Profiles in History: W.M. (Bill) Lyle

CJO

At what age did you enter Optometry and what prompted the decision?

BL

Well, what happened was that some friends of ours knew Ed Bind. Ed was the first Director of the School, before Dean Thompson — actually, he hired Thompson. Anyway, these friends said to him, "We know a young fellow out in the country who we think should be in the program." And when they called me, I said, "What's optometry?" I'd never heard of it. So they said, "Well, it's almost a profession." To me that sounded pretty good, although I'd actually come to Toronto to register in Engineering — a family friend was going to help me pay my way through Engineering School. But when these closer friends told me about optometry, I agreed to take a look at it.

CJO

Were you in Winnipeg at that time?

BL

No, I was living in the little village of Prince Albert, about fifty miles east of Toronto.

CJO

So your concept of optometry at the time was . . .

BL

Nil.

CJO

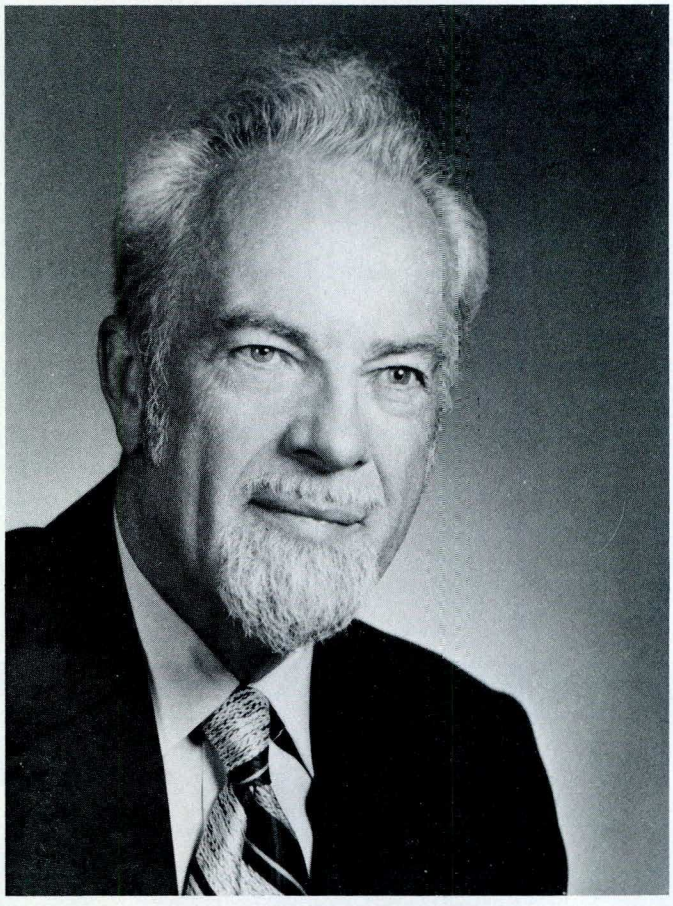
Other than the recommendations of your friends, did you make any attempt to find out anything about optometry?

BL

None of all.

CJO

You took it entirely on faith?



BL

Blindly, yes. There is one other thing. My mother was a public health nurse, and I was brought up in an environment which constantly revolved around health. She ran a sanitarium — she was the first superintendent (as they were called in those days) of nurses in the Royal Victoria Hospital in Montreal, when it opened. The city later gave her a diamond ring and an engraved scroll in appreciation of her years at Vic. So the health field was not a strange one to me. Hypodermic needles, morphine, care of mentally disturbed people — that was regular conversation to me.

CJO

But you had no concept of what you were actually getting into as a student?

BL

None at all. My high school principal in Port Perry had said, "Why don't you go to university?" But I couldn't possibly afford to do so. Don't forget we were in the very depths of the Depression — this was 1933. So these friends in Toronto, who had considered my potential and recommended me to Ed Bind, actually brought the two of us together.

CJO

Did your initial impression of the School and its facilities re-inforce the perception of Optometry as "almost a profession"?

BL

Yes, it did. We were taking biology

with the dental students, physiology and psychology with another group of students, and so on. We took our courses on the University of Toronto campus, and it seemed as if the dentists and optometrists were equal — we had the same biology instructor, and wrote the same exam. So I began to feel that optometry was actually a health-related science.

CJO

Did the fact that the School was so small (it was still at 138 St. George St.) have any effect?

BL

Yes, that was depressing. Mind you, I was a very unsophisticated farm boy, and I really had no knowledge of Toronto. But I did think it was a tired-looking facility, not at all impressive. That old red brick building was not my idea of a very substantial, or even modern, institution.

CJO

What were your first impressions of Dean Thompson and what influences did he have on you?

BL

He was a man with a sense of humour, clearly a man who was humane, in that he recognized the struggles students were going through, and the many problems they faced. And he encouraged me.

I also remember one night I went to play bridge at his house. I had never played bridge before in my life, so Mrs. Thompson suggested which cards to play, and helped me all through the game. Well, I had extraordinary cards that night at Thompson's house, and actually won the prize, something that hasn't happened since.

He was not a man who was domineering. He never seemed to be unfair or unjust.

At that time, Ed Bind was still there, teaching pathology. (Dean Thompson taught physiological optics and Colonel Cooper was an administrator.) In the second year of this (then) two-year program, Ted Fisher, Fred Attridge, Art Stemp and Clark Patterson were clinicians. Don Graham was a student in the year ahead of me, and I believe he became a clinician, as well.

CJO

What about other members of the faculty?

BL

Well Fred Conboy, the Mayor of Toronto, was very impressive. He'd come in with a flower in his buttonhole, and a sharply-pressed suit, and give his lecture, from the same notes that he had been using for dentistry for twenty years, with no change. But he was somewhat inspiring nevertheless. He said the right things, even though they were hackneyed and rather trite. After all, he was the Mayor of Toronto, with all the front and nerve that such a role requires. It's like being an army officer; you've got to look the part, or you are apt to be unsuccessful.

CJO

He was a dental surgeon.

BL

Yes, and he taught us what he called "praxis" — practice management. He taught for years; he taught me and he also taught the veterans. Actually, I suspect there was no transmission from his brain to our brains. There was, rather, a bit of transmission from his notes to our notes. Nevertheless, his model was effective. He taught us what a professional person's demeanour should be.

CJO

Now, of the various subjects you took, which do you feel were the most important to the profession, and are they different from the ones you think are most important today?

BL

It probably sounds very old-fashioned today, and it may actually be surprising, coming from me, but I still think optics is the key subject. I'm rather unhappy about the temptation today to overemphasize pathology, even though I have spent my life teaching pathology. I enjoy it; I'm knowledgeable; I'm specially trained in it, but today I remind the students that the purpose of acquiring an understanding in pathology is to protect the patient and, secondarily, to protect the practitioner. Studying pathology is necessary, important and interesting, I remind the students. But I tell them, "You must *not* assume that pathology is optometry." Optometry is *not* pathology. Optometry is based upon binocular vision, refraction, optics and related physiological functions. Optics becomes downgraded by some people, because they think it's been studied to death, for over a hundred years. But our essential distinction from ophthalmology is our broad-based knowledge of the physiology of vision.

CJO

You were a practitioner before you became an academic. Do you think that today's academics in optometry should have some more basic training in clinical work?

BL

Somebody has said, "You can't stop a good student, and you can't do much to help a bad one." I feel the same way about the people who take on the faculty role. If they have what it takes, they're going to do a good job, and one should not attempt to direct them too much. You can write a course description; you can apply pressure; but professors are going to teach what they believe should be taught and they are going to emphasize what they want to emphasize, to a great extent. So the critical decision really occurs when you hire that person. At the same time, I believe that a teacher who is hired because he has done interesting research relevant to optometry, is better able to teach, regardless of whether he has much clinical experience. But I also believe that clinical experience adds another, positive dimension to a teacher. The students who graduate now have a great deal of background knowledge, and they're going to adopt their own clinical procedures anyway. What

they need is to be able to think about what they're doing, and to understand it. Why they're performing a test, and what is occurring, are more important than any technique that one can teach.

CJO

We weren't speaking necessarily of teaching techniques, but rather the overall concept of the practice of the profession. Do you feel that it is enhanced by a person's having had experience as a practitioner?

BL

Well, there are certain benefits in clinical experience. It's possible, as you know, to put two new graduates into associate practices, and one would benefit, and one would not, because not *all* practice experience is good. Practitioners generally feel that they could come to the school and give the students a useful series of lectures. Some may feel that they could give better lectures and better instruction than the present people do, but most practitioners who do enter the teaching program have said that they actually found themselves with much to learn or re-learn. I don't think you can equate hours or years in practice with research and teaching. I realize that it has been said many times there is some danger that the School will be filled with Ph.D psychologists who have only a remote concept of what actually happens in an optometric office; what kind of problems are presented by patients; what kind of solutions have to be arrived at by the optometrist; who pays the rent and the secretary, who pays for the stationery, who arranges for the parking and so on. How much time and effort we should be applying to courses related to practice management is an important question. But you can't teach practice management thoroughly and at the same time cover the program that the students have to learn anyway. Some seem to learn how to manage their finances early and others don't begin to learn until they have an overdraft at the bank.

CJO

Is the clinical environment here adequate preparation?

BL

It's far from ideal, but it offers many advantages. More time can be allocated to an individual problem. There are back-up people whom you don't have in practice. There is a different attitude, more equipment and facilities here than there can be in any one practice; and there's a sense that, "If the problem is too difficult, I can call on others for help."

One disadvantage of this clinical environment is that the patient population contains an excess of university students. A graduate is apt to leave here thinking that the average patient is a 20-year old myope, whereas the average patient, I keep telling them, is a 55-year old woman. That's the person you must appeal to; that's the person you've got to think about and learn to communicate with.

On the other hand, an educational institution offers great opportunities. Only this way can we gain entry into the mental hospitals, old folks' homes and the Caribbean area, for example. These situations provide superior learning opportunities, and these experiences are unforgettable. You see more pathology there, and you have the opportunity to provide more care for the whole patient. patient.

CJO

What's happened to eliminate those programs?

BL

Money. The Federal government's restraint program. We were serving the Caribbean people, and training students, — effectively, and not very expensively.

CJO

When *you* graduated, did you feel you had adequate clinical experience?

BL

No, I think I saw a dozen patients all told; and some of these, I brought in myself. I went into practice in Kirkland Lake for a few months, and then I went to Winnipeg. I completed two years in an internship, where I saw 20 patients a day. Now, mind you, it's not as bad as it sounds, because we worked until 6 p.m. in those days. We had complete lab facilities and complete, modern visual training equipment. We didn't have to do any dispensing; other staff did that. So we examined one patient right after the other. We did the examination carefully and completely in half an hour and we saw a broad spectrum of pathology problems. It was great training for me. There were five optometrists; James Shaen was the optometrist who owned the practice. He had taken his optometry courses in Chicago and opened up in Winnipeg.

CJO

Is the office still in existence?

BL

Very much so. It is run by James Shaen's nephew, Manuel Lecker and his son, Robert.

CJO

How long were you there?

BL

I was there for three years or so. It must have been about 1939 - 41, I guess.

CJO

Is it about this time that you enlisted?

BL

Well, that's another long story. I could see the war was coming, so I went to the University of Manitoba and took the Officer Training Course. After that, I entered the reserve army. That is, The Winnipeg Rifles, Third Battalion. Then in 1942, when they went active, I went active.

CJO

And you were discharged when?

BL

In 1946, at the Exhibition Grounds in Toronto. I was actually given my discharge examination by a class-

mate of mine (Lew Collins). Then I came back to the School and took a three months' (I think it was) refresher course, because I'd been out of optometry for the four years I'd been in the army. I returned to Winnipeg and bought the practice of Dave McGuire, who had been the President of C.A.O. and had died a month before I got there. Next year, the H.A. Nott practice became available, and I bought that, on a loan from the Imperial Optical Company, which was very happily arranged on the strength of a handshake only.

CJO

In 1950, the U. of T. informed us that it would cease providing optometry students with instruction in basic science subjects. What is your impression of the effect that this has had on the optometry curriculum and on the profession as a whole?

BL

I don't think it had a very great adverse effect because, shortly after that, optometry got hold of itself to the extent of saying, "Our course merits it, so it is time to start granting the O.D. degree." I think that was a very significant and progressive move, giving that O.D. to the graduates of the school in Toronto. (They did that in 1956, I think.) And the school accomplished this without the blessing or the help of the U. of T.

CJO

Around the same time, the Board of Directors was helping students who showed potential or interest in advanced degrees, by providing some funding. Can you elaborate on the benefits you received under this program?

BL

Well I received, I think, two cheques from the Maybee Fund, and I confess that I can't remember the exact amount. But these two cheques were most helpful to me while I was attending Indiana University. In order to go to Indiana (I had a wife and three small kids), I sold my practice and I sold my house, and I was there for five academic years. I received no government support, so you can appreciate just how much the Maybee Fund helped me. (I also received some financial help from Indiana University, and from the United States government research grants.) However, the time at Indiana consumed the money I had received for my house and for my practice.

CJO

Was it your intention to head into education once you left private practice?

BL

Yes. I had been involved in C.A.O., and was meeting various political people on behalf of the Association; I went to the legislature in Manitoba, for example, and met the Minister of Health, who actually said to me, "You optometrists are nothing. You have an old house down there in Toronto, and you give yourselves some kind of a little 'degree' and it doesn't mean anything." And I thought, "I'm not going to take that from you. The next time I sit across from you, I'm going to have a Master's degree." I agree that this is probably poor motivation — I was reacting instead of leading — but nevertheless, that's what I did. So then I took the O.D. program in Toronto and, while there I talked to Dean Fisher about getting into university. Ted said he would introduce me to Henry Hofstetter, the Dean at Indiana University. So, in Chicago, in the Drake Hotel, Ted introduced me to Henry Hofstetter who advised me to finish the O.D. program, and take additional courses at the University of Manitoba. So I took two years there, and entered the graduate program at Indiana University.

CJO

What subjects did you take?

BL

I can only give you an approximate idea. At Manitoba, I took genetics, two chemistries, — organic and bio, two courses in bacteriology, a course in economics and a course in statistics. Actually, I suspect that Dr. Hofstetter thought that these courses would satisfy me and dampen any urge to undertake more study. However, I went to Indiana and completed both the Master's and the Ph.D. programs there. I was an A student, and, in fact, took courses every summer as well as throughout the academic year. I actually completed a major and three minors. While I was there, it was clear to me that pathology instruction was a problem. (I had taken pathology from Dr. Bal Sparks, the first year that he taught. I registered in general pathology in the Medical School and took the course. Emerson Woodruff was also there. He took the anatomy, I took the pathology and we were the only two that did that. And we were both successful.) I also took another few courses in bacteriology, including pathogenic bacteriology. I took minors in anthropology and psychology. Naturally, all the basic courses dealt with physiological optics.

CJO

You mentioned briefly your involvement in political optometry, — through C.A.O. What led you into that area?

BL

Well, the same inferiority complex. I got involved in C.A.O. not so much from the point of view that it was a challenge. I would interpret it now as simply being that optometrists in Manitoba had elected me to be President of their group, and the next step up was to be appointed as a C.A.O. delegate. About that time, one begins to see the profession in a little broader light and one sees the need to identify optometry, not just to your patients, but to every level of government as well.

CJO

What brought you specifically into the pharmacology area?

BL

Clair Bobier was teaching an introductory course in pharmacology here and he said that he felt he didn't know enough about it, but that it should very definitely be taught.

Since I'd had some recent courses in organic and biochemistry and related topics, I thought it might be possible for me to help in this area. What we did was to go to the Faculty of Pharmacy at the University of Toronto where, fortunately, we found a very congenial group. Ted had some connections and he talked to the Dean. We contacted three professors, Patterson, Kennedy and Marshman, who teamed up and said, "Let's really provide a worthwhile course for optometry." They provided, in fact, our first pharmacology program. I took that course, and was involved in it, both as a student and an organizer.

CJO

It's been fortunate . . . you in pharmacology and pathology, Clair in binocular vision and orthoptics, Ted in optics and contact lenses, — the whole core of our curriculum . . .

BL

I think it's important to understand that Ted Fisher is really an unrecognized genius. Few people give him the credit he deserves. He not only gathered us together and kept us together, he inspired us and made it possible for us to work together. What Ted managed to do by the strength of his own personality, while he ran the School, was to accomplish several important things. He ran the School in very bad times, when there were six students, no money and everybody was saying, "Optometry is dead." But he also ran the School in very good times. I look at my own graduating class and I see that among those whose personal lives seemed the most disastrous, are the ones who made the most money. In other words, it's just as hard to run affairs in good times as it is in bad times. Usually, it takes two different kinds of people; but Ted did it in both, — successfully. He managed the School through all the changes of moving to the University of Waterloo. To maintain cooperation amongst a whole group of individualistic professors is no small achievement.

In addition, I am convinced that Clair, by his dogged personality and his insistence on physiological optics, played a major role in the School's success. He managed to keep the school on an even keel in spite of the emotional involvement many of us felt. He was the stabilizing influence, over the whole period of time. No matter how angry we were, or how discouraged we were, we'd always go back to Clair, and after a few hours of talking to him, he would come up with a rational and reasonable solution to most of these problems.

At the same time, there are two other people who played key roles and were recognized for their leadership by being appointed Directors of the School, Emerson Woodruff and Wally Long. I won't go into the background details of their contributions now, because neither of them are retiring so it's a story still to be completed.

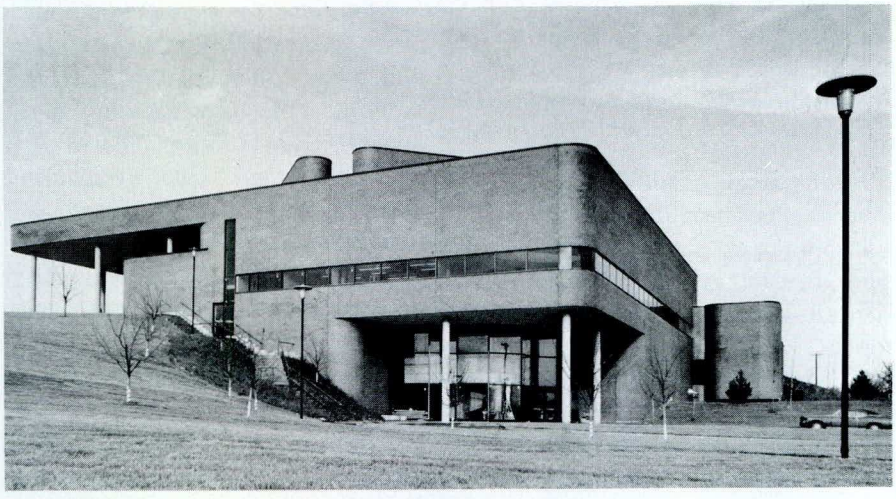
We also have to remember that Irving Baker has made a big contribution. Irving has faced some opposition over the years, but ever since he started seeking cooperation with the Workmen's Compensation Board, he has been a key man all across Canada. His contribution tends not to be recognized by recent graduates and the younger group who are apt to think he's just insisting on rules. But he has done a tremendous job to advance the cause of optometry. He is a thoroughly competent teacher, too, and, like Clair, he doesn't panic but always works for the rational coming-together of ideas to produce the correct solution. No one person has all the answers, but if you can get a team to work together for a common cause, you will have a better answer than any one individual could ever come up with.

CJO

Do you think there will come a time when the teacher of clinical skills has the same rank and prestige as the academic in the basic sciences?

BL

Very hard question, because the answer doesn't depend on optometry. It depends on science; it depends on the university; it depends on outside people; and it depends on personality. You could put some optometrists in the clinic, and if they have enough initiative and enough good ideas, and work hard, they can achieve most of their goals. If status and rank are what you are concerned about, then it is almost impossible to win until optometry becomes a separate faculty. When that happens, it can be determined what the ranks and titles of the various people should be. What they do in medicine is appoint many practitioners as assistant professors. I wouldn't be against that for optometry. There is, however, almost no way such teachers can gain a promotion to become associate professor, in any university, unless one follows the university pathway, which is to perform research and publish the results. Not



"Optometrists from coast to coast all became six inches taller when that happened."

everybody can do it. Especially since a clinician's time is heavily taken up with his or her duties. Some are not interested in research techniques. Personally, I am in favour of a professor title for clinicians and don't feel any jealousy about it. As long as the clinician is aware that any further promotion is possible only if research is done, in other words, following the standard pattern for any professor. Do research; get a grant; produce papers; that's how you get promoted. You could be the best teacher, possibly the best clinician for thirty years and everybody will say, "Great!", but you will not be promoted.

CJO

The Australian schools are now giving Masters of Science in strictly optometric sciences. What is your feeling about this?

BL

I don't disagree with it. There are optometrists here, also, earning Master's degrees in specific optometric fields, like binocular vision and that sort of sub-specialty. These optometrists, at the same time, become better clinicians. There are about six practising in the country now who have Master's degrees in a relatively narrow, but *specific* optometric area.

CJO

How do you see the effect of external pressure on moulding the profession, i.e. its curriculum, its policy and attitudes?

BL

Very greatly, although I'm afraid that too often we are reactors instead of innovators. I think we owe a big debt to ophthalmology. If it hadn't been for an aggressive attitude on their part, optometry would not have achieved the progress it has. One of the reasons for the great improvement in the quality of the program is because, as a defensive measure in response to their political stance, we *had* to teach better. We've had to teach more pharmacology and to learn to understand electrodiagnosis; these are two areas in which the opposition has forced us to advance.

Another pressure that exists is financial pressure. Canada so often follows the United States, where there are now big cosmetic companies and similar conglomerates buying up and franchising optometric practices all across the country. Such organizations argue that they protect the beginning practitioner and guide him in the early stages but they, of course, extract a sizeable portion of his income. The fact that they do some advertising for optometry or for the practitioner is really secondary because the benefit goes to the corporation and not to the practitioner.

I think we still face a threat from ophthalmology because they are moving into dispensing. In the U.S., between 37% and 40% of all ophthalmologists dispense glasses and contact lenses in their own offices. And quite a number of the rest have somebody downstairs or around the corner with whom they have a tie-in. Right now ophthalmology is in transition, and 70% of their work is in refraction. They have never admitted it before, but they're now admitting that most of their work is in refraction. I talked to the Chairman of the Department of Ophthalmology at a Canadian university who says to his students, "You are going to make your living out of refraction. You'd better learn how to do it." It's not as exciting as surgery, not as glamourous, but they are learning, and it's not impossible to learn how to do an average refraction. So far, most of them aren't interested in the problems of binocular vision, or in aniseikonia. One of the weaknesses of optometry is that a second-rate refraction will actually satisfy 85% of the patients. Another 12% require the skills of a real expert, and the last 3%, nobody could satisfy.

CJO

Hopefully, that doesn't mean you spend 85% of your time doing a second-rate job.

BL

No, I never went at it that way. I always did the opposite and actually may have been too involved in precision. I was a practitioner who specified lenses right down to 0.12 diopters when it seemed best for the patient, and I prescribed more vertical prisms than most (one of every 16 patients).

CJO

You said you felt the greatest thing that ever happened to optometry was when we gave the O.D. degree. Would you say that was more significant than the move to Waterloo?

BL

No, but it was a necessary preliminary. It seems now not to have been the greatest thing, but it was an essential turning point. It was probably more important to get into the university system, but one may not have happened without the other. I was in Indiana at the time it was done, and I commend the courage and forethought of the people who were involved. Optometrists from coast to coast all became six inches taller when that happened.

CJO

Do you feel that the people coming into optometry today are as dedicated to "optometry defence", i.e. would they be prepared to go through the same combat that you were obliged to go through? Or do you think that, perhaps, they have been spoiled by what you and your peers achieved?

BL

That's another difficult question, but I'll tell you my views. You can't really tell about people until they are in deep trouble. It's true that the students who enter today have never faced the hard times, the depression, the wars and all the things that our generation went through. But at the same time, they're quality people; and if you take quality people and present them with a challenge, enough of them are going to have the guts and brains and stamina to make their presence felt. I know they would fight for optometry. It would be a shock to them, because they're used

to the easy way, — lots of money; and a few believe that the world owes them a living: "I'm a big Doctor, and I'm a university graduate." But I know that they're quality people, and that if it came to a fight, they would fight very well. They would be fighting on a more sophisticated level than we were able to do, because they are better educated. We all seem to forget, even though it may seem a nasty kind of sociological thing to say, current graduates have brothers who are lawyers, aunts who are physicians, uncles who are judges and, on the average, they come from a higher social stratum. Those connections are valuable and give current graduates a better chance to deal with opposition. I'm not at all pessimistic on that score.

The other thing I would like to mention along the same line relates to inspiration and dedication. I think it was Hitler who said that if you had a hundred people who were absolutely committed to a cause, you could do anything. What happened at the School was that, for 15 years or so, we had five or six people, who worked like beavers to make this place go. We met almost every day, and almost every night, and we worked weekends. There was nothing that anybody wouldn't do for the good of the school, in spite of personal problems, age, needs or wants. That dedication is bound to taper off in time, and it was successful because this small group of single-minded people agreed on the goal. They brought different kinds of skills, but a common aim: the enhancement of optometry. A small group of people like that, with the determination and the commitment and the will to hang together for a cause, constitutes a very powerful force.

Pace from P. 28

Management

The diagnosis of ocular myasthenia gravis was confirmed by the neurologist. Treatment was undertaken using Mestinon. After two months of treatment the diplopia cleared completely. Medication was discontinued and there was no recurrence of symptoms.

The final diagnosis was given as ocular myasthenia gravis currently in remission.

Followup

E.S. remained free of symptoms for one year. Treatment with Mestinon was resumed when occasionally diplopia reappeared, however it was not as severe as during the initial occurrence. He is currently controlled with medication.

Discussion

Myasthenia gravis is a condition which often presents initially with ocular signs. Ptosis, diplopia and lid twitches are among the classical early signs of the disease. There is no affect on pupillary reflexes, visual fields or visual acuities. The patient described above is unusual in that his condition has remained purely ocular; more often there are varying degrees of systemic involvement. Periods of remission are common as was the case with E.S.

The patient presented with recent onset diplopia resulting from a noncomitant deviation. This is always a serious symptom as it may be caused by intracranial pathology or neurological disease. Prompt medical referral is always indicated in such cases.

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