they are provided by ophthalmologists or other doctors of medicine. These include prescription of lenses, vision training, rehabilitative services, as well as post-surgical monitoring of referred patients. The study further concluded that optometry is qualified to provide a broad range of services that go beyond the mere provision of eyeglasses and refraction. In regard to detection and diagnosis of disease, the report stated "that optometrists, in general, are qualified to provide services for the detection and preliminary diagnosis of ocular disease and ocular manifestation of systemic disease."

The Medicare study also touches on a protocol for optometric services which, the report states, should rely upon the educational qualifications of the optometrist. In discussing optometric education, it notes the curriculum and clinical training received in the various schools of optometry; outlining the curriculum elements that an optometry student is schooled in, as well as observing that the students are taught in clinical settings under supervision with a variety of patients.

Optometrists are prepared by educa-

tion and training to provide vision/eye care services. An essential element to the appropriate use of optometrists within any system is a protocol statement which will delineate, as well as assure uniformity of these services to be provided by the optometrist to the patients in VA facilities. The protocol that was recommended by the Joint Project Team is that currently in use at the Birmingham VA Hospital.

### **Recommended Operating Procedures**

#### **A. Outpatients:** The Optometry Clinic will:

(1) Provide triage service for those patients with ocular and/or vision complaints.

(2) Supply all services within the scope of practice of optometry and the capability of the clinic to patients in need of such services.

(3) Refer directly to Ophthalmology those patients suspected of having ocular disease and/or ocular trauma.

(4) Refer back to the admissions area, with impressions and recommendations, those patients suspected of having systematic disease.

#### **B. Inpatients:**

(1) Ward physicians may refer patients to the Optometry Clinic, for services within the scope of practice of optometry and the capability of the clinic, by written request for such consultation.

(2) The Optometry Clinic will supply such services and report directly to the ward physician. If further consultation is desirable from Ophthalmology or other services, such referrals will be made only with the approval of the ward physician.

#### **C. Recording:** All diagnostic results and recommendations will be included in the patient's medical record.

#### **D. Treatment:** Treatment offered by the Optometry Clinic will include:

(1) The prescribing and employment of ophthalmic lenses, prisms, frames, ophthalmic aids and prosthetic materials.

(2) The prescribing and employment of contact lenses.

(3) Administering visual training, orthoptics and pleoptics.

(4) Providing advice regarding environmental factors which influence visual performance, safety and comfort.

Prescribing of drugs for the medical treatment of eye diseases or the performance of surgery will not be offered. Drugs may be stocked and used for diagnostic purposes within the Optometry Clinic.

#### **E. Optometry Services:** See Attachment.

#### **F. Hours:** Services are available during normal duty hours.



## Recommended Optometric Services

- A. *Vision Screening*
- B. *Eye Health Evaluation*
  - Ophthalmoscopy
  - Bi microscopy
  - Visual Field Studies
  - Tonometry
  - Color vision test and consultation
- C. *Diagnostic and Treatment Services*
  - General Vision Examinations
    - Objective and subjective refraction
    - Binocular function tests
    - Accommodative facility and ranges
  - Contact Lens Services
    - Corneal, scleral, cosmetic (prosthetic)
    - Including care of aphakic
  - Aids for the partially sighted
  - Aniseikonia evaluation
  - Ocular prosthetics—artificial eyes
  - Visual Performance Problems
  - Visual Training and Orthoptics
  - Ocular Motility Evaluation
  - Dispensing services
    - Lens design
    - Routine and special frame design
    - Verification and dispensing
- D. *Consultation and Documentation*
  - Occupational visual requirements analysis
  - Eye safety consultation
  - Photograph—fundus and anterior segment

## Qualification Standards For Optometry

The limited number of O.D.'s within the VA can, additionally, be traced to the career salary levels offered there, as well as the entry level and promotion qualification standards. In order to improve the competitiveness of optometrists' salaries, optometrists have been legislatively removed from the Civil Service standards and placed under Title 38 authority with dentists and physicians. Now the question remains as to what the qualifications are that an optometrist must possess in order to be eligible for the five clinical grades specified therein.

It is obvious that an optometrist in the VA should at least be paid a comparable salary to those with similar qualifications who are employed by the schools and colleges of optometry, HMO's, the military and private practice. With regard for the inequities now present in the Civil Service salaries and grades within the VA, it is difficult, if not impossible to recruit and retain qualified optometrists. Further, the Joint Project Team is not convinced that an overly detailed and restrictive qualification standard is the answer to quality assurance for the VA optometrist. Qualifica-

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## The role for the optometrist, then, is to function as the main contact within the health service system for individuals with visual problems . . .

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tion Standards to be established within Service should be as simple and direct as possible based on the clinical qualifications, education and experience of the optometrist.

By analogy, the project team finds appropriate the qualification standards that are used for dentists in the VA and suggests these simple, direct clinical standards as the overall requirements for appointment as an optometrist within the DM&S. It is felt that similar standards, once approved, should be applied to those optometrists who are presently employed either full-time or part-time, whether both attending or consulting regardless of what their present classification is under the Civil Service.

## Organization of Optometric Services

The fact that such optometrists who have been employed in professional service roles in the VA for many years, variously report to the Chief of Staff of the hospital, to the Chief of Surgery, to the Chief of Ophthalmology or are simply unaware of any specific reporting relationship is further indication of the need for organization of optometric services.

Even with the passage of P.L. 93-82, which created a Director of Optometry, there was some confusion as to whom the (newly designated) Director should report within the Central Office. He was first placed under the Prosthetics Division of the Surgical Service, and later under the Chief of Surgery. However, after the passage of P.L. 94-581, an Optometric Service (theoretically equal status with Surgery and other services) was created in the DM&S and, therefore, a Director of Optometric Service in the Central Office (VACO).

There remains a great deal of concern as to the proper organizational placement of the Director of Optometric Service especially in the field. The issue has two distinguishable elements. Both the AOA and ASCO feel that the Director of Optometric Service (VACO) should report to the Assistant Chief Medical Director for Professional Services. In fact, during the writing of this report, the re-

porting relationships of that Director have been changed from reporting to the Chief of Surgery to reporting to the Assistant Chief Medical Director for Professional Services (ACMD).

The second issue is more complicated, that being the kind of reporting relations optometrists in VA field stations should have with their local administration. Due to existing service arrangements, the size of the programs, and the existence of affiliated education programs, several alternatives are possible. However, again, both ASCO and AOA believe that optometrists in Veterans Administration hospitals or clinics should report to the Chief of Staff of the hospital or clinic for their patient care services.

Those programs which are clearly affiliated involve large numbers of full-time, part-time attending or consulting optometrists and optometry students should be designated Optometric Services and have a Chief of Service who would report to the Chief of Staff of the hospital or clinic. This autonomy then assures that these services are responsible for their budget, staffing, equipment, patient services reporting, and the educational aspects of affiliation.

At the present time, most optometrists employed by the VA report to the Chief of Staff of their hospitals or clinics and the Project Team feels that they should continue to do so. Those not reporting in this fashion should be changed to this formulation. In the case of field stations which are staffed by a very small number of persons, the designation of "section" rather than optometric services is acceptable. However, the optometrists responsible for this section should continue to report to the Chief of Staff of the hospital or clinic.

To further develop organized optometric services, some consideration has been given to joint eye clinics which involve both optometrists and ophthalmologists who would serve as a vision eye care team. While this concept is theoretically sound, it is most difficult to carry out on an organizational basis. Optometrists that serve in the VA normally provide an independent service and normally refer to other professional services more than they do to ophthalmology. It is suggested that such teams could be established as special experimental programs which would be subject to review and the approval of the Chief Medical Director.

## Interprofessional Relations

In order to assure accountability and allow for development and growth in

meeting the needs of the veterans, the organizational and reporting relations of optometrists who worked within the VA structure should be clear and distinct from other services as we have noted above. In their interprofessional relations pertaining to their service to patients, research and education, optometrists have traditionally related to many other professionals. In this regard, ophthalmologists are considered to be just one of the spectrum of health service providers with whom they interrelate.

Unfortunately, there is often a significant overlap of the type of services performed by the optometrists and the ophthalmologists in private practice. This kind of economic competition has long encouraged the professional conflict which is concerned with issues relating to education, social programs, etc. However, exemplary programs where one can find the optometrist and ophthalmologist working side by side for the benefit of their patients exist. Often these can be found in military eye clinics and HMOs where there is a type of role definition that prevents or reduces the overlap of the services provided. In these models, the optometrists provide the primary vision/eye care services, and the ophthalmologists provide the medical and surgical treatment for eye diseases and trauma. This arrangement, of course, contributes to the efficient and effective delivery of the vision/eye services to the veteran patient.

Unfortunately, however, when an optometrist has been employed in the VA under the supervision and control of an ophthalmologist, he has frequently and unnecessarily been restricted. In spite of this, where the VA has managed to develop clearly established protocols for the optometric service, exemplary services have developed. We must continue to work towards harmonious interprofessional relations within the VA between optometry and ophthalmology if we wish to continue to provide cost effective service to the patients.

In order to fully utilize optometry to provide the vision/eye care services necessary for veteran patients, substantial resources should be called upon. Since there are obvious restraints on such resources for facilities and operating costs, it is suggested that such plans would be developed over a period of time. There are so many variables involved in the development of a clinic that it is almost impossible to predict the cost with any accuracy. The team, however, divides them into two types of clinics: one for a school-affiliated optometric clinic where the professional optometry student will be trained, and the second for an unaffiliated clinical service. Because of the many variables involved in these situations, operating cost estimates are very difficult to make.

It is felt that to develop a proper optometric service at field stations, the VA will have to begin recruitment of quali-

fied optometrists. A high priority should also be given to the development of affiliated teaching clinics. This will ensure that more optometry students have the experience within the VA, and, therefore, may become interested in professional careers there.

If the VA is willing to implement the suggested protocol, qualifications standards and organizational relations, the joint project team believes that the VA would be able to develop and expand so as to provide an attractive place for professional employment.

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## Joint Project Team Recommendations

### Recommendation I

It is appropriate that the VA-DM&S significantly expand the utilization of optometrists in its hospitals and clinics to provide primary eye and vision care services for eligible veterans, and that, where possible, such programs be developed to include clinical education and services in affiliation with schools of optometry.

### Recommendation II

A standard protocol for optometric services should be developed to provide comprehensive primary vision/eye care services that are directly related to the education, knowledge and skills of optometrists similar to that provided in those hospitals and clinics affiliated with schools of optometry.

### Recommendation III

The Optometric Service should provide on-going review to assure the quality of care provided through participation in the SERP and PSRB programs, and qualification standards and salary scales should be developed to attract highly qualified optometrists to VA service. SERP (Systematic External Review Process) PSRB (Professional Standards Review Board)

### Recommendation IV

The Director of the Optometric Service and the VA develop programs to utilize the knowledge and skills of optometrists in special service and outreach programs.

### Recommendation V

The VA develop affiliated sharing agreements, and contracts for scarce optometric specialists services, with schools of optometry, including the professional and graduate training of optometrists.

### Recommendation VI

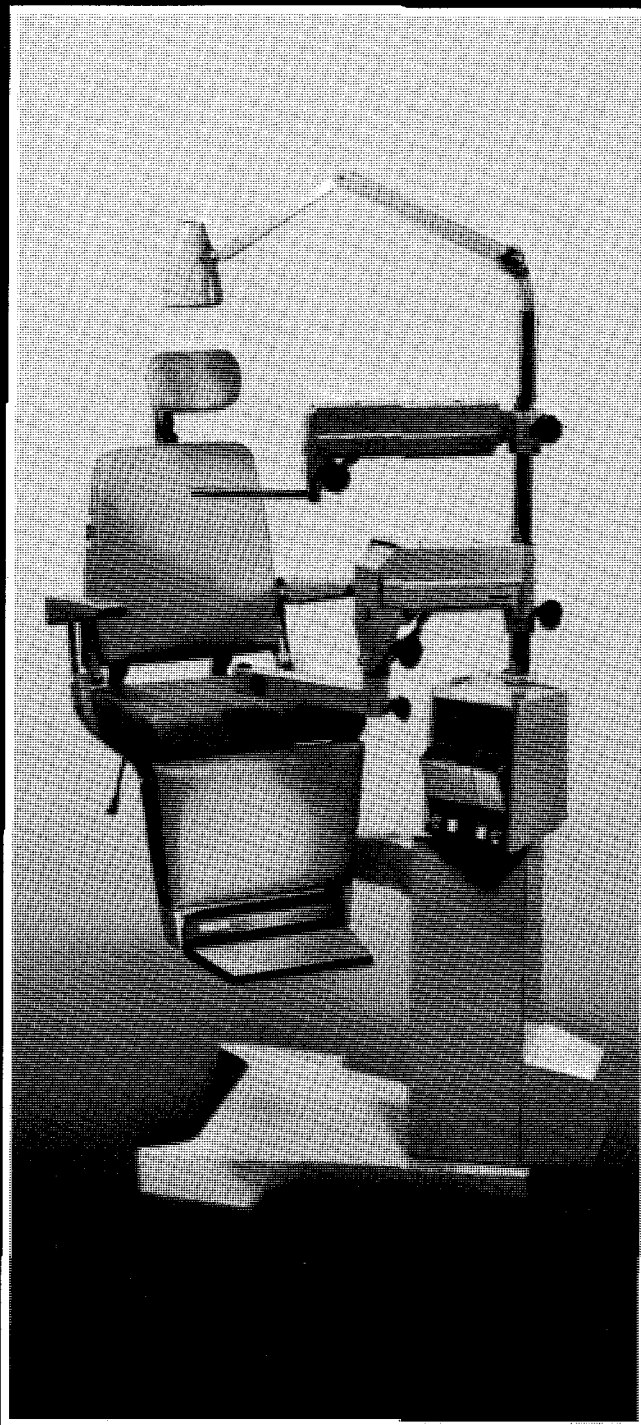
An appropriate organizational and reporting relation be established for optometry that treats the Service and its Director in a manner similar to other services and recognizes the independence and the responsibility of the profession.

### Recommendation VII

There be developed an Optometric Advisory Committee to the VA and its Director of Optometric Service for short and long range planning and policy, with representatives from both AOA and ASCO, and that an optometrist be appointed to SMAG (Special Medical Advisory Group)

### Recommendation VIII

The Director of Optometric Service establish a budget for the orderly development of the Optometric Service, with initial emphasis on affiliated sharing agreements with schools of optometry.



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**Richard Averill on  
ASCO, Education and the Profession**





*Editor's Note: Mr. Richard W. Averill, nine year veteran Washington Office Director of the American Optometric Association, was recently selected to head the AOA's entire staff operation from the St. Louis headquarters.*

**ASCO:** Richard, your recent appointment as AOA Executive Director brings simultaneous happiness and concern as you take on new obligations and leave a post of great influence for the schools and colleges. First, may we ask how you view the responsibilities of your new position?

**Averill:** The responsibilities are quite awesome in the sense that to be the Executive Director of the third largest independent health professional association in the country brings to light the tremendous amount of effort this profession must make to assure that primary optometric care is rendered in this country. I am looking forward with confidence to being able to maintain a strong and viable independent optometric profession.

**ASCO:** Will you continue to have a close working relationship with the Washington Office in matters that are so familiar to you?

**Averill:** Well, having been the Washington Office Director of the American Optometric Association for over nine years, I think I will bring to the position of Executive Director a thorough understanding of the tremendous needs and priorities that the staff and the volunteer structure have in dealing with federal government issues, both from a legislative standpoint, as well as from the standpoint of implementing the laws which Congress enacts. I am confident, therefore, that we can maintain a viable government relations program while I am the Executive Director.

Given the St. Louis operation and their tremendously capable staff, I am sure that we can meld a well-coordinated team with both the St. Louis and Washington offices concentrating on priority areas.

**ASCO:** Do you plan on making any major changes in the organizational structure?

**Averill:** I think any viable organization continues to stay alive by responding to the demands of current events and of projections as to where that particular organization should be. Until I am installed as the Executive Director, I cannot make any firm future assessments regarding reorganization. The Board of Trustees of the American Optometric

Association will make sure that our organization is responsive to the needs of its membership, and the needs of the optometric educational institutions so that we can maintain the dynamic aspects of the profession of optometry.

**ASCO:** If the question of moving or consolidating the St. Louis and Washington offices comes up again, will you look on the issue with any new perspective?

**Averill:** As the Executive Director, I would keep an open mind as to where the organization should be housed. From the last study I know that the Board of Trustees is continuing to take under consideration the Association's future needs. I think we will have to proceed from there.

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**Without the assistance  
of ASCO in the legislative  
and administrative  
agency area,  
this profession could not  
have gone as far as it has  
in such a short  
period of time.**

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**ASCO:** Will you make any administrative changes in the Washington Office after you begin your term as Executive Director?

**Averill:** I think the Washington Office has to be responsive to the needs of the membership, and I think it can, like any other operation, be improved. One of my major concerns is to maintain the primary goal of the Washington Office to be the front line troops for liaison with government agencies, the Congress, the White House, and inter-association activities centered here in Washington. It is not an internal membership structure—it is an external structure, and my concern is to make sure that those outside contacts are maintained and that we eliminate some of the unnecessary internal workings that we have required of the Washington Office staff.

**ASCO:** I take it then that you don't anticipate any major changes, but a continued effort along the same lines.

**Averill:** I see no major changes.

**ASCO:** What about your selection for the new Washington Office Director?

**Averill:** That has been the primary responsibility that I have undertaken, and fortunately I have employed Mr. James W. Clark, Jr., twenty-year veteran Executive Director of the Kansas

Optometric Association to be the new Washington Office Director. Jim is an outstanding individual and will strengthen the AOA staff team effort.

**ASCO:** Do you see a role for ASCO in relation to the AOA Washington Office effort to influence decision-making in Congress and the Administration?

**Averill:** Absolutely. I think that the continuation of the present system of a closely coordinated effort by the Board of Directors of ASCO and the AOA Washington Office through their respective Directors which has worked so well in the past, must be maintained and continued. Without the assistance of ASCO in the legislative and administrative agency area, this profession could not have gone as far as it has in such a short period of time.

**ASCO:** In your opinion, what constitutes the greatest issue currently facing the profession and the schools?

**Averill:** The major issue facing both Associations today is one concerning the ability of the profession and the school structure to determine their own role, their own destiny in the health structure evolving in America. There are many outside influences affecting this profession's future existence and we must be prepared to deal with them. For example, the Federal Trade Commission, the Social Security Administration, and the Department of Health, Education and Welfare are daily making decisions which affect the practice of optometry. Further, third party payment programs where labor unions and employers are making decisions on prepaid vision care programs have a definite effect on this profession. AOA is aware of these forces, and therefore, I think, can be ninety percent effective in guiding them so that the profession can make its own decisions as to 1) how it can render the best possible vision care to the American people and 2) how education should be undertaken to continue a viable profession.

**ASCO:** What do you feel is the single greatest accomplishment of the Washington Office during your tenure?

**Averill:** There is not just one; I think we have had nine years of continuing successes building upon each other to ensure that optometry remains a primary care profession. Without the membership involvement, however, some of these positive accomplishments could not have been made. It is a great credit to the optometrists who are dedicated to this profession to have given so much, so fast.

# A Survey of Attitudes of Optometry Instructors

By Lester E. Janoff

Each fall young people arrive in droves to begin the study of optometry at 13 optometry schools across the nation. By and large, they look forward to this new experience and they eagerly await the day when they can call themselves optometrists. They have come because of varied motivations but all have come to learn. Some go on to become great practitioners or laboratory scientists while most become the competent bulwark of the profession. Very few fail to reach the level of minimal competence considered necessary to serve the community adequately.

Unfortunately, there are some who leave their institution after four years of education with their curiosity stifled, their enthusiasm diluted, and their thirst for knowledge diverted. Why is this so? Certainly, events associated with their education must have helped shape such an attitude. Intelligence alone does not insure that a student will possess a favorable attitude toward learning. Strangulation of the willingness to

learn could result from repeated insensitive teaching behavior, distractions, unrealistic demands upon the student, excessive time devoted to irrelevant details, and a host of other thoughtless actions. Some of these impediments to learning might derive from an institutional policy, while others might be the result of the personal attitudes of optometric educators.

Of particular importance is an educator's philosophy, for it can affect the way in which one structures or controls the learning experience. Not only do we rarely know the attitudes of our educator personnel, but admittedly, these attitudes are difficult to evaluate.

An attempt to document the attitudes of educator personnel has never appeared in the literature of optometry. Therefore, the question we asked was, "What are the attitudes of some influential optometric educators as determined by a short written survey employing a simple rating scale"? and "How does their measured attitude correlate with the educator's personal perception of his own attitude"?

## Method

In mid-January 1975, the Association of Schools and Colleges of Optometry (ASCO) funded the first teacher's institute in conjunction with the Association of Optometric Educators (AOE) on the campus of Southern California College of Optometry, Fullerton, California. Representatives from 11 United States optometry schools and one Canadian school, and invited guests were present at the meeting. Some schools sent more than one representative.

On the second day of the three-day program, an attitudinal survey was given to the assembled group and 15 completed forms were returned. They were coded and unsigned. After completing the survey, the respondent was asked to rate himself in four general categories.

*Lester E. Janoff, O.D., M.S.Ed., is coordinator of Curriculum at Pennsylvania College of Optometry.*

The statements in the survey were constructed to sample attitudes in these categories and this fact was unknown to the respondent. In this way, we developed both measured and self-evaluations in the same general categories. All respondents were optometric faculty responsible for a significant portion of their schools didactic optometry program. The survey was an abbreviated modification of one developed by Rosinski and Miller (1962)<sup>1</sup> and used on medical educators. The four categories were based on an opponent theory developed by McGregor<sup>2</sup> and consisted of the following:

A		B
Democratic	←————→	Autocratic
Critical	←————→	Complimentary
Liberal	←————→	Traditional
Appreciative	←————→	Depreciative

The measured attitudes were scored on a five point scale and a category index (CI) developed by the formula

CI = category A minus category B. If a positive score resulted, this meant an attitude more in category A than category B, while a negative score placed the attitude in category B rather than category A. A zero score was considered neutral and, therefore, not representative of either category.

## Results

Table 1 presents the raw data for the 15 respondents for measured and self-evaluation in the four categories. Table 2 summarizes the scores on the four categories. The measured values show that: 1) Most of the group appeared to be democratic (86%) and of these, 31% are highly so. Only one member is autocratic and he appears to be very much so. One member is neutral. 2) Most of the group appear to be critical (73%) and of these, none are markedly so. 3) Most of the group appeared to be liberal (53%) and of these, none are highly so. Again, of the large group which constitutes the traditional, none

**Table 1. Individual Test Score Compared to Self-Perception**

RESPONDENT	DEMOCRATIC + AUTOCRATIC -	CRITICAL + COMPLIMENTARY	LIBERAL + TRADITIONAL -	APPRECIATIVE + DEPRECIATIVE -	SCORE TOTAL
A	+4/+	+3/+	-3/+	0/+	+4
B	+7/+	+7/-	+9/-	-5/+	+18
C	+14/+	+10/+	+6/+	+10/+	+40
D	+13/NA	+7/NA	+9/NA	+5/NA	+34
E	+8/+	+2/-	0/+	-3/+	+7
F	0/-	+2/-	-5/-	-12/+	-15
G	+14/+	+9/-	+4/+	+10/+	+37
H	+10/NA	+5/NA	+6/NA	+10/NA	+31
I	+8/NA	+2/NA	+1/NA	0/NA	+11
J	+14/+	+5/-	+3/-	+3/+	+25
K	+7/+	+7/+	+5/+	-3/+	+16
L	+7/-	-5/+	-5/+	-2/+	-5
M	+5/+	-2/-	-1/-	0/+	+2
N	-12/-	-9/NA	-6/NA	-12/NA	-39
O	+7/-	-5/-	-3/-	0/+	-1

NA = NO ANSWER  
MEASURED/SELF EVALUATION

appears to be highly so. 4) More of the group are depreciative (40%) and almost an equal amount are appreciative (33%). In this category there appears the largest neutral group (27%).

Table 3 lists the mean values for the group and may be considered as an expression of the group's characteristics. It shows the average person being democratic, only slightly critical, liberal, but neither appreciative nor depreciative. A point bi-serial correlation was performed on the data to see if there was a relationship between measured and self-perceived attitudes (Table 4). Only the democratic/autocratic category produced a significant correlation coefficient, ( $r = +0.57$ , significant at the 0.05 level). All other category coefficients were very low indicating that there is little value in using the one measure to predict the other.

A look at the individual scores for measured attitudes when compared to the self-perception is enlightening. First, four instructors did not rate themselves. This was a purposeful omission since all were strongly encouraged to do so when the group had finished the questionnaire. It should be noted that one who did not complete the self-evaluation was respondent "N" (see Table 1), who had the highest negative scores and the lowest score in all four categories, although respondents "D" and "H" also did not answer and they were close to the positive extremes. Respondent "C" is at the other extreme from

**Table 2. Summary of Scores for Group**

DEMOCRATIC	13 = 86%
AUTOCRATIC	1 = 7%
NEUTRAL	1 = 7%
RANGE	+14 to -12
CRITICAL	11 = 73%
COMPLIMENTARY	4 = 27%
RANGE	+10 to -9
LIBERAL	8 = 53%
TRADITIONAL	6 = 40%
NEUTRAL	1 = 7%
RANGE	+9 to -6
APPRECIATIVE	6 = 33%
DEPRECIATIVE	6 = 40%
NEUTRAL	4 = 27%
RANGE	+10 to -12

respondent "N". He is the highest in three of the four categories and is accurate in his perceptions of himself.

Three people—"A", "M", and "O"—hover around neutrality and seem to not be strongly moved in any direction (except for "O" who appears to have a democratic disposition). Self-perceptions generally lack accuracy as shown by Table 5. More than 33% of the group saw themselves as autocratic, yet scored democratic. Almost half of the group were erroneous when their self-perception was compared to their measured score on the complimentary/critical and liberal/traditional categories. From

the comparison in the appreciative/depreciative category, it is possible that some respondents misunderstood the concept involved and thus viewed themselves inaccurately (note "F" on Table 2 who had the highest depreciative score but who listed himself as appreciative).

### Discussion

To quote Mager,<sup>3</sup> "One of the important goals of teaching is not only to prepare the student to use the skills and knowledge he has learned, but also to stimulate him to learn more about the subjects he has been taught. One way of reaching this goal is to send the student away from the learning experience with a propensity to approach rather than avoid, the subject of study." If optometric educators can do this (and there is no reason why they cannot), they will have met the real challenge which is to create the type of optometrist who will continue to learn throughout life.

The first step along this road is to define the attitudes about optometric education our optometric educators hold, so that we can analyze these in terms of the educational effectiveness of such beliefs. The attitudes in the categories measured in our survey, although certainly not generalizable to all optometric educators, suggest student morale problems encountered in some optometry programs may be in part attributable to attitudes about education

some optometric educators hold. Just as important, some of these educators may have no idea, or an erroneous one, of what their attitudes are. Defining and becoming aware of these attitudes should precede any attempt at a radical change in some of our current educational practices.

## APPENDIX A - EXAMPLES

**Democratic Statement** Teachers have a responsibility for being sensitive to students' physiological and emotional needs.

**Autocratic Statement** The rigid use of authority in a classroom develops student respect for the teacher.

**Critical Statement** There is a great need for the improvement of instruction in Optometry schools.

**Complimentary Statement** Compared with other professional schools, optometry schools are doing as good or better a job of educating their students.

**Liberal Statement** Optometric education should do away with the "ground covering complex" in relation to subjects being taught.

**Traditional Statement** Course offerings in optometric education should be completely prescribed by the optometric faculty.

**Appreciative Statement** Student

evaluation of instruction can aid the teacher in becoming a more effective teacher.

**Depreciative Statement** Most students enter optometry school because of the money they will make.

## REFERENCES

1. Rosinski, E.F. and George E. Miller, "A Study of Medical School Faculty Attitudes," J.M.E. 37 (2): 112-123, February 1962.
2. McGregor, Douglas, *The Human Side of Enterprise*, McGraw Hill Book Co., New York, 1960.
3. Mager, Robert F., *Developing Attitude Toward Learning*, Feown Publishers, Belmont, California, 1968, p. 5.

**Table 3. Group Characteristics (Means)**

1. DEMOCRATIC	(+7)	MODERATE
2. CRITICAL	(+2.5)	WEAK
3. LIBERAL	(+1.3)	WEAK
4. APPRECIATIVE - DEPRECIATIVE	(+0.1)	NEUTRAL

**Table 4.**

CATEGORY	r	SIGNIFICANCE
Democratic/Autocratic	+0.57	.05
Critical/Complimentary	+0.11	Not Significant
Liberal/Traditional	+0.06	Not Significant
Appreciative/Depreciative	0.0	Not Significant

**Table 5. Accuracy of Self-Perceptions**

**Self-Perception = Measured Score**

(N = 12) Democratic/Autocratic	= 8 (67%)
(N = 11) Critical/Complimentary	= 5 (45%)
(N = 11) Liberal/Traditional	= 6 (55%)
(N = 11) Appreciative/Depreciative	= 3 (27%)



# BOOKS

## Construction and Use of Written Simulations

By Christine H. McGuire  
Lawrence M. Solomon  
Philip G. Bashook

By Lester E. Janoff, O.D., M.S.Ed.

Written simulations have hardly been utilized in the process of optometric education. Their use in the education of other health professionals, although more frequent than optometry, has still been rather limited. Yet the value of the opportunity for the student to perform in a fashion similar to that of the "real world" is acclaimed by educators as most desirable. Possibly one reason for the lack of activity in the arena of written simulations has been the absence of a definitive text that one could use to assist the creative faculty person in developing a creditable product. Most of us involved in trying to develop management problems have heretofore literally flown by the seat of our pants.

The problem solvers have solved the problem by publishing a superb text for the uninitiated which is just as valuable for the dabblers. It is a basic reference for anyone contemplating the production of a written simulation from the creators of the PMP (Practice Management Problem).

Let us note at the outset that the printing is large and clear, the format easy to follow, and the diagrams as easy to interpret as flow charts can ever be. It has truly been designed for a beginner. Incidentally, if that fact turns off a potential reader, just one attempt at preparing a written simulation without prior knowledge, will return him humbly to the text.

The introduction and all of Part I deals with the concept of a written simulation. Even if the reader never progresses beyond Chapter I, he will have benefitted immensely by being aware of what written simulations can do, what they cannot do, and whether they are something that can provide a useful tool that fits his own educational philosophy. Part I of the book is a good

overview of written simulations. Part II gets down to the nitty gritty of the creation. Creating the Opening Scene, Building the Option Segments, and Final Debugging are only a few of the many chapters that are really the heart of the creative process in devising a management problem. There are adequate examples that allow the reader ample opportunity to practice what the authors preach. The coup-de-grace is the last chapter in which the reader is treated to an exercise in debugging a management problem by analysis of a flawed version. The debugged version is now presented for comparison.

Parts III and IV follow, and if Parts I and II represent the heart of management problems, then the section comprising Parts III and IV is the soul. Part III is the interpretation and use of these simulations. The portion about scoring is minimally statistical even though we must deal with the need to make inferences from the data we accumulate about students. The final part (Part IV) I would have to characterize as "advanced creation", since it deals with other, more complex models of written simulation than the simple linear, single problem model most of us begin with. Undoubtedly, once one has mastered the simple models, he will become addicted to written simulations and will more than likely need some direction for the creation of branching, multiple-problem, "mind-blowers".

The book is not very long. Parts I and II total 194 pages. Parts III and IV start at page 195 and end at 301. There are a final few pages of glossary. The book is in soft back and although a price is not available, it should be within reason.

Optometry is in dire need of written simulations in its educational process so that students can be better prepared



early in their education to meet the responsibilities of being a health care professional. Optometric faculty, particularly those in the clinical sciences who function in the classroom, need to know how to structure the learning experience so that real world responsibilities are practiced. The authors of these volumes are the authorities in the field and have generously given us a road map and identified some landmarks. What else need be said?

### Preliminary Announcement Fourth Annual Symposium on Ocular and Visual Development

The Symposium sponsors, the Department of Biology, Temple University in Philadelphia, Pennsylvania, have selected tentative dates of November 3-5, 1977, for its presentation. The major topic, announced by S. Robert Hilfer, Ph.D. will be: "Patterns of Regulation During Ocular Development".

Sessions will include discussions of regulation of retinal size and intraretinal synapses, metaplasia of pigmented epithelium and iris, initiation and regulation of lens protein synthesis, and endocrine control in development. Two sessions will be devoted to contributed papers. Comments are invited.

# ABSTRACTS

## A COMPARISON OF THE PRODUCTIVITY OF WOMEN AND MEN PHYSICIANS

A study entitled *A comparison of the Productivity of Women and Men Physicians* was prepared for the Department of Health, Education and Welfare by Wayne State University faculty as part of a larger study entitled *Practice and Life Patterns of Men and Women Physicians*. The study concentrated on a small sample of Detroit area physicians.

The comparative paper attempts to update previous studies on the productivity of women physicians, showing the amount of time they devote to the practice of medicine compared to their male colleagues, as well as discuss factors affecting the productivity of both sexes.

Comparisons were made between men and women physicians regarding certain demographic variables, medical training, practice patterns, membership and participation in various kinds of organizations, and perceptions of role overload and/or role conflict. Control groups used in the study included male physicians and women "neighbors", all of whom answered the 207 item questionnaire in an interview situation administered by trained interviewers.

Basic findings of the study included information that:

1. 96% of the men and 84% of the women were engaged in medical work at the time of the survey; Only 7% of the women physicians were not working due to reasons of marriage, childbirth and/or child rearing.

2. more men than women felt that there were too many demands on their time or energy with three times as many men as women relating this overload to the pressures of work.

The authors concluded that both women and men physicians work productively, although popular opinion usually indicates otherwise. Utilizing a Medical Work Ratio (MWR), women physicians work 9/10 as much as men physicians do, and significantly more than reported by previous studies.

## National Health Directory

This is a compilation of some 6,000-plus influential health policy and health delivery persons in the nation.

It contains an extensive section on the key Congressional health committees and a complete state-by-state section on all Congressmen and their staff aides, both in Washington and in the district offices (Congressional district maps for each state are included).

A free update is planned for this month dealing with Senate and House Committee reorganization, and future editions will be revised annually.

The book is available only by direct mail for \$19.50. Write: **National Health Directory**, c/o Science and Health Communications Group, Inc., 1740 N Street, N.W., Washington, D.C. 20036.

## VISION AND SPECIFIC LEARNING DIFFICULTIES—PART I THE AUSTRALIAN JOURNAL OF OPTOMETRY, VOLUME 59, NO. 12, DECEMBER 1976

This article summarizes the major portions of a submission by the Australian Optometrical Association to the Australian House of Representatives, Select Committee on Specific Learning Difficulties.

The Australian Optometrical Association undertook the study of learning difficulties in children and the role of vision in the learning process. Since different forms of learning difficulties exist, the Select Committee had defined "specific learning difficulties" in rather broad terms. This study includes references to all ophthalmic professions and their interest in learning disorders.

Formal programs have been established in Australia to study specific learning difficulties and have become an increasingly large part of the pediatric syllabi in the training curriculum of schools of optometry. According to the authors, ophthalmologists have been slow to address the question of vision and learning disorders.

Discussion of the development of the visual process is presented with reference to pre and post-parturition functions. The relationship between vision and learning experts regard as axiomatic that 80% of the information acquired by the brain is acquired through visual channels, is described with emphasis on current thinking of optometrists, ophthalmologists and professional organizations.

The study concludes with statements concerning the role of vision defects in the etiology of learning disorders, the role of optometrists in the care of children with learning disorders, and the determination and care of vision defects among children. It also offers suggestions for further study into the prevention, detection, and remediation of learning disorders.

## **Indiana University School of Optometry:**

The Department of Biological and Health Sciences announces two faculty positions available for September, 1977. Physiologist, graduate degree and research experience in ocular physiology and/or biochemistry of the eye; Ocular pathologist with clinical experience.

Academic rank and salary will depend upon qualifications and experience. Resume and a list of references may be submitted to the Chairman, Search Committee, School of Optometry, Indiana University, Bloomington, Indiana, 47401. Indiana University is an equal opportunity, affirmative action employer.

## **The Indiana University School of Optometry.**

Faculty positions for September, 1977 are available within the Department of Clinical Sciences. Applicants must have a strong background in the clinical practice of optometry.

Academic rank and salary will depend upon qualifications and experience. Applicants should submit a brief statement describing any special training, special interests, or unusual clinical qualifications. Resumes and lists of references may be submitted to the Chairman, Search Committee, School of Optometry, Indiana University, Bloomington, Indiana, 47401. Indiana University is an equal opportunity, affirmative action employer.

**University of Alabama:** Opening for an instructor, Optometric Technician Program, starting June 1, 1977. The responsibilities of the Instructor position will include laboratory and selected lecture presentation, as well as coordination of clinical rotation of Optometric Technician students.

Applicants must have received at least a certificate from an AOA approved Optometric Technician Program. Responsibilities of the position require that the applicant possess skills and knowledge in contact lenses, Keratometry, tonometry, visual fields, dispensing, etc. as provided by these programs. Salary is competitive, based on applicant qualification and experience.

Submit a complete resume to: Melvin D. Shipp, O.D., Director, Optometric Technician Program, School of Optometry, the Medical Center, University of Alabama in Birmingham, University Station, Birmingham, Alabama 35294. The University of Alabama in Birmingham is an Equal Opportunity/Affirmative Action Employer.

## **The School of Optometry, University of California, Berkeley,**

has a full-time position available at the assistant professor level. The School is looking for an individual with the following qualifications: An optometrist with an advanced degree (Masters or Ph.D.); experience in teaching in optometry is desirable; demonstrated ability or potential to identify important research problems in optometric science and to carry out the research necessary to provide solutions to these problems; demonstrated interest in a special clinical area, preferably public health optometry or ocular disease recognition.

Submit complete curriculum vitae and reprints to Dr. Anthony J. Adams, School of Optometry, University of California, Berkeley, California 94720.

The University of California is an equal opportunity employer with an Affirmative Action Program and welcomes applications from women and minority candidates.

## **Illinois College of Optometry:**

One full-time faculty position for 1977-78 academic year in the Division of Visual Science and Optometry. Applicant must have an OD degree and a graduate degree with a background in clinical optometry, the visual sciences particularly in the areas of ocular motility and visual perception, and research.

Two individuals needed for full-time instruction in contact lenses and in patient care clinic instruction. Part-time faculty appointments in patient care clinical instruction and in basic health science curricular administration are available. Evidence of scholarship and teaching ability is highly desirable.

Rank and salary commensurate with experience. Send curriculum vitae and the names of three professional references to: Dr. Morris Berman, Chairman, Faculty Recruitment Committee, Illinois College of Optometry, 3241 South Michigan Avenue, Chicago, Illinois 60616. Equal Opportunity/Affirmative Action Employer.

# 25 Years Later—

## The University of Houston College of Optometry



This year the University of Houston, celebrating its Golden anniversary, capped its remarkable fifty year pattern of growth with the dedication of a \$10 million building for its College of Optometry. The University opened its doors as a junior college in 1927 and became a full four year University in 1934. During the post World War II era a large influx of veterans contributed to its growth as a private university. In 1963 the University became the twentieth member of the Texas state system of higher education.

A new dimension in education came to the campus in 1952 when the Board of Regents authorized a College of Optometry. The Texas Optometric Association figured prominently in the planning, development and formation of the college as well as providing continued support over the years to its many programming endeavors.

As in other university based programs in optometry, the Bachelor of Science degree, now awarded optometry students on completion of their second professional year and upon completion of all university requirements for the Bachelor degree by the College of Optometry was originally awarded by the College of Arts and Sciences. Today the four year professional program offers the O.D. (Doctor of Optometry) degree. The College also offers a graduate program leading to the M.S. and Ph.D. in Physiological Optics.

### Early History

The College of Optometry got off to a shaky start in the early fifties and barely survived two successive years of plunging enrollment. At the time however, interested leaders in the Texas Optometric Association joined with Dean Charles Stewart in raising funds and re-

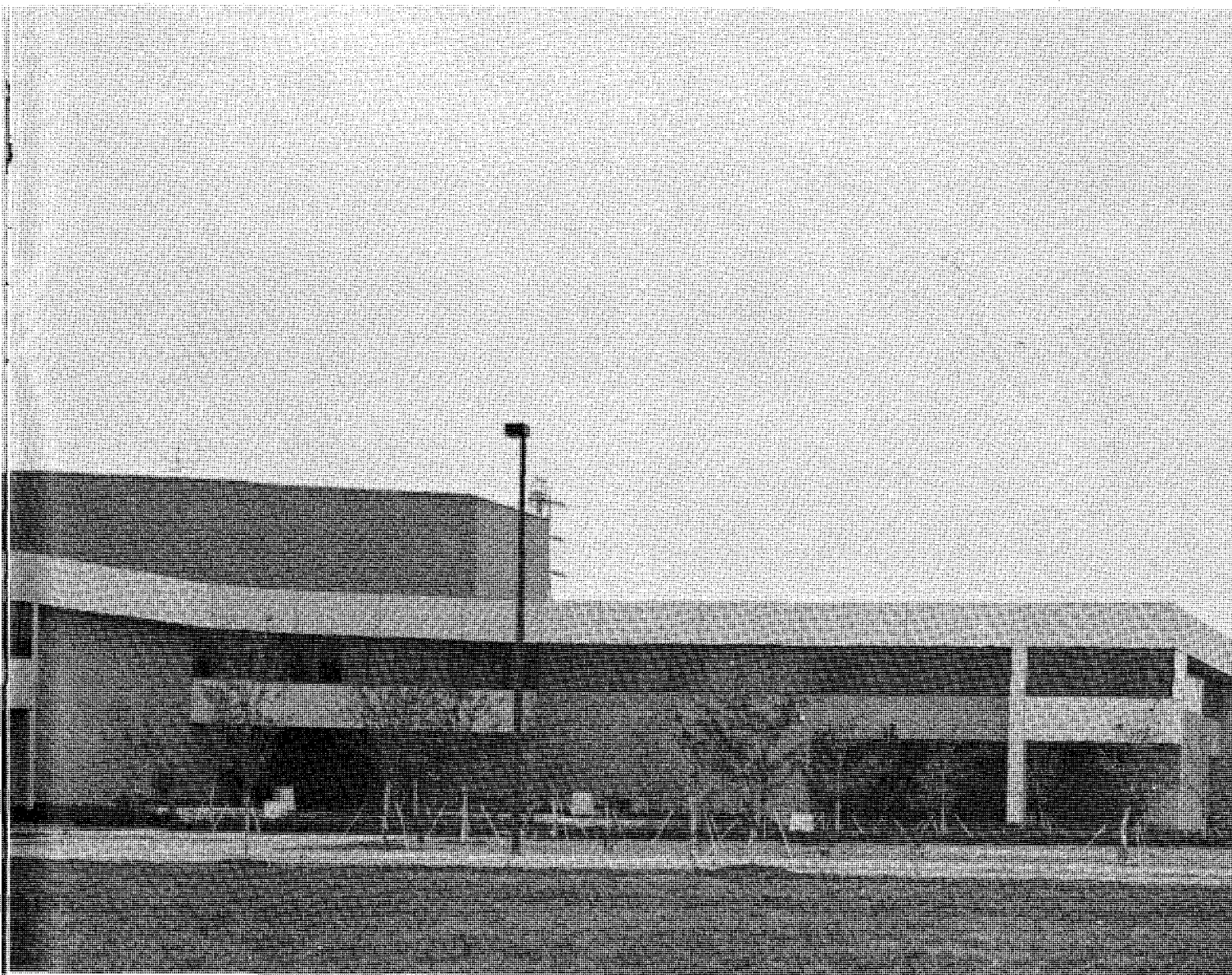
cruiting students to keep the college program alive.

Early classroom and laboratory facilities were provided by a number of academic units on campus. Most recently, the college existed in some renovated temporary military units, patiently awaiting the completion of the new facility.

### Curriculum Innovator

The curriculum too has seen a number of changes over the years, but the university can proudly point to the fact that as early as 1959 the college was introducing freshman or first year students to technical and clinical skills including the basic optometric examination. The college recognized that the students must have abundant experience before they can readily grasp and understand theory, which brought the college to modify the curriculum so that





the student's first semester involved them with optometric tests and procedures.

The college began teaching courses in developmental vision as early as 1955 and pharmacology as early as 1962. Students have rotated through a program of observing ophthalmological surgery since 1974 and have been required to serve an external residency since 1964. The program has continued to grow and prosper until it is one of the outstanding programs in the country.

### **Continuing Education**

The college's continuing education program is an active and vital part of the college activity. The college presented continuing education courses on contact lenses in the late 1950s on a monthly basis. With an increasing interest in vision development, guidance and rehabilitation, the college has presented

at least one program each year in this area. Over the years the faculty of the college has presented almost every optometric subject in the continuing education program.

### **The New College of Optometry Building**

Built at a cost of \$10 million, the College of Optometry Building was financed by a \$5 million grant from the U.S. Department of Health, Education and Welfare, with the matching \$5 million raised from the University of Houston building fund. The college's new facilities include community clinics which can serve 31 thousand patients annually with 20 thousand patients receiving a basic vision examination in the new building.

The three story building contains 135,496 gross square feet, including teaching clinics on the first floor for vi-

sion examination, contact lens, electrodiagnostic, pathology, vision therapy, and low vision, plus a reception area, a dispensary and a business office. The new second floor contains academic and administrative offices, teaching laboratories, libraries, student activity rooms, lecture and seminar classrooms, and a word processing center. The third floor is devoted almost entirely to research. Laboratories, academic support services, research instrumentation, storage, advanced training student offices, and laboratories and animal quarters are found on this floor.

Graduate student areas provide 26 offices and 10 research laboratories concentrated on the upper level of the brand new building. Current enrollment of 324 students is the largest since the college was established in 1952. The final expanded full time faculty of 73 will allow, on the average, 1 faculty

member responsible for about 7 students. In the new building, the enrollment will increase to a maximum of 424, and the new faculty to student ratio includes an additional 45 faculty members.

In his address at dedication ceremonies on March 27, 1977, Congressman George Mahon (D-Texas) congratulated Dean Chester H. Pheiffer and other members of the University community on the completion of a job well done. He added that "tens of thousands of people in Houston and the Southwest will see better, enjoy better health, and share a greater abundance of opportunity and happiness as a result of this facility which we dedicate today." He further noted that federal dollars spent here were used effectively and the public will reap the benefits for years to come. In a lighter view, Mr. Mahon said he was pleased the project had been completed so that he and Regent Davis Armstead could continue as friends.

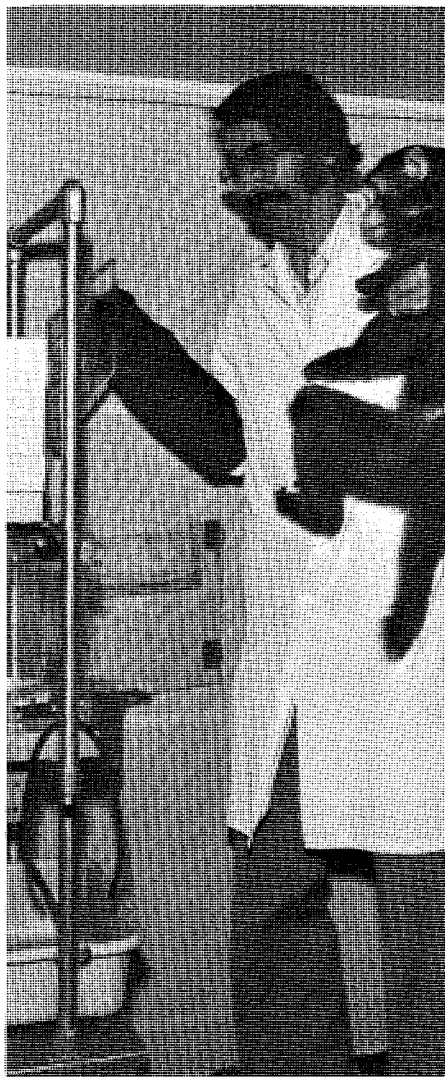
Former Congressman Bob Casey, now Maritime Commissioner, commented that Dr. Pheiffer had spent so much time in his office to acquire funding for the building that he probably still had lint from his, Casey's, carpet on his shoes. Commissioner Casey also noted that much credit was due other Congressmen who actively assisted in obtaining the necessary legislation.

### Service to the Community

The College of Optometry serves a dual purpose in the community. It is a major teaching unit and a regional center for clinical service. The number of patients served by the college will almost double with the new clinical facilities and an additional 10 thousand elementary school students will receive eye/vision screening exams provided by the college.

Special services are also provided annually to the Richmond State School for the Mentally Retarded, the Harris County Juvenile Detention Center, the West End Clinic, several institutions for the aged and the Interdisciplinary Clinic. The Interdisciplinary Clinic of the University of Houston Central Campus is one of the first of its kind in the country. It is specifically designed to train graduate students to coordinate therapy in the different disciplines to help children with learning disabilities. Faculty and students from Optometry, Special Education, Speech Pathology and Psychology are currently teaching or enrolled in the course.

Faculty and students from the disciplines of nursing, pharmacy, social



work, sociology, medicine, and optometry participate in the Public Health Interdisciplinary course.

### Research

Research has been greatly expanded and accelerated in the new facility. Each of the three clinical areas, vision analysis, contact lens and vision therapy, has four research laboratories. There are 29 laboratories for faculty and students including 10 research laboratories for graduate students. Current areas of research include validation and correlation studies involving traditional examination procedures vs automated examinations, studies involving validation of refraction procedures at a remote distance from the patient, studies to improve methods of detection of diseases of the eye, effectiveness of vision therapy, and many other topics, including research in contact lens, corneal topography, diabetic retinopathy, orthokeratology, ultraviolet radiation, electrodiagnoses, amblyopia, stereoscopic vision and developmental neuropsychobiology.

### The Graduate Program

The graduate program is administered and conducted by the College of Optometry faculty. In addition to their own outstanding library facilities, the students have access to the libraries of nearby Rice University, Texas Medical Center and the National Aeronautic and Space Administration. The graduate program in physiological optics also has agreements whereby graduate students may enroll at the University of Houston for courses offered at Rice University, Baylor College of Medicine, the University of Texas Graduate School of Public Health. The graduate faculty includes a wide range of scientific disciplines and graduate students are urged to establish a course track along the areas of his interests.

The program in physiological optics encourages clinically oriented study as well as a core course science oriented research preparation. The university feels that most graduates will be teaching or researching optometric science and clinical science subjects which require emphasizing a core curriculum on research design, technique and methodology with a strong clinical science emphasis.

### Summary and Conclusion

The primary goal of the college has been and is to produce outstanding Doctors of Optometry. Other goals of the college are to live up to its heritage of teaching the broadest scope of optometry and its related services; to remain flexible so that new knowledge and procedures may be developed and incorporated into the spirit of optometric services; to keep abreast of the times and changes in society and health care trends so that optometric graduates may be prepared to provide optimal vision care to the fullest extent and be cognizant of their responsibilities to society and their communities; for all individuals to develop and improve instructional techniques; and to promote research and advanced study in the fields of vision and vision care.

The University of Houston College of Optometry in its brand new facility looks forward to a bright, bright future.

### References

1. University of Houston College of Optometry, JAOA, V39, No. 10, 1968, p 926.
2. History of a Degree, Optical Journal and Review of Optometry.
3. New \$10 Million Facility, Opt. Observer, Vol 2, No. 1, 1977, p 4.

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

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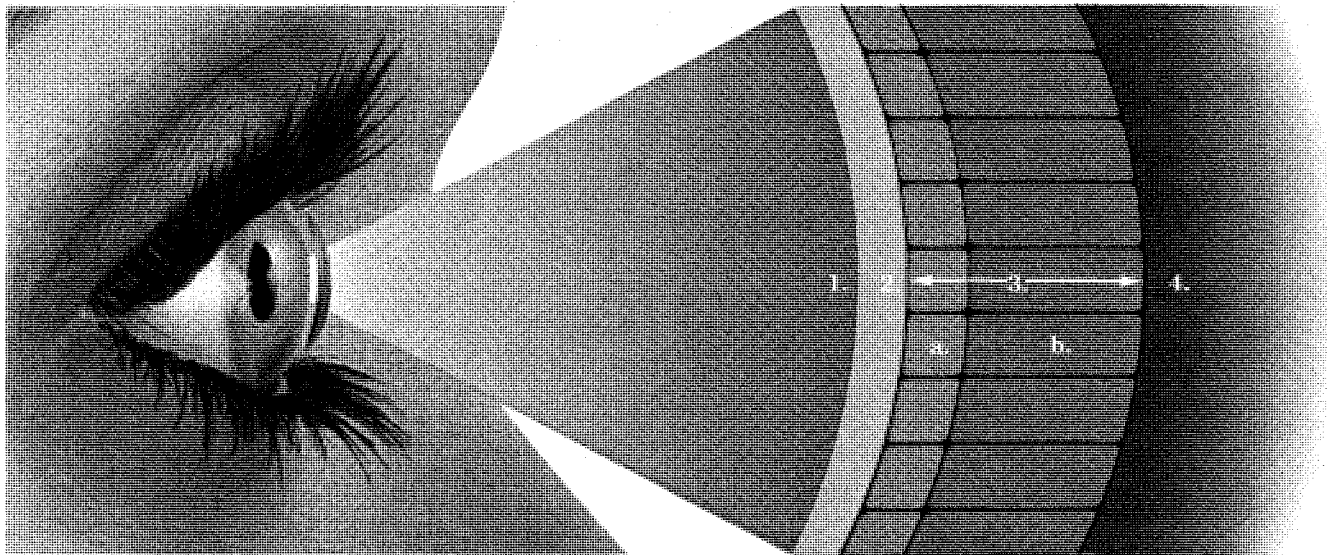
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