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PERMANENT

THE CANADIAN JOURNAL OF Optometry

LA REVUE CANADIENNE d'OPTOMÉTRIE

DECEMBER/DECEMBRE

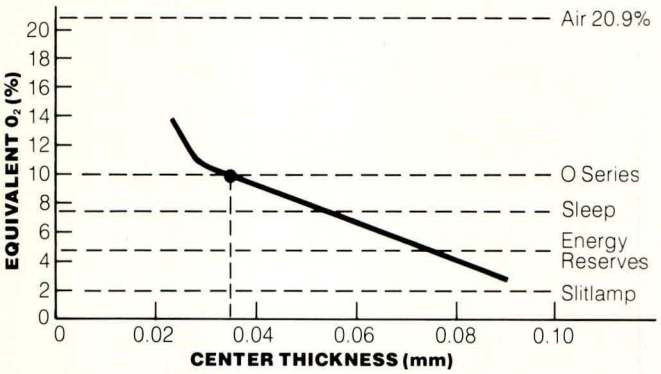
VOL. 42. NO. 4

Introducing a lot less lens. And a lot more oxygen.

Bausch & Lomb brings more oxygen to the cornea with the new O Series SOFLENS (polymacon) Contact Lenses

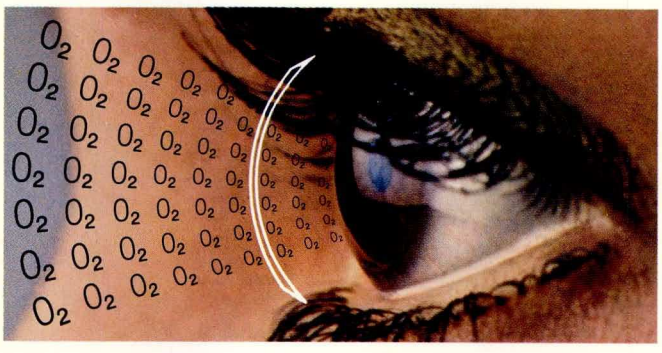
Greater oxygen transmissibility

The new O Series Soflens Contact Lens transmits more oxygen than our standard lens or even our Ultra Thin lens. In fact, during daily wear with O Series, the eye receives more oxygen than during sleep.[1]



"Equivalent oxygen" responses to a series of HEMA (Bausch & Lomb 38.6% water content) lenses having center thicknesses of less than 0.10 mm.[2]

Thinner than other soft contact lenses



This high oxygen transmission is possible because the new O Series soft contact lenses are only .035 mm in center thickness—one third the thickness of standard soft contact lenses, 50% thinner than other "thin" lenses and consistently thinner than lenses from any other source.

Reduced likelihood of edema

The greater oxygen transmissibility of new O Series SOFLENS Contact Lenses should reduce the likelihood of corneal problems, such as edema.

Excellent reproducibility

As with other Bausch & Lomb SOFLENS Contact Lenses, the O Series is spincast which means the prescription you order is the prescription you get—*every time.*

Available now for all your new lens fittings and replacements.

O Series soft contact lenses are manufactured in two series, 03 (13.5 mm diameter) and 04 (14.5 mm), in powers from −1.00D to −9.00D. They are available *now*, so you can start fitting patients immediately. Your Bausch & Lomb Representative is ready with all the details—to help you order them *today.*

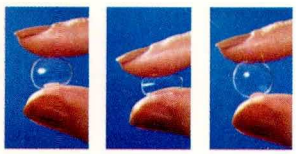
1. Hill, R.M. Hydrogel Lens Design: The Second National Research Symposium. The Thick and Thin of It. Aug. 16 & 17, 1975.
2. Ibid.

Fit the best first.

O Series SOFLENS

(polymacon) Contact Lenses

BAUSCH & LOMB SOFLENS (polymacon) Contact Lenses



Prescribed more than any other soft contact lens.

BAUSCH & LOMB ▼ L213-80JA

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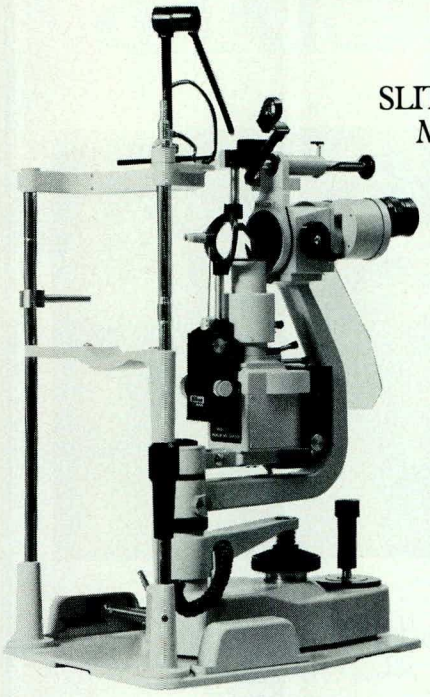

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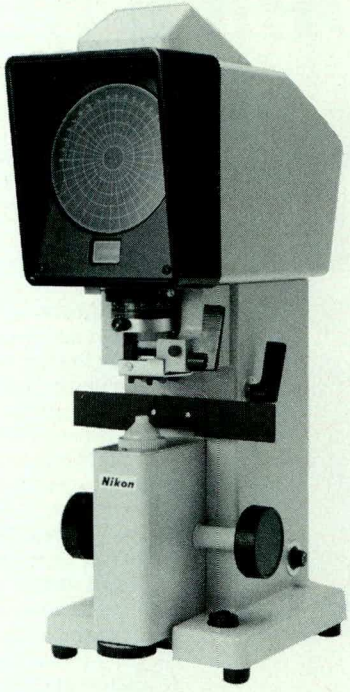
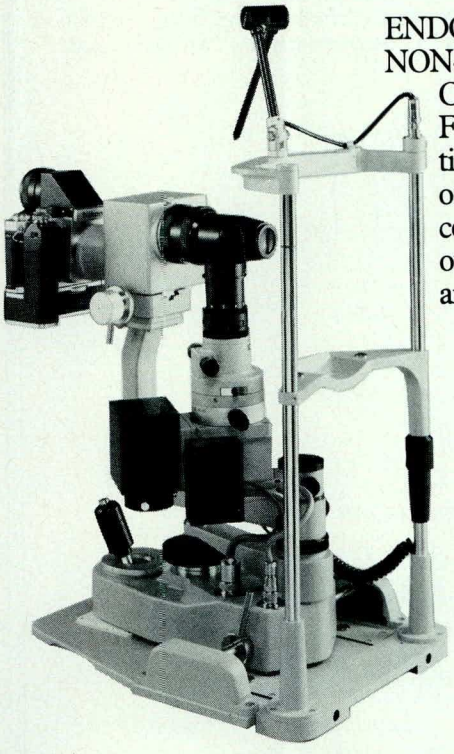
For general clinical use, an applanation tonometer is available

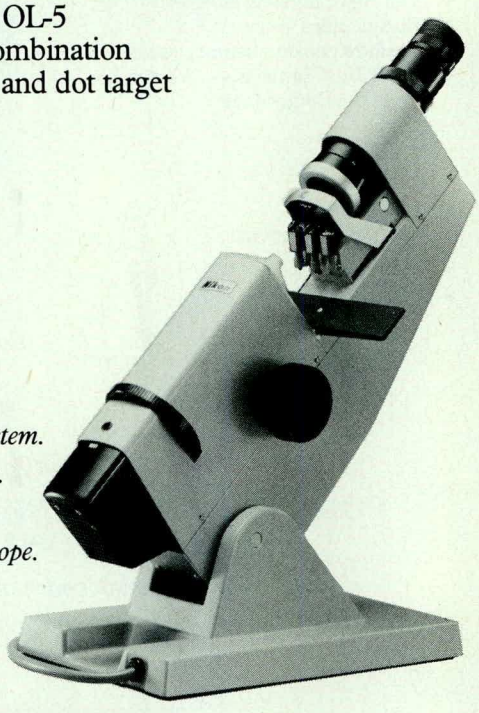


PROJECTION VERTEXOMETER
For fast, accurate readings – ideal for contact lenses



ENDOTHELIAL NON-CONTACT CAMERA
For high resolution photography of the endothelial cell layer and other areas of the anterior-segment

OCULAR VERTEXOMETER MODEL OL-5
With a combination crossline and dot target



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Aspherical Ophthalmoscopic Lenses.
Fundus Camera Retinapan 45-II.
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Nikon

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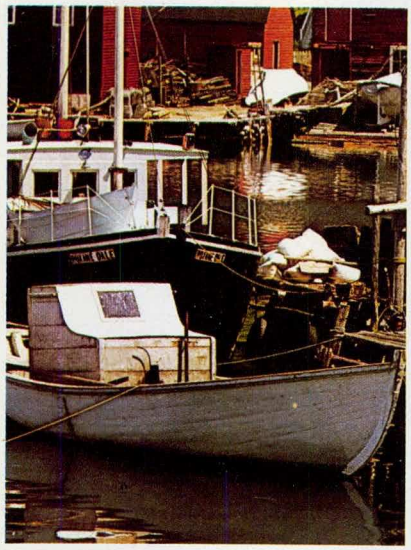
Canadian Association of Optometrists'

17th BIENNIAL CONGRESS

July 5-7, 1981

ST. JOHN'S NEWFOUNDLAND



- **CAO Business Meeting**
- **Ophthalmic Exhibition**

Featuring a wide spectrum of educational lectures — Some of the Speaker's and topics to include:

Dr. Ernst Goldschmidt, MD, PhD
- The Etiology of Refractive Errors

Dr. Ted Grosvenor, OD, PhD, FAAO
- topic undetermined

Dr. Brian Payton, MD, PhD
- Lecture and demonstration on the use of photography in the eye care practitioner's office.

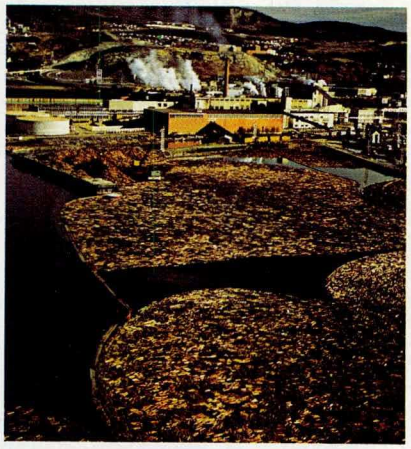
Dr. Indra Mohindra, OD, MS, FAAO
- Lecture and demonstration on latest techniques in the refraction of infants.

Dr. John C. Bear, PhD
- Lecture on the Inheritance of refraction.

Dr. Avrum Richler, OD, PhD, FAAO
- Report on Research on the Effects of Nearwork on Refraction.

Mr. Gerry Power, Computer Specialist
- Lecture and demonstration of the uses of the microcomputer in an optometric office.

and more . . .

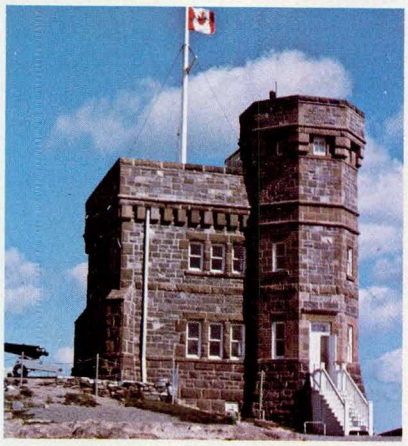


Spouses Program:

- Visit to Government House
- The Newfoundland Museum
- Historic Sites Tour
- Seafood cooking demonstration
- Royal Trust Seminar — "What to do when the Doctor Dies."

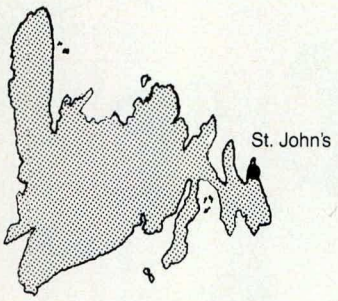
Childrens Program:

- Supervised Recreation
- Evening Babysitting



Additional Events:

- President's Banquet and Ball
- Poolside Lobster Boil
- Traditional "Fish and Brewis" Evening
- Fish Luncheon
- Photo Contest (see pg. 180 for details)
- Entertainment by the "Wonderful Grand Band"



Hosted by the Newfoundland Optometric Association

FOR MORE INFORMATION CONTACT: CAO, 2001-210 GLASTONE AVE. OTTAWA, ONT. K2P 0Y6 TELEPHONE 613-238-2006

Deadlines to be announced in our March issue — plan ahead to attend — registration will be limited.

REGISTRATION FORMS AVAILABLE IN OUR MARCH ISSUE

	Preregistration*	Registration
Optometrist	$170	$200
Spouse	$155	$170

CLEAN-O-GEL

A new enzyme approach to cleaning soft contact lenses.

New Approach
The new Clean-O-Gel enzyme granules solve the problem of lens deposits.

Effectiveness
Clean-O-Gel removes organic deposits which accumulate on soft lenses.

Rapid Action
Clean-O-Gel removes organic deposits after six (6) hours of soaking activity. (Soaking for more than six hours will not harm the lens.)

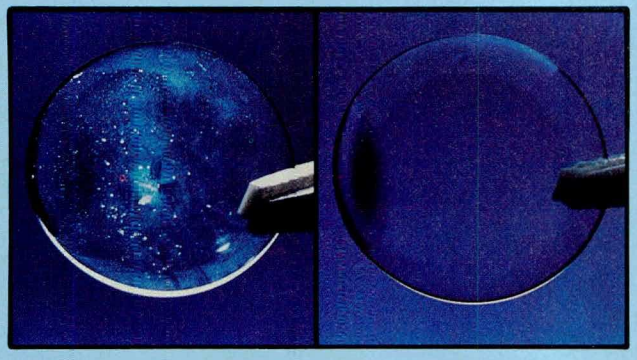
Widely Useful
Clean-O-Gel can be used with all soft contact lenses.

Safety
Clean-O-Gel will not harm lens surfaces or your patient's eyes should the lens be inserted by mistake immediately after soaking.

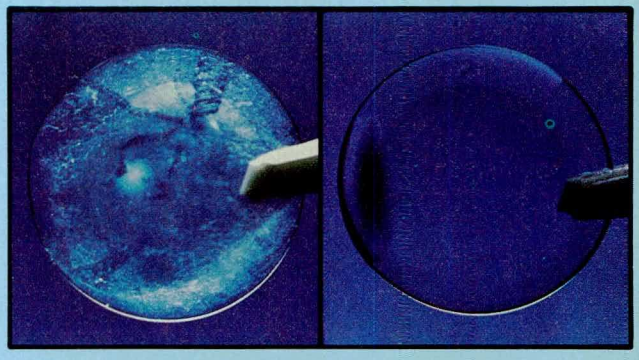
A Simple Cleaning Schedule
Clean-O-Gel should be used weekly or, periodically, as directed.

Clean-O-Gel works.

LIPO-DEPOSITS
Before & after cleaning with Clean-O-Gel.



MUCO-DEPOSITS
Before & after cleaning with Clean-O-Gel.



One of the few disadvantages of soft contact lenses is that they collect deposits over time.

These deposits are caused by several agents including cosmetics, ocular medications and other products the lens wearer may use, lipids, lipo-proteins, muco-proteins, and other tear film components which are adsorbed or absorbed into the lens. Once the deposits occur, removal is difficult.

Clean-O-Gel removes these problem causing substances, including deposits resulting from tear components, which cannot be removed through the use of a daily surfactant type cleaner. Clean-O-Gel relies on enzyme action to break up and remove these substances. In addition to being effective, Clean-O-Gel is safe for soft lens material as well as delicate ocular tissue.

Alcon bp

Burton-Parsons Division
Alcon Laboratories Limited
Toronto, Canada L5N 2B8

Announcing a *PHOTOGRAPHY CONTEST* 1981 CONGRESS C.A.O.

Open to all Optometrists registered at the 1981 Congress.

Categories

Black & White

1. Portrait or Human Nature (photos in which the human body or actions play the major role).
2. Scenic (landscapes, seascapes, etc.)
3. Nature (flowers, animals, etc.)

Color

1. Portrait or Human Nature (photos in which the human body or actions play the major role).
2. Scenic (landscapes, seascapes, etc.)
3. Nature (Flowers, animals, etc.)

Rules

1. Prints only – in sizes 5 x 7, 8 x 10, or 11 x 14 only.
2. All must be mounted.
3. No framed photos permitted.
4. Name and address on the back of each print and the category listed.
5. Technical data may be included but not required.
6. Can enter one picture only for each category, i.e. 6 maximum.
7. Must be submitted no later than May 1, 1981.
8. Entrants must pick up photos after judging at the Congress or if unable, must supply return folder and postage.
9. There will be a limited entry and those received first will be given preference.
10. In submitting a picture, the entrant grants the C.A.O. the right to publish that photo in the C.A.O. Journal and represents that the photograph has not previously been published and is not subject to copyright.
11. There will be prizes for winners – to be announced later.
12. All photos will be prejudged and winners only will be displayed at the Congress.
13. **Submit photos no later than May 1, 1981 to Dr. R.A. Rosere, 152 Ochterloney Street, Dartmouth, N.S. B2Y 1I.**

The two-solution system designed specifically for all gas-permeable hard contact lenses

BARNES-HIND Cleaning Solution

For gas-permeable hard contact lenses

BARNES-HIND Wetting & Soaking Solution

For gas-permeable hard contact lenses

- Complete compatibility with all gas-permeable hard contact lenses
- Economical to wearer
- Readily available
- Made in Canada

The trend toward gas-permeable lenses continues to grow at a steady pace. Synonymous with this trend, practitioners continue to express a desire for specific solutions for each type of lens—hard, soft, or gas-permeable.
Recognizing this need and trend, Barnes-Hind has responded with a specific two-solution system for all gas-permeable hard contact lenses... including the Boston Lens.

James L. Jansen, General Manager, Barnes-Hind Canada

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NEED PERCEIVED—EXCELLENCE ACHIEVED

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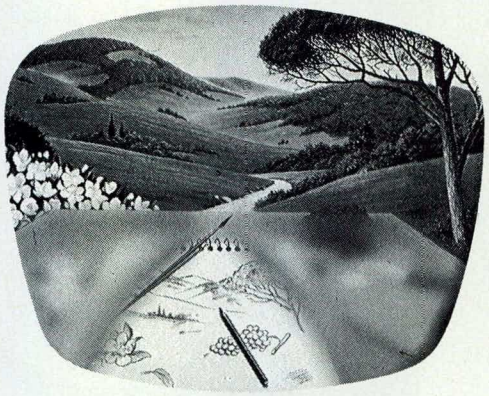
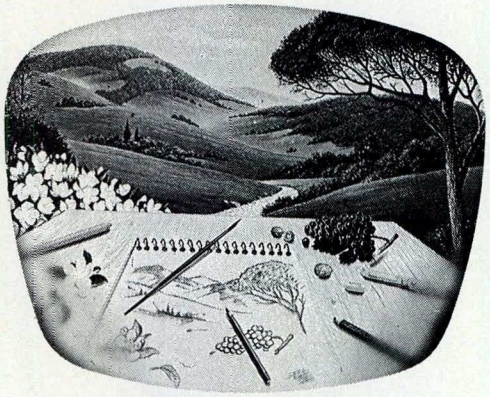
T-1062/9/80

VARILUX 2
from ESSILOR

Clear, clean correction for presbyopia



"Invisible" bifocals:
a fuzzy central zone.



Varilux 2: clear, clean
vision at every distance.

Varilux 2, from Essilor, is the only true progressive lens in the world—a happy revolution in the world of optics. Unlike invisible bifocals, Varilux 2 does it all: eliminates major aberrations and assures maximum visual comfort **up close, far away and in between.** Varilux 2 is a clear advantage your patients will appreciate. It's the far-sighted answer to the psychological trauma of presbyopia.

VARILUX 2

ESSILOR

THE CANADIAN JOURNAL OF OPTOMETRY

LA REVUE CANADIENNE D'OPTOMETRIE

Vol. 42 OTTAWA, ONTARIO, DECEMBER, 1980 No. 4

Contents

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LETTERS

Ed. Note – The following letters were recevied in response to the Inns Contact Lens article Mar CJO – see next pg for Dr. Inns' Reply

Dear Editor:

With reference to the article entitled "Soft Contact Lenses and Solutions in Canada" by Doctor H.D.E. Inns, that appeared in the Canadian Journal of Optometry of March, 1980, I wish to respond to what I feel are not completely accurate statements.

While I agree with Doctor Inns in dividing soft contact lens cleaners into three specific categories, I do not agree with his statement that "the purpose of a surfactant cleaner is to mobilize, emulsify and remove proteins . . ." Studies done by Doctors Kleist and Thorson[1] have shown surfactant cleaners to be ineffective in removing protein deposits from the surface of soft contact lenses. Various other studies have recorded similar findings.[2][3] The enzyme (papain) cleaner must be categorized by itself, and not be grouped with surfactant cleaners.

Under (C) Enzyme Cleaners (page 29), Doctor Inns states that "papain (as used in meat tenderizers) is the enzyme usually used in this type of cleaner." It is true that papain in a crude form is used in meat tenderizers, but the highly purified and sophisticated form used in Hydrocare Protein Remover Tablets is quite different in quality as there is a chance of its coming into contact with delicate human tissues. I can assure Doctor Inns that the enzyme product manufactured by Allergan always contains this very special quality papain.

Doctor Inns goes on to say that a "greater drawback is the danger of ocular sensitization to papain with potentially injurious effects." When the enzyme is used as indicated in the instructions leaflet i.e. the lenses are rinsed well with saline after the cleaning process, no serious side effects occur. This has been confirmed in studies done by Doctor Amano[4] and Doctor Bellemare.[5] Further, no ocular sensitivity and certainly no "potentially injurious effects" have ever been demonstrated on clinical challenge. Anything coming into contact with the eye can be termed potentially dangerous, e.g. a finger.

Please note that Hydrocare Cleaning/Soaking Solution contains alkyltriethanol ammonium chloride and thimerosal. This formulation was omitted in the section (3) Chemical Disinfection (page 30).

Because of its widespread use, it must have come as a surprise to many optometrists that Hydrocare was not mentioned as a system and, in addition to trying to clarify some of Doctor Inns' statements, I would like to describe the Hydrocare Multi Pack, which comprises of:

- Hydrocare Cleaning/Soaking Solution: a sterile, buffered, isotonic solution containing alkyltriethanol ammonium chloride, thimerosal 0.002% and surfactants, in a special polymer vehicle (120 ml);
- Preserved Saline Solution (120 ml);
- Hydrocare Protein Remover (6 tablets);
- Storage case.

Method of use:

Lenses cleaned with Hydrocare Cleaning/Soaking Solution, rinsed with additional solution and stored in lens case containing Hydrocare Cleaning/Soaking Solution. The lenses are rinsed with Allergan Preserved Saline prior to insertion in the eye. Once a week, the lenses are cleaned with the Hydrocare Protein Remover. Our recommendation is to dissolve the Hydrocare Protein Remover Tablet in distilled water and not Saline, as indicated in Table 5.

We think that the objective of clarifying the care products available is a desirable one, and Doctor Inns has done quite a bit of work. It is with the spirit of further clarification that this letter is written.

Respectfully,
Mehbs Remtulla B.Sc. (Pharm)
Marketing Associate
Allergan Inc.

REFERENCES

1. Kleist F.D. Thorson J.C.—"How effective are soft lens cleaners?", Review of Optometry, April 1978, 115 (4) 43-45.
2. Leiblen J.S.—"How important is enzymatic cleaning? An in-office evaluation", International Contact Lens Clinic 1979, 6 (3) 80-82.
3. Kleist F.D., "Appearance and nature of hydrophilic contact lens deposits—Part I: Protein and other organic deposits", International Contact Lens Clinic, Vol.6, No.3, May/June 1979.
4. Amano J.—"The effects of an enzyme cleaner on soft contact lenses", Toyo Contact Lens Co. Ltd.
5. Bellemare F.—"Compatibility of enzymatic cleaning with cold contact lens disinfection", International Contact Lens Clinic, Sept/Oct 1979.

Dear Dr. Belanger:

Further to many enquiries we have received relating to the article entitled "Soft Contact Lenses and Solutions in Canada" by Dr. Harry Inns in the C.J.O. March 1980 Edition, I would like to clarify a statement in the article which has led to some confusion. Table 1 of the article indicates an incompatibility of the Aquaflex lens with enzymatic cleaners. Many practitioners in Canada have used enzymatic cleaners with the Aquaflex lens over several years with no apparent incompatibility problems being reported. The manufacturers of enzymatic cleaners also have informed us that their products are compatible with the Aquaflex lens.

We would like to congratulate Dr. Inns on an excellent article and hope that this correction will be noted by those practitioners using this article as a reference source.

Sincerely,
Uno Leis
National Sales Manager
Union Optics Corporation
(Canada) Ltd.

LETTERS

The Author Replies:

In a paper as all encompassing as "Contact Lenses And Solutions in Canada" there are certain to be some omissions and such a paper is almost out of date from the moment it is written. The tables should be amended from time to time as necessary, and several manufacturers have offered suggestions. Union Optics states that enzyme cleaning systems can now be used with its Aquaflex lenses. This letter will deal with the question of enzyme cleaners and offer changes or updates where they are required.

In answer to the letter from Mehbs Remtulla of Allergan Canada Ltd. Canadian practitioners should be aware of the research papers that confirm my statement that there is "the danger of ocular sensitization to papain with potentially injurious effects."

In a paper "Iatrogenic Red Eyes in Soft Contact Lens Wearers" (International Contact Lens Clinic Sept/Oct 1978) Fichman, Baker and Horton report on research supported in part by a National Science Foundation (Canada) research grant. They used Biochemical studies to assay the amount of lens-bound papain in soft contact lenses using a modified spectrophotometric procedure. They report as follows. "Biochemical assays of new lenses not worn by patients reveal that, in general, residual papain appears to be associated with hydrophilic lenses that have been exposed to enzyme cleaning solutions and that the absorbed papain remains enzymatically active. In most instances, attempts to remove proteolytic activity appeared ineffectual. It is important, therefore, that patients wearing soft contact lenses be informed that use of an enzymatic soft contact lens cleaner containing papain is likely to cause ocular irritation due to active enzyme remaining on the lens surfaces."

Therefore, there seems to be a contraindication for the use of the enzyme in association with the chemical soft contact lens regimen, as this may lead to "enzymatically induced" red eyes.

They did a further clinical study in which 25 patients were supplied with new lenses and were instructed to use the chemical regimen daily and once a week to clean only the RIGHT LENS with the enzymatic cleaner. Eight of the 25 patients returned within the two-week period with redness in the right eye. Twelve others developed a red eye within 3 months, while the remaining 5 showed no adverse symptoms within the 3-month study period.

A letter in the Contact and Intraocular Lens Medical Journal (July/Sept 1980) vol. 6 no. 3 by Jack W. Moore states as follows: "When we applied the indiscriminate use of the product (enzyme cleaner) to all of our soft lens patients, some of whom were using higher water content lenses, we began to experience difficulties. The difficulties encountered were superficial keratitis with punctate distribution, extreme conjuctival infection, and mucus discharge. These complications were all medical management problems that required treatment with steroid-antibiotic combination drops. The majority of these patients returned to the same chemical disinfection regimen, except for the removal of the Enzymatic Contact Lens Cleaner, without additional problems, indicating to us that the Enzymatic Contact Lens Cleaner should not be used in the higher water content lenses. We still recommend the use of Enzymatic Contact Lens Cleaner in Bausch & Lomb or other soft lenses of water content under 40%.

Jack W. Moore also stated that Stuart Eriksen Ph.D. (Vice-President, Allergan Contact Lens Research) recommended that he modify the Enzymatic soaking regimen to be no longer than 2 hours with a longer overnight soaking in the prescribed saline to permit greater dilution of the enzyme.

In my original paper I drew attention to the danger of ocular sensitization to papain. Scientific honesty required that this danger be reported in any paper on contact lens solutions. The reader should carefully evaluate all the information he can obtain on any product before he takes the professional responsibility of supplying it to a patient.

Last fall, Bausch & Lomb introduced a further cold disinfection system and they suggest that the following changes and additions should be made to the tables. On page 34, Table 2, the Systems under Details of Use, it should read Lenses are pre-cleaned with surfactant cleaner (Bausch & Lomb Daily Cleaner) then put in Lensgard case containing Bausch & Lomb Soflens Saline Solution, then heated at 90°C for 60-75 minutes—has automatic shut off. The next column under Additional Details, lenses are stored in Bausch & Lomb Soflens Saline Solution and not Soflens Soaking Solution. Soflens Soaking Solution on page 35 should go on Table 2 under cold disinfection on page 34. A rinse with saline solution is advocated. The Aseptor Heat System, the Soflens Soaking Solution System, the Disinfecting Solution System should go under "Systems" on page 34. On Table 3 the Salines, page 35, instead of Soflens Soaking Solution, it should be Soflens Saline Solution and the purpose is for rinsing, soaking, storage and disinfection with heat. On Table 4 under the Surfactants, Bausch & Lomb Daily Cleaner should be included. On Table 5, Soflens Cleaning Tablets should remain and the purpose is to remove protein. Bausch & Lomb Salt Tablets should be taken out. In Table 6, Bausch & Lomb Lens Lubricant should be included.

H.D.E. Inns O.D., F.A.A.O.

EDITORIAL

The Past is the Key to the Future

It was not so many years ago that entry into the profession of optometry was a relatively simple and easy procedure. The candidates more often than not were the relatives of practising optometrists or the part-time employees of dispensing opticians and optical supply houses, or at least relatives of the owners of these businesses. A few of the entrants were patients of optometrists or those few students successfully recruited by guidance counsellors.

By and large however, by virtue of their large number of family and personal contacts, these candidates were usually well-acquainted with the history of optometry. They were sensitive and committed to the reversal of optometry's status at the time as second class citizenry vis a vis health planners, government officials, politicians, public health nurses, ophthalmologists and other medically trained and oriented individuals. Students entering optometry knew beforehand that they would have to battle to gain their rightful place in society.

With the advent of university integration and the granting of a university doctorate degree, the informal and relatively easy access suddenly changed and a very competitive and formal university admission system became the rule. It must be emphasized that the admission requirements to the College of Optometry of Ontario were similar to those in force in Ontario universities in 1967, namely high school graduation with a minimum grade level and certain required subjects.

But because of the high prestige and greater visibility associated with the university course, applications became a flood. Subject to standard university requirements for limited enrollment programs, the applicants with the highest grades were the fortunate few. However, high grades did not necessarily ensure an awareness of the history and heritage of optometry, nor did they guarantee any sensitivity to the broader responsibilities involved in becoming a successful practising clinical optometrist.

It has been this editor's observation that graduates of the seventies appear to lack a knowledge of our history and heritage, a knowledge essential to the fostering of an "esprit de corps" which led the profession to its many recent successes in the academic, professional and political arenas. In short, more recent graduates have had little battling to do in order to establish themselves. Relative to the experience of others before them, the profession of optometry has been served to these graduates on a "silver platter."

Because of their lack of purview, the '70s' graduates do not appreciate the efforts, the tears and the heartbreaks which occurred in order to present them with such a favourable social and economic situation. Are they prepared to put a shoulder to the wheel, to learn the ropes so as to assure replacement of the "old guard" which is reaching the age of retirement?

If concerned optometrists read nothing more than the several C.A.O. and provincial reports published herein under the general heading "The Seventies in Review" they will at least acquire a rudimentary concept of the nature and extent of the difficulties confronting the profession. Hopefully they will be inspired to activity and convinced participation.

Not too many months ago, the novel "Roots" created social and emotional upheaval as people realized the value of being aware of their origins. We hope that we can inspire a similar upsurge and revival within the ranks of optometry. With this foremost in our thoughts we append a list of historical readings about optometry, its heritage and its history. If such readings do not stir pride in an optometrist what hope can there remain for our survival as a unified profession?

1. Charlemagne Bourcier – D'un Oeil a l'Autre – Editions Beauchemin Montreal 1943.
2. Wilbur M. Brucker – The Story of Optometry – American Optometric Association, Minneapolis 1939
3. Maurice E. Cox – Optometry, the Profession, its Antecedents, Birth and Development – Optical Journal and Review of Optometry, October 1945 to January 1947.
4. Albert J. Fitch – My Fifty Years in Optometry, Pennsylvania. College of Optometry Press
5. Edward J. Fisher – History of Optometric Education In Canada – Can. Journal of Optometry, Vol.29, No.3, December 1967.
6. Armand Messier – l'Histoire de l'Education Optometrique au Canada – Can. Journal of Optometry, Vol.29, No.3, December 1967.
7. Maxwell Miller – Optometry's Historic Contribution to Science and Medicine – Can. Journal of Optometry, Vol.26, No.4, March 1965 and Vol.27, No.1, June 1965.
8. Henry Hoffstetter – Optometry, Professional, Legal and Economic Aspects, C.V. Mosby Co., St. Louis 1948.
9. E.J. Fisher – Optometry in Canada – The First Seventy Years – Transactions of the International Ophthalmic Optical Congress, British Optical Association 1970.
10. Munroe Hirsch, Ralph Wick – The Optometric Profession, Chilton Press, Philadelphia, 1968.
11. D. A. Sheard – The Heritage of Applied Optics – Transactions of the International Ophthalmic Optical Congress, British Optical Association 1970.
12. M. H. Revell – Strabismus – A History of Orthoptic Techniques, Barrie & Jenkins in association with the British Optical Association, 1971.

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C.A.O. BULLETIN

CAO President Dr. Jack Huber Presents President-Elect Dr. Hervé Landry with his Gavel and Badge of Office

CAO Council Elects New Executive

During the CAO Council meeting in Edmonton October 27-29, Councillors chose their executive members for the year October 1980 to October 1981. Dr. Jack Huber of Regina, Sask. becomes Past-President and Saskatchewan Councillor as former Vice-President, Dr. Hervé Landry of Moncton, New Brunswick assumes the President's position. Former Treasurer, Dr. Reid MacDuff of Gander, Newfoundland is now Vice-President while Dr. Roland des Groseilliers of Ottawa becomes Treasurer. Dr. Ray Corbin of Edmunston, is the New Brunswick Councillor while Dr. Landry is President and Dr. Bruce Rosner of Winnipeg will represent Manitoba replacing Dr. Roy Brown of Manitoba who leaves CAO as Past-President. Dr. Don Cleal of Lloydminster, also retires from his one year stint representing Saskatchewan during Dr. Huber's presidency. Both Dr. Brown and Dr. Cleal received a hearty vote of appreciation for their dedicated service while on Council.

EDITORIAL

Canadian Contact Lens Society

In March 1962, a group of interested contact lens practitioners banded together to form the Canadian Contact Lens Society. It is worthwhile, even at this late date, to list the names of these farsighted individuals: Cedric Passmore of London and John Price of Kitchener, the driving force behind the group, were ably assisted by Mac Rowe of Woodstock, Warren Currie of Hamilton and Gerry Beuglet of Windsor. The society filled a real need but it may have been ahead of its time.

Among the many activities of the group was the preparation of a constitution which is reproduced herein. Since then, progress of the art and science of contact fitting and the level of training at the undergraduate level has been phenomenal, so much so that a revision of the constitution is in order. The basic principles however, continue to remain as valid today as they were seventeen years ago. A second and perhaps more important achievement was the white paper on "contact lenses" prepared for the CAO contact lens committee. Cedric Passmore was the principle author of this report of some 25 to 30 pages.

The society was plagued by many problems but the lack of interest of practitioners across the country was the greatest because it stunted growth and development of this pioneer body. At the height of its activity the society never exceeded 47 members.

After four years the group voted its dissolution in 1966. Four reasons were given for its decision to dissolve:

a - inability to attract sufficient membership
b - lack of enthusiasm by members in preparing papers and reports
c - the presence of contact lens committees in CAO and the provincial associations
d - lack of members restricting the pool of practitioners from which successors for the executive could be drawn.

At the time of its dissolution the society turned over its small capital funds in trusteeship to the Board of Examiners in Optometry, to set up a Contact Lens Prize for the graduating student demonstrating the most ability in contact lens work. The prize still exists and will continue to exist as only the interest on the fund's principal is awarded to each recipient.

Recently attempts have been made to re-establish a Canadian Contact Lens Society. Details of the proposal are scarce but a letter of invitation has been circulated to many Canadian practitioners. It would appear that Josh Josephson of Toronto has assumed the task of organization. We have no knowledge of the names of his co-sponsors.

We cannot but offer encouragement to the sponsors to push along with their project, but sincerely hope that they will call upon the former members for help so that the society will be able to benefit from their experiences and prosper. Greater practitioner interest and more intensive undergraduate training should increase the potential for continued growth and survival of the society.

We also hope that the society will avail itself of the support facilities of the CAO head office, thus providing a fixed base of operations and permanency of records.

The Canadian Journal stands ready to assist the resurrection of the society by allocating space in each issue for the publication of society activities and the publication of papers and reports.

The society should not be considered as a competitor of local groups but more as a co-ordinator and synthesizer for all contact lens activities across the country. **G.M.B.**

Ed.note – Text reprinted here from original C.C.L.S. Constitution 1962

CONSTITUTION
of the
CANADIAN CONTACT LENS SOCIETY

PURPOSE

The Canadian Contact Lens Society is organized for the purpose of encouraging a high standard of contact lens practice in Canada. It also seeks to form a group of qualified and experienced practitioners to whom patients can be referred for initial contact lens fitting or for post-fitting care. It also aims to encourage and foster research and education in the science of contact lenses.

ORGANIZATION

Executive Council shall consist of:
Past President
President - to be elected annually
Vice-President - to be elected annually
Secretary - to be elected every 2 years
Treasurer - to be elected every 2 years

Honorary Membership may be conferred on any practitioner for distinguished contribution to contact lens work at the discretion of the Board of Directors.
Such individuals will not have voting power but may attend any meetings of the Council and Board of Directors.

Liaison Representatives from related associations

ORGANIZATION of the EXECUTIVE COUNCIL

Past President

President - The duties of the president will be to preside over the Executive Council at all meetings, and to preside over general meetings of the Society. In the event of a tie vote he shall have the authority to cast the deciding vote.

Vice-President - The duties of the Vice-President will be to assist the President. He will assume Chairmanship of any meetings in the absence of the President. The Vice-President will be elected annually, for no more than two successive terms.

Secretary - The duties of the Secretary will be to receive and send correspondence, to convey the correspondence to the Council, and to generally conduct the business of the Society under direction of the Council and/or President.

Treasurer - The duties of the Treasurer will be to keep records of all Society financial matters and to maintain a Society bank account. He is authorized to collect such dues as may be decided from time to time and is authorized to pay accounts as approved by the Council. All cheques issued by the Society will be signed by the Treasurer and President.
The Treasurer shall be responsible for the preparation of an annual audit and financial statement which will be presented to the annual meeting of the Society.

ELECTION OF EXECUTIVE COUNCIL

All members of the Executive Council shall be elected annually except the Secretary and Treasurer for not more than two successive terms.
Elections will take place at the annual meeting of the Optometrical Association of Ontario Mid-Winter Congress.

MEMBERSHIP

Membership in the Canadian Contact Lens Society shall be open to all licensed Optometrists in Canada who meet the requirements of membership as follows:

1. The applicant must be a member of the Canadian Association of Optometry or member in good standing in his provincial optometrical association.

2. The applicant must observe the code of professional ethics of his provincial association.

3. The applicant shall have graduated with a Doctor of Optometry degree from a recognized College of Optometry or shall have taken a total of forty hours instruction in post graduate course on contact lenses acceptable to the Society.

4. The applicant shall have completed a minimum of 10 contact lens patients supported by case reports or shall have demonstrated adequate ability in fitting contact lenses.

5. The applicant shall be required to attend some recognized form of educational session every two years to keep abreast with the new developments in the contact lens field.

6. The applicant shall have acquired the basic instruments and equipment listed under para.4bl of the General Policy of the Contact Lens Society as follows:

   (a) An ultra-violet radiation source for study of fluorescein pattern in the contact lens-eye relationship.

   (6b) An instrument designed to obtain keratometric measurements of the cornea. Above any other consideration the instrument of choice must be accurate.

   (c) Instruments to verify the finished lens:
   a) A lensometer for power readings.

   b) A magnifier with vernier scale for noting bevel widths, surface finish, and edge finish.

   (d) Radius measuring device for accurate measurements of the radius of curvature of the contact lens.

   (e) Equipment for lens modification; i.e. equipment which will modify size, edge, bevel, finish edges, repolish surface scratches, and change power within certain optical limitations.

   (f) Recommend additional equipment: A standard slit lamp or biomicroscope.

APPLICATION FOR MEMBERSHIP:

Application shall be made on the proper form procurable from the Secretary of the Society. Admission to the Society shall be granted to an applicant meeting the requirements of membership outlined above, upon payment of a $20.00 application fee which includes membership for the balance of the current year.

Sections and Classes of Members:

1. General Membership
2. Honorary Membership.

Termination of Membership:

The Executive Council by an affirmative vote of the majority of those present at any regularly constituted meeting shall terminate the membership of any member who violates the requirements for membership or who shall be in default in the payment of dues for 1 year.

Certification of Membership:

Upon qualification, a member shall receive a certificate of Membership. Such certificate shall be issued in trust and shall be returned upon termination of membership. This certificate may be displayed in professional surroundings but under no circumstances shall it be used for purposes of advertising. Violation of this section shall be grounds for termination of membership.

MEMBERSHIP DUES

The annual membership fee shall be $20.00 per year, payable on January 1st of each year.

MEETINGS

The Executive Council will meet at least once each year. Special additional meetings may be held at the discretion of the President.

COMMITTEES

The following Committees shall be appointed by the Executive Council for a two year term, half the members retiring initially at the end of the first year.

a. Membership
b. Discipline and Ethics
c. Educational
d. Nominating

The Chairman of each Committee shall be a member of the Executive Council.

CAO President Hervé Landry's Inaugural Address

Discours Inaugural de M. Hervé Landry, Président de l'ACO

It is obvious that with the advent of the one year term for the presidency of CAO the direction and emphasis of the different programs undertaken by the Council of CAO cannot change drastically from year to year with the change of each president.

Therefore, during the coming year we will continue the various programs now in progress and initiate new ones according to the need and with the resources at our disposal.

In the coming year we will be focussing our energies on three major programs that seem to me to be the most important at this time.

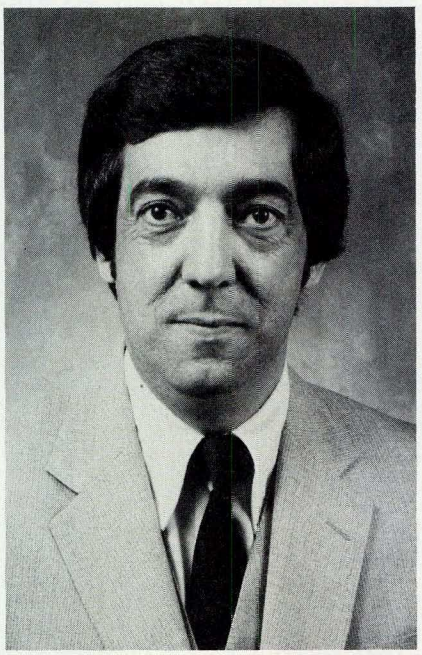
The first of these is the creation of a new school of optometry in Western Canada. It has become quite evident that a great need for such a school exists in order to safeguard the vision care of the people of the four western provinces.

Without an increase in the profession's ability to graduate more practitioners we will not be able to either offset manpower ratios due to attrition and population growth or meet the ever increasing public demand for vision care services.

We will therefore do everything in our power to see to it that this school is created within the near future.

The second major program is the Optometric Education Trust Fund. This fund was initiated by CAO because we believe it is vital to the progress of Optometry in the future. We will continue the Trust Fund Drive until the goal is reached.

Also, within the coming year we will try to solve the problem of disunity that now exists within our own organization. The fact that the



APOQ is no longer a corporate member of CAO has created a situation which is foreign to organized Optometry in Canada. We will do everything in our power to resolve the problem so that once again we can speak as one voice for all Canadian Optometrists.

We will continue to expand all of the Association's programs which are designed to assure you that through a collective voice the conditions under which you earn your livelihood are not subject to change by outside influences without your knowledge and that your position in the health care delivery system is recognized and maintained.

I am sure that the coming year will be both challenging and rewarding to me as I travel across the country visiting the different provincial associations, and I am looking forward to meeting all the friends that I have made in optometry during my association with the profession.

Avec le début du mandat d'un an pour le président de l'ACO, l'orientation et l'accent des divers programmes entrepris par le Conseil de l'ACO ne peuvent évidemment pas être modifiés de façon draconienne d'année en année à l'élection de chaque nouveau président.

Par conséquent, au cours de l'année, nous continuerons les divers programmes déjà prévus et nous mettrons en oeuvre de nouveaux programmes si le besoin s'en fait sentir et selon nos ressources.

Pendant mon mandat, nous orienterons nos énergies vers trois programmes majeurs qui, à mon avis, revêtent le plus d'importance à l'heure actuelle.

Le premier programme vise la création d'une première école d'optométrie dans l'Ouest canadien. Il ressort nettement que cette école est des plus nécessaire pour sauvegarder les soins visuels des gens des quatre provinces de l'Ouest.

Si nous n'augmentons pas le nombre de praticiens diplômés en optométrie, nous ne pourrons ni compenser la baisse du taux de main-d'oeuvre qualifiée causée â la fois par le roulement des professionnels et par la croissance démographique, ni satisfaire à la demande sans cesse grandissante du public pour des soins de la vue.

Nous ferons donc tout ce qui est en notre pouvoir pour assurer la création de cette école dans le proche avenir.

Le Fonds de fiducie des optométristes canadiens pour l'éducation constitue le deuxième programme. Le fonds fut créé par l'ACO parce que nous croyons qu'il est essentiel

au progrès futur de l'optométrie. Nous continuerons la campagne jusqu'à ce que nous atteignons notre objectif.

Au cours de la prochaine année, nous essaierons aussi de trouver une solution au problème de désunion au sein de notre organisme. Le retrait de l'APOQ de l'ACO a mené à une situation totalement étrangère à la notion d'un organisme canadien d'optométrie. Nous ferons de notre mieux pour résoudre ce problème afin que, de nouveau, nous puission représenter tous les optométristes du Canada.

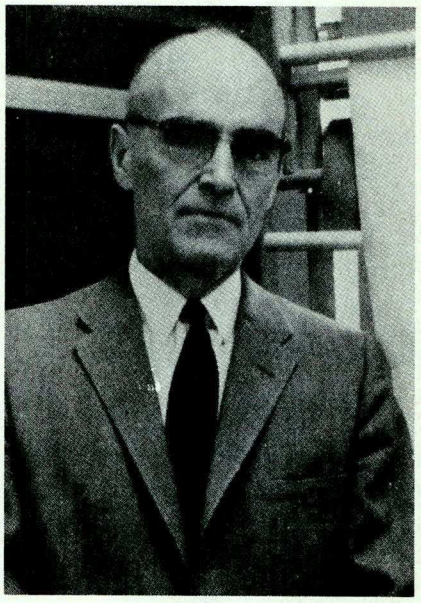
Nous continuerons à élargir tous les programmes de l'Association qui visent à assurer par une voix collective que les conditions qui régissent la pratique de votre profession ne seront pas assujetties à des changements causés à votre insu par des influences venant de l'extérieur, et que votre position dans le système de soins de santé soit reconnue et maintenue.

Je suis persuadé que l'année qui commence m'apportera à la fois défis et satisfactions au cours de mes voyages dans tout le pays et de mes visites aux diverses associations provinciales. De plus, j'anticipe avec plaisir de rencontrer tous les gens de la profession avec qui je me suis lié d'amitié au cours de mes années de rapport avec notre profession.

In Memory of Balfour Beverly Sparks, M.D. 1905-1980

The recent death of Dr. Balfour Sparks ends a long and friendly association with optometric education and optometry. Dr. Sparks, who died on August 9, 1980, graduated from the Faculty of Medicine of the University of Toronto in 1931 and interned at the Christie Street Hospital. He was a member of the outpatient staff of the Toronto General Hospital from 1937 to 1939 and a member of the medical staff of St. Joseph's Hospital in Toronto from 1939 until his retirement in 1976. Bal was a native of Toronto and maintained his home and medical practice in Toronto until his retirement, at which time he and his wife Jean moved to their country home near Mount Albert, Ontario. Bal and Jean celebrated their fiftieth wedding anniversary in February, 1979.

Bal joined the faculty of the College of Optometry of Ontario in Toronto in September, 1937 and remained as a professor until the College moved to the University of Waterloo in 1967. A celebration of his twenty-fifth anniversary at the College of Optometry was the highlight of the students' formal banquet on March 3, 1962. When the college transferred to the University of Waterloo in 1967, Bal was appointed to the faculty of the School of Optometry, University of Waterloo and continued lecturing until 1970. Bal was noted for his demanding but fair academic standards, his dry wit, his penchant for early morning lectures at which he was invariably in top form, and the pleasure he took in the social activities of the students. Two generations of optometrists are indebted to Bal for the knowledge and skill which he so freely imparted in the disciplines of anatomy, neurology, physiology and pathology. Those of us who were fortunate enough to be able to maintain a close friendship with him after his retirement could not fail to be impressed by his continuing interest and concern in optometric education, optometry and the many optometrists he remembered so well. His friendly advice will be much missed by those who knew him.



Bal leaves his wife Jean, his daughter Barbara, two sons Robert and Bruce and six grandchildren. He is also survived by two brothers, one of whom, Dr. Stuart Sparks, practices optometry in Smith Falls, Ontario.

Walwyn S. Long

A "Special Donation" to the Canadian Optometric Education Trust Fund would be a fitting and lasting tribute to the pioneer contribution made by Dr. B. Sparks to optometric education in Canada.

Tax receipts issued with an acknowledgement letter sent to Mrs. Sparks with each special donation

THE SEVENTIES IN REVIEW
C.A.O. IN THE DECADE OF THE SEVENTIES

In tracing the progress and activities of C.A.O. through the 'seventies it would be impossible to comment on all of the projects and programs so an attempt has been made to highlight some events in each year. It was an exciting and progressive decade and one in which C.A.O. matured in a great many ways. Many of the projects, such as a western school of optometry, were continuing throughout the ten years and still have not come to fruition, but nevertheless, progress has been achieved and a great many people have been educated as to what optometry is.

The decade began under the very capable and efficient leadership of Woody Spearman and the Executive Director Mr. Mel Mellow. In 1970 Mr. Greg Walsh was engaged as an assistant to Mr. Mellow and served C.A.O. over the next four years. During the year a sophisticated keyman project was undertaken and a successful lobby conducted with the Federal government. A comprehensive brief was prepared regarding a western school of optometry under the chairmanship of Hugh MacKenzie and was widely distributed in order to promote a third school of optometry in Canada. Ten years later this is still a high priority within C.A.O. and we remain eternally optimistic. This was also the year that C.A.O. embarked upon the production of T.V. public service announcements under the able guidance of Ron McPherson. This project was and is an unqualified success and Canadians from coast to coast have viewed these films.

The same Ron McPherson assumed the presidency of C.A.O. in 1971 at the Biennial Congress in Vancouver. Fred Attridge received the President's Award on that occasion and Greg Walsh took over the duties of Executive Director upon the departure of Mel Mellow. C.A.O. Council took the formative steps during this year to establish the Canadian Optometric Trust Fund which was eventually constituted as the Canadian Optometric Education Trust Fund. This year saw optometry attempt to resolve the differences between ourselves and ophthalmology by initiating discussions and meetings with the Canadian Ophthalmological Society and the Canadian Medical Association in the role of mediator. There was great optimism at the time but the benefits of these meetings were very limited as history will show. Another major project in 1971 was the preparation and presentation of a brief to the Federal Government regarding the controversial Competition Act.

In 1972, the Council approved the change in location of the C.A.O. office from Metcalfe Street to the present quarters on Gladstone Avenue. This provided our staff with a more pleasant and efficient working environment as well as improving our image to the public and other organizations who visited the office. Steve Finlay was employed as an executive assistant and allowed us to broaden our programs. As a result of our lobby, the Federal government ruled that federal funds could be used by provinces to cost share for optometric services. C.A.O. received many compliments on the effectiveness of our lobby. C.A.O. hosted a national conference on legal affairs in which all provinces participated and gained an in depth insight as to optometric law across the country. Another significant milestone in 1972 was the sod turning for the new School of Optometry Building at the University of Waterloo.

In 1973 a very successful Biennial Congress was held in Winnipeg and saw the inimitable Ivan J. McNabb installed as President of C.A.O.. A tireless worker on behalf of Canadian optometry, Ted Fisher, was the worthy recipient of the President's Award. This was a year of vigorous contacts with various Federal government departments and optometry gained significant credibility within these departments as a result. It was realized that the constitution of our organization was in need of revision and this project was embarked upon in 1973. Council recognized the advantages of a standard academic qualification across Canada for entrance into the practice of optometry and work was begun on a National Council of Optometry and this project is still under way. A notable conference was held during this year when the New Academic Facilities Committee arranged a visit to the School of Optometry in the University of Waterloo for representatives of the Health and Education departments of the four western provinces. This very successful meeting was another effort to educate the right people as to the need for a third school of optometry. Council also approved the concept of a joint meeting of C.A.O. and the American Optometric Association to take place in Toronto in 1977.

The priorities for 1974 did not change significantly as the western school, interprofessional relations and a national board of examiners topped the list. C.A.O. played a supportive role in the hearings conducted on the Ontario Health Care Disciplines Act and optometry emerged from the discussions with a very healthy and creditable image. We indicated our cooperation to the Federal government in relation to metric conversion and appointed a member to this committee. A successful tour was sponsored to Aus-

tralia and Greg Walsh resigned as executive director to return to school and study law. Don Schaefer was engaged as Greg's successor.

Half way through the 'seventies saw the Council move their spring meeting to the beautiful city of Montreal in order to enhance relationships with the Quebec Association. Up until now, it had been the Quebec College of Optometrists who was represented on C.A.O. Council and it was thought it would be more appropriate if the Association were the member. While in Montreal, Council members were privileged to have a delightful tour of the School of Optometry, University of Montreal. Steve Finlay resigned as executive assistant and was replaced by Mike DiCola who assumed the position of Public Information Coordinator which included responsibility for the administrative duties for the Canadian Journal of Optometry. The first Bienniel Congress which C.A.O. administered instead of the local provincial association was held in Halifax, Nova Scotia. Appropriately, a prominent member of the Nova Scotian Optometric Association, Garson Lecker, was installed as President. Clair Bobier, a household name in Canadian optometric circles, was the surprised recipient of the President's Award and the Association in general session approved the new constitution. Hearings on the ophthalmic industry were initiated by the Restrictive Trade Practices Commission and C.A.O. as well as most provincial associations appeared before the committee in various cities. The important document "Role of the Optometrist in Health Care Delivery" was published this year and C.A.O. contracted with Crawley Films for a new series of public service announcements for television.

In 1976, the C.A.O. Council held their first meeting of the year at the new School of Optometry building at the University of Waterloo and the Quebec Association was represented for the first time instead of the Order or College. Discussions were held with the Ministry of Transport regarding certification of visual fitness for aircraft pilots and successfully resolved. This was the era of the Anti-Inflation Board and optometrists, like other self-employed professionals, had to learn about income reporting, compliance forms, and other bureaucratic paraphenalia. C.A.O. sponsored a successful tour to Israel which was very well attended.

The following year saw Mike DiCola leave C.A.O. and Tom Little was employed as his replacement. The Index of Canadian Optometry was published and distributed to all C.A.O. members to assist them in identifying colleagues across the country for referral and other purposes. This was the year of the big joint congress with A.O.A. in Toronto and the dynamic Roy Brown ascended to the chair of president. The president-secretary meeting was most successful and took on a new format which is still in use at the end of the decade. Four topics of keynote importance were presented to the meeting and these were—Scope of Practice, Education, Legislation and Communication. Firm goals were established and time frames were set up for achieving those goals. From my viewpoint, it was at about this stage that C.A.O. as a professional organization moved from adolescence to young adulthood. Harold Coape-Arnold, a past-president of C.A.O., received the President's Award on this occasion. That meeting was also a memorable one for another reason—it was here that the formation of the Canadian Optometric Education Trust Fund was publically announced and the first donation was received from E.J. Fisher.

In 1978, the Council, in keeping with its objective of coming in contact with practitioners across the land, held its spring meeting in Victoria. Two events took place during that meeting, one of which was pleasant and the other sad. The latter was that the Council reluctantly accepted the resignation of Don Schaefer. He and Maureen were desirous of serving in a third world country and had plotted their course accordingly. The enjoyable event was the visit to the University of Victoria, where at that time there was sincere hope of establishing a school of optometry. C.A.O. collaborated with the Canadian Public Health Association in the publishing of a journal on eye and vision care. Public Health workers in all areas of Canada received this journal and the joint venture was very successful. This was the first year a president-secretary meeting was held in the absence of a Biennial Congress. Provincial leaders felt that the meetings were of sufficient value and benefit to be held on an annual basis and the 1978 meeting did not disappoint them. Two excellent speakers in the persons of Ron Hansford and Bruce McDonald presented keynote addresses and it was particularly interesting to hear from Mr. McDonald, an expert on consumer law, who gave an objective view on our profession. His experience as counsellor for the Couture Commission provided him with a deep insight into the ophthalmic industry. Another gratifying event during this meeting was the tribute paid to Maurice Belanger on the occasion of his twenty-fifth anniversary as Editor of the Canadian Journal of Optometry. Few people have demonstrated faith and dedication to optometry on a par with Maurice. This was also the year that the Canadian Ophthalmological Society submitted a brief to the Drug Directorate in the Federal Department of Health recommending that certain ophthalmic diagnostic pharmaceuticals be placed on Schedule F. which would make it difficult if not impossible for optometrists to utilize them. These consisted of cycloplegics, mydriatrics, topical anaesthetics, and miotics among others. C.A.O. responded with a very comprehensive brief and the outcome was that the C.O.S. recommendation was not acted upon. A tour was sponsored to the Orient and as well 1978 was a year of extensive press coverage mainly due to

the efforts of Roy Brown and Tom Little.

The Fall Council Meeting was held in Quebec City and Councillors experienced the opportunity of a tour through the facilities of the Quebec Health Insurance Board. The impact of third party contracts in optometric care became more evident and a separate committee was formed to coordinate a study in this area. Sue Jabour, a long time employee of C.A.O. left our employ and she was replaced by Ruth Wilcox.

Nineteen seventy-nine brought still more staff changes when Peter Welsh resigned and we were fortunate that Don Schaefer's plans did not jell and he was able to return as our executive director. The biggest event of the year in terms of publicity was, of course, the eclipse. C.A.O. in concert with the provincial associations did a fine job of publicizing both the scientific phenomena and the dangers associated with it. As a result, injuries were kept to a minimum and optometry received extensive and excellent public recognition. A record attendance at the Biennial Congress in Edmonton was an indication of the unqualified success of that event. The Alberta Association Committee under the chairmanship of Scott Brisbin did an outstanding job and set a high standard for future Congresses. Bill Lyle was the worthy recipient of the President's Award and at that same meeting the National Council of Optometry became a reality. Keynote topics at the president-secretary meeting were Consumer Education and Third Party contracts and the two capable speakers were Harry Basman of Manitoba and Bill Reinertson from the American Optometric Association. In this closing year of the decade some of the goals of C.A.O. have been achieved and some have been shelved or forgotten and others are being aggressively pursued. The Trust Fund is alive and well, the third school is still a wish but by no means neglected, the National Council and Third Party Care Committees are very active and C.A.O. is in a firm and stable position to carry on its work on behalf of optometrists in Canada.

As the decade of the 80s begins the Council is resolute in its intent to promote and enhance the interests of Canadian Optometry because they know this will in turn make possible more efficient, available, economic eye and vision care for the citizens of Canada.

Jack Huber O.D.

The Dynamic Optometric Program Planning of the 1970s

It is a privilege for me to be given this opportunity to comment upon the attitude changes in program strategy that have occurred in the philosophical approach of Canadian optometry to the vision care issues in the 1970s.

I would summarize the 1970's as being a vital period where the leaders of Canadian optometry consolidated their thinking into specific objectives for the profession's future and developed a plan of action for achieving the objectives. They identified the obstacles to the achievement of these goals and built in response, a goal-orientated organizational structure capable of dealing effectively with them.

For an appreciation of how we consolidated our thinking about our future objectives and set about developing a future plan of action, I would refer you to two specific documents. The development and publication in 1974 of our position paper "The Role of the Optometrist in Health Care Delivery" was a bold and courageous move by the profession. Within this single document we stated in a very concise manner the future goals and aspirations of our profession for public, governmental, and medical consumption as well as our own internal uses. We have worked diligently towards the achievement of it's major themes. We ended the decade by participating in the Federal government's review of the national health care delivery system which was directed by Justice Emmett Hall. Our detailed brief to this federal commission further reflected in specific terms the future goals and aspirations of the profession as a leading component in the primary vision and care delivery system. Both of these documents placed the profession on record as being committed to the objective of moving the profession beyond our present modes of service delivery and into the position of providing for the unmet vision and eye care needs of the Canadian public.

Our 1970 activities also included the identification of the obstacles currently in place within the political and health care systems that would prevent us from achieving our specified objectives as identified in the Role Document and the brief to the Hall Commission. We isolated and then summarized these issues into the following four categories of obstacles. a) The **Legislative** obstacles to the achievement of our Scope of Practice ambitions were identified as being centered around the need to introduce a provision in the provincial optometry acts for the use of pharmaceutical agents, the maintenance in government legislation of a relevant definition of optometry and patient referral criteria, and the curtailment of the delegation of optometric procedures to non-licensed or unqualified individuals. b) The reactionary position of the **Medical Profession** to our programs has been

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anticipated in terms of their opposition to: progressive changes in provincial optometry acts which would expand the role of the optometrist, further inclusion of optometric service coverage under provincial health insurance commissions, and the creation of a third school of optometry. c) Since our services are part of a complex and wide ranging economic system, **Political Developments** have a direct impact on the profession's activities as evidenced by: the changes in the Competition Policy Act of Canada with regards to the advertisement of fees and the use of fee schedules established by provincial optometric associations, the governmental investigation of the monopolistic position of several companies within the ophthalmic industry of Canada by the Restrictive Trades Practices Commission, the Bureau of Consumer and Corporate Affairs critical investigation into the effects of the licensing process of professional groups on earnings and the manner in which the process reduces competition throughout our economy, the Federal Trade Commission in the United States extensive investigation into optometric fees and prescription portability issues. d) The **Optometric Manpower Crisis** has been identified as a result of the careful evaluation of such issues as: anticipated attrition rates among practicing optometrists due to age, death and disability; increased population growth and inter-provincial migration patterns, the changing demand patterns for vision care services due to the general aging process within our society. These manpower demand factors when balanced against our present limited capacity for educating and placing new optometrists in the field has left us with the sobering realization that additional optometric training facilities are immediately required. The failure by the government to create a new school of optometry in the 1980s will result in the erosion of our present position in the vision care delivery system and increase the complications associated with unmet vision care needs of the Canadian public.

We closed out the decade by developing and putting into place an organizational structure that is capable of overcoming these obstacles and moving the profession towards the achievement of our stated objectives. The creation of the Canadian Optometric Education Trust Fund serves as a cornerstone to our efforts to satisfy the manpower and unmet vision care needs problems. The National Council of Optometry will assist in improving licensing procedures and optometric manpower portability on an inter-provincial basis. The National Advisory Committee on Vision Care programs will help the profession to become more fully integrated into the health care system and to respond to the public desire for access to quality vision care at affordable prices. The Canadian Journal of Optometry with the full support of CAO has further expanded its academic excellence and scope of clinical investigation. CAO and provincial optometric associations have gained new administrative expertise that have allowed them to provide the practising optometrist with a broader range of services and the needed assurance that the political demands being placed on the profession are being handled with an unprecedented level of efficiency.

As we leave the 70s we can honestly say that Canadian optometry has effectively moved from the important planning and analytical stage into the demanding and critical program implementation phase. We are confident that we have thoroughly investigated both our strengths and weaknesses and have developed a clear and realistic set of objectives to be incorporated into our future course of action. The 1980s should therefore be regarded as a period of dynamic change and opportunity. I respectfully challenge each of you to become part of this well thought out masterplan by actively participating rather than merely benefiting by the goal orientated programs being implemented on your behalf by your provincial association and CAO.

Donald N. Schaefer
CAO Executive Director

Right-hand Eye Man

The School of Optometry at the University of Waterloo has formally established the position of Associate Director, and has named Dr. T.D. Williams to the job for this year. (Dr. W.S. Long was doing it "unofficially" before he went on sabbatical leave, Dr. Williams says.) The Associate Director will, among other duties, chair the monthly meetings of optometry faculty, and act as liaison among the faculty members, the school's administrative council, and the dean of science.

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CJO INTERVIEW:

Optometry in Canada – A Review of the Seventies and a Forecast for the Eighties

Dr. Jack Huber

Dr. Roy Brown

At the time of the preparation of this hallmark edition of the Canadian Journal of Optometry – A Review of the Seventies – CJO's Editor Maurice Belanger and Associate Editor Joseph Mittelman invited CAO President Dr. Jack Huber and Past-President Dr. Roy Brown to meet and exchange views with CAO Executive Director Mr. Don Schaefer on the major trends which have influenced the profession of optometry during the last decade.

In their wide-ranging discussions they dealt with many issues, the most important of which were the influences of government and medicine and the implications of consumerism for the practice of optometry in Canada.

Other areas receiving attention were the evolution of optometry in the field of practitioner training and the matter of specialization in optometric practise. We are pleased to present our readers with a brief summary of their remarks as they fielded the questions posed by CJO's Editors.

CJO: Two factors have affected the mode of optometry in the past decade and will continue to do so in the future. One is medicine which has dominated the health care field and the other is government. How did you see their roles in the 1970's?

Dr. Brown: Well I think there has been a real shift in their roles. Granted, for many years medicine did dominate the health care field and the delivery of health care. But with the advent of national health care schemes and with the provinces participating in them, government has played a much greater role and will continue to play an even greater role since government is paying the bills and naturally will be much more concerned where the dollars are going and whether it is getting a true value for the money that is being spent. So I can see a much heavier influence coming from both federal and provincial governments.

CJO: Do you feel that the cooperation of medicine in a health plan is an essential factor to a well balanced health care service in Canada?

Dr. Brown: Certainly. But I think we must remember that out of every 100 practitioners in the health care field there are 87 (roughly) in fields other than physicians. So we should count dentists, nurses, optometrists, druggists, physiotherapists, the whole gamut in fact. While it was unbalanced before, the balance is beginning to come about now because the economic delivery of health care is better understood. Formerly medicine was playing its traditional role but now I think that medicine will have to accept the fact that it is only a part of the modern health care scheme and not the whole health care scheme.

When this is fully understood by medicine and health care planners there will be a much more efficient delivery of health care to Canadians.

CJO: Dr. Brown mentioned 87 of 100 are not physicians. How does this affect health care delivery?

Mr. Schaefer: I think that what we have to bear in mind is that all health care is not medical care. If you look at the one national payment pro-

gram that we have under the federal government's Health Service Commission Act it is related to payment for services provided by the physician. The trend which has been developing in the 70's as evidenced in the submissions to the recent Hall Commission Inquiry is that service should be paid for in terms of the person's qualification to render the service rather than their status as a medical practitioner. This is a vital change and hopefully in the 1980's the services of optometry, podiatry, chiroprators, the so called fringe groups or allied groups, will be recognized because they are cost efficient, they are accessible and more importantly the quality of service is as good as that provided by physicians. So health care is not medical care and if the payment mechanism relates to the provision of care in terms of the practitioner qualified rather than just medical specialist there is going to be a major change in the eighties.

Dr. Brown: I think you can confirm what Don has said by taking a look at the seven provinces that are included in health care schemes across Canada. The only place where they receive payment is where there is an overlap of optometry and ophthalmology and/or medicine. And now we're finding that even this is changing. For example, in Quebec you have a range of diagnostic services that are covered for payment, possibly the broadest in Canada. And certainly all the other provinces' benefits have also been gradually expanded to include more of the diagnostic roles. Someday it will include the whole range of those professions' services. And it will happen because of three fundamental reasons: first is economics, second is quality care, and a third, that the geographic and demographic distribution of those practitioners better meets the needs of the population.

CJO: Health care in Canada and the proposal for instituting a plan came mainly from the proposals of health care administrators; they had a very restricted concept of health care, that health care was solely medical care. Is this not a true statement of fact? Can you relate how the changeover came about?

Dr. Huber: I think the term medical care traditionally comes from the longstanding domination of health by the medical profession. However, in recent years other personnel within the health care field have become much more vociferous in their demands for autonomy and optometry is one of these allied health professions. I think that government has been educated to realize that health care is not limited to medical care.

Consequently most provinces have now assumed the title of Health Care Insurance Commission for thier insurance boards. This I think is significant in the fact that they realize this change in concept.

CJO: Do you see this trend continuing in the future?

Dr. Brown: I would think there would be no doubt about this. The fact is that where we have governments paying the bill, we have an economic incentive; they find that prevention is far cheaper and provides a better quality of health care than catastrophic care does. And this is what medicine was usually doing, providing catastrophic care. So groups like the Canadian Public Health Association and different public health care associations across the country are now playing a much firmer role in the prevention area.

Mr. Schaefer: I think the interesting part is in the early 1970's when optometry came into the programs as an extra benefit. This simply meant that not one federal dollar was going to this extra benefit called vision care. But the provinces offered it because the population wanted vision care. They have demanded its inclusion within their system. If we review what has happened within the last seven or eight years we will see that we started out by having the western provinces, Ontario, Quebec and Nova Scotia in the health care system, and they started by having visual analysis or a refraction covered. Over the years partial assessments and reassessments are introduced. In Quebec, the complete range of diagnostic services are covered whereas in the other provinces we have varying degrees. But, you can see that as the services of optometrists are offered and as they are being accepted by the public, their demands for our services grows and grows. If you look at the 1980's I cannot see this trend slowing down. The objective of every provincial optometric association is to have visual training or contact lenses therapy also offered as a covered service. That is in response to the demands of the people you are servicing. So the 1980's look pretty good for optometry from that point of view.

CJO: Can you describe how the relationship between optometry and ophthalmology has evolved in the 1970's and what do you think of the outlook in the 1980's?

Dr. Brown: In 1971 CAO began a series of meetings with the Canadian Ophthalmological Society which were chaired by the Canadian Medical Association on all occasions. It was brought about by the fact that ophthalmology had written a statement on eye care for Canadians and wanted it published and accepted by the Canadian Medical Association. C.M.A. in turn turned it over to the Canadian Association of Optometrists to accept or to alter. These meetings weren't always easy but out of those sessions came a statement on vision and eye care for Canadians, one by optometry and one by ophthalmology which still stand today. Also the Role of the Optometrist in Health Care Delivery was developed and remains a very important document to Canadian optometry. The meetings certainly helped us to define where we were, where we came from and where we were trying to go. I think that it brought us to the point where we could see some common relationships between our two professions. And for the 1980's, I can now see a much closer working relationship between ophthalmology and op-

tometry. First of all when one takes a good look at the vision and eye care field, we find that in the North American continent roughly 92 per cent of the people are bothered by a vision problem. We have minor eye problems, 5 per cent of which are commonly administered to by the general practitioner or the family practitioner and we have 3 per cent of this total area that falls under the classification of surgery or pathology which are in the ophthalmological field. Governments have begun to take a real look at the education and future production of optometrists and ophthalmologists. This has made both of the professions and the government more aware of the manpower situation, an awareness of which will lead to a more balanced manpower situation and better vision and eye care at lesser costs to the taxpayer.

Dr. Huber: I wish I could be as optimistic as Roy. The Canadian Association of Optometrists was the initiator of these discussions. We were hopeful that if we could sit around a table and discuss these things in a gentlemanly way that they could be resolved. However, as history has shown, we were disappointed in our anticipation of this. Unfortunately, I feel that ophthalmology has taken the attitude that they are going to go their own separate route. This is a sad commentary as far as the public is concerned. I really don't feel that they can benefit from this schism between the two groups. I personally am not optimistic about the situation improving in the foreseeable future.

CJO: I have noticed that sometime ago ophthalmology used to stress the inability of the optometrist to recognize eye diseases, particularly glaucoma. We had a rash in the early 1970's and late 1960's of glaucoma days. The glaucoma days disappeared for a number of years and now they have started to come back. You will see that they are now talking about the ability, the super ability of the ophthalmologist to be able to recognize systemic diseases in the eye, inferring all the while that we are unable to do so. It strikes me now that you just have to open the newspaper to see reports of medical groups and physicians particularly ophthalmologists speaking to lay groups with this matter consistently being stressed. Have you noticed that?

Dr. Huber: Yes. I would like to just comment on the fact that unfortunately I feel a lot of these trends are politically motivated. Scare tactics that have been used have included glaucoma, cataracts, and the fact that we could not dilate the pupil and see the total fundus, the use of pharmaceuticals.

And it seems to me that even when these things are resolved by optometry there is yet another hurdle to go over. A typical situation existed at the Waterloo School when the pharmacology became suspect. The school had an independent study done and the report came out in a very positive way that the students were properly trained in the use of facilitative pharmaceuticals. The pharmacology training had hardly been resolved when ophthalmology once again questioned our ability to recognize pathology. I understand that as a result the school has asked McMaster University to study and report on the quality of this training.* Unfortunately I must conclude that such attacks are politically motivated, not by any desire to improve service to the public.

Dr. Brown: The situation that arose in 1978 with the Drug Directorate when the COS tried to have Health and Welfare put a number of ophthalmic drugs, practically everything next to water under schedule F** is another example of this trend.

As a result of our presentation to the Drug Directorate and our dialogue with them not only were none of the ophthalmic drugs put on Schedule F, we have gained a far greater stature today amongst pharmacologists and certainly with the Department of Health in Ottawa than we have ever had before. It appears to me that every time something is thrown at us we are capable of dealing with it.

CJO: It is thought that the scope and practice of a profession can be influenced by two main factors: the educational institution and the profession. Which of these two groups has been the most influential in developing optometry and is there not a justification that the two should cooperate in order to evolve a more comprehensive unifying plan for the future?

Dr. Huber: In response to the latter part of your question there is no question about the idealism of a cooperative approach to the determination of the scope and mode and role of the practice of optometry. However, up to this point in time or in very recent times, the educational institution has been far more influential in the determination of this particular issue. I don't say that as a criticism or in any derogatory way. We are speaking of the University of Waterloo which is the resource for 9 out of 10 provinces in Canada and it is a very strong and progressive institution. Unfortunately the profession has not been as strong in its consideration of this particular issue so that by our own default the educational institution, or academia has determined our course. It was interesting to sit in on a meeting a year ago in B.C. during a debate on the use of pharmaceuticals. The debaters were Dr. Bert Jervis and a young recent graduate from Waterloo. Of course they were of opposed views, especially in the area of treatment drugs. This was perhaps an example of the error in thinking that the professions could easily influence practitioners after they graduate. I think they are receiving the training at the undergraduate level to anticipate what they are going to be practising. The greater example of this today is in the United States where young

*Ed. Note.
The LaRiche study on optometric practice reports favourably on the quality of training in this area. Reference. LaRiche, H.W., 1980 – Vision Care – A Survey of Optometrists in Ontario, Dept. of Preventive Medicine Biostatics, Faculty of Medicine, University of Toronto.

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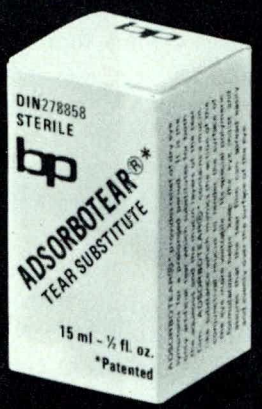

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graduates are coming out fully convinced that they are qualified to use treatment pharmaceuticals. The point is that I don't think this is really the consensus of the profession at large. So, to answer your question, I would say that up to this time the educational institutions here in Canada have had a far greater influence on the determination of scope. However, I think the profession is very much aware that this has come about. Certainly a consideration of this situation is now a definite priority within C.A.O. as a result of this awareness.

CJO: Optometry has not always been blessed with strong institutions. Can one of you recount the evolution of optometry in the field of practitioner training?

Dr. Brown: Historically public acceptance of optometry has been built upon proper training and service. The quality of training has been confirmed by adequate legislation. Practitioners banded together to foster proper standards by self education. They founded institutions and then approached Government to obtain legislation. So from an historical aspect the profession was the primary factor in setting up institutions and determining what subject matter should be included in the curriculum to produce practitioners with the desired qualifications. Post graduate education although administered by the school was practitioner orientated.

Practitioners made it a personal responsibility to study and read. The Optometric Extension Program and the summer courses in Saskatoon and at the Ontario College in Toronto are prime examples of this. The profession by deferring to academicians and university traditions has lost influence in the development of curriculae. The off-campus projects have rectified some deficiencies by providing clinical experience. Practitioners have on their own developed expertise in many fields such as low vision, learning disabilities and contact lenses, the knowledge of which is now a part of formal curriculae in the schools. Residency programmes are of value because they provide both better instructors at our schools and practitioners for the field. But one cannot obtain proper legislation unless the profession has the training and the institution to back the demand for legislative changes. We should not forget that our admittance to Waterloo was achieved only after demonstrating the suitability of optometric training as a university discipline. The profession and the school have each enjoyed its heyday in formulating curriculae. Progress in the future will result from cooperative efforts of the profession and the faculty to produce practitioners able to meet the ever changing needs of this society.

CJO: There has been a growing demand for optometric certification of specialties. Should the process be institutional or professional in such approval?

Dr. Huber: I think that your comment that there has been a growing demand is well taken. The fact that there is a demand is being responded to by the educational institution in residency programs is something which I personally don't have any particular quarrel with. I understand that most of the schools rationalize these residency programs on the basis of actually educating somewhat better teachers as opposed to better practitioners. However, I think that the sooner we get some of these so-called specialists into private practice the better off we will be because I think there is a need, there is an area for them to practice in, particularly in larger urban centres. I think that the profession should have a very definite input in terms of certifying these people but I don't think it is a black and white question of either the profession or the educational institution. Again, I think that a cooperative approach should be taken. There are definitely needs in terms of pediatrics, geriatrics, low vision in a number of regions of Canada for this sort of specialization within the profession.

Dr. Brown: I would like to agree with Dr. Huber but I would hope though that optometry would not make the same mistake that has been made by medicine in Canada where we have got well over 50 per cent of physicians who are specialists. As a result of this, medicine is having a great deal of difficulty in rendering a real medical service to all Canadians. While the development of the super GP is an admirable goal, and certainly one that optometry should aspire to, there is always that question of maintaining a balance. Take the case of the small town optometrist. It is not uncommon to examine a three months old baby and then a patient that is a 93 year old lady. He or she (the optometrist) must romp all over the field from contact lenses to people of all ages with all sorts of difficulties from low vision to goodness knows what. All of which is very challenging and very interesting. Optometry must remain aware of the fact that while there is an area for specialties there is also the established need for the general practitioner to meet everyday demands for primary vision and eye care.

CJO: The 1970's have been the age of consumerism. What has been its effect on optometry in the 70's and its outlook in the 80's?

Dr. Brown: It is going to have a profound impact upon Canadian optometry. Certainly with Part I of the 1976 Competition Policy Act passed in Ottawa and Part II just sitting in the wings there is potential for a great deal of change. The idea of the portability of the prescription and the idea that each and every patient will receive a prescription automatically is certainly a part of government bureaucratic thinking. They do pay the vision care bill now in seven of the ten provinces. And possibly they will be paying in all of them before too long. It is bound to have an effect upon where the prescription goes and where it is filled. You could take a look at it from a point of economics, or you could also take a look at it from our traditional view that the filling of prescriptions is the therapeutic end of optometry. The

optometrist continues to feel that in order for the diagnostic service to be properly carried out they should provide the therapeutic service too. So the future of consumerism in optometry is just beginning to touch the tip of the iceberg.

Dr. Huber: Optometry is probably unique in the sense that they do participate with the consumer in terms of both services and materials. What I find somewhat disconcerting is that the government has not distinguished between the ophthalmic appliance as a medical device or a consumer item. I think that in terms of materials, if one buys a microwave oven or if one buys a car, or if one buys "glasses" that is one aspect. However, I think when you get into health services you cannot be too certain that the consumerism trend is all that beneficial. Health care is a pretty specialized area and I think the diagnostic procedures of the diagnostic phase of our practice as Roy mentioned probably lends itself less to consumer scrutiny. I really don't think health services have a lot to be gained by getting onto the consumer bandwagon.

Dr. Brown: But of course then, the government will say to you there that the diagnostic end is the health care portion, the other is a purchase item. And here again, the consumer is very aware of how he or she is going to appear on the street. When you take a look at what really goes on in the consumer's mind when it comes to vision and eye care you'll find that first of all there is concern about blindness, they don't want to go blind. They want to see. The second thing that enters the consumer mind is style, what kind of style is he or she going to have and down the road comes the cost of the style. So I think optometry in order to render a complete service, the one stop service to put it in a consumerism form, is going to have to take a long look at its treatment service end. It is going to have to expand itself. Many people are still pulling open a drawer with a few frames in it and that no longer satisfies the consumer today. They expect a better choice in the automobile they drive and in the clothes they wear . . . and their glasses. While they may be a health aid, they are still worn on someone's face. As I have travelled across the country from one side to the other the one complaint I have repeatedly encountered is that optometry has not kept itself up-to-date in providing adequate frame selection facilities. If Optometry is going to stay alive in this area, the profession is going to have to take a long and realistic look at itself.

CJO: Do you foresee that government on the basis of qualifications would eventually restrict optometry from participating in the treatment service? I am thinking of the division of services which was proposed some years ago in optometry, that ophthalmology would do only medical care, optometry would take care of the physiological aspects and the optician would do all the mechanical work.

Mr. Schaefer: That role model is a contradiction of the free enterprise system. The consumer, not government will decide who will provide the services to them based on quality and performance. That type of consumer issue we have always been able to deal with. The fact is that optometry in the 1970's and the 1980's is starting to respond positively to this aspect of consumer needs. We have recently talked about the advertising of optometric fees and services and come to an agreement that there are articifical barriers within the optometry Acts of every province of Canada that keep needed information away from the consumer. It works to our benefit as well as to our detriment. I honestly feel that the consumer should know before he or she goes into a professional office what services you are prepared to provide and at what cost. That isn't something that optometry should be threatened by. In terms of the other consumer issues such as standards of practice and licensing procedures we have already introduced the idea of public representatives on licensing and disciplining committees of each association. That is something optometry is voluntarily moving towards. Again, that is part of the new consumer movement. You have to recognize that it is not just the advertising. It is also standards of practice, licensing, and a question of the monopolistic position that the profession holds as a whole. Well, do we in fact have such a close-door policy a positon of monopoly that we are artificially trying to protect? My answer to that is no. In optometry we really believe in the theory that when you serve the public, you serve the profession. We will grow because of service and so we shouldn't be afraid of these things. All we have to do is understand them and move towards them in a positive way. There was a very good survey in the U.S. that pointed out why and how a consumer picks his eye care practitioner. Quality of care was not first and foremost in the consumers mind. It was accessibility, both in terms of location, hours of operation and the efficiency of service in terms of time. All of these are aspects of consumer needs as a purchaser. By addressing them you do not compromise the standards of practice or the ethics of an optometrist as a provider of health care. But what you are doing is responding to a consumer need. As long as we are providing quality care with the access to the public based on their concept of service optometry will prosper and remain at the corner stone of vision care in Canada. It is as simple as that.

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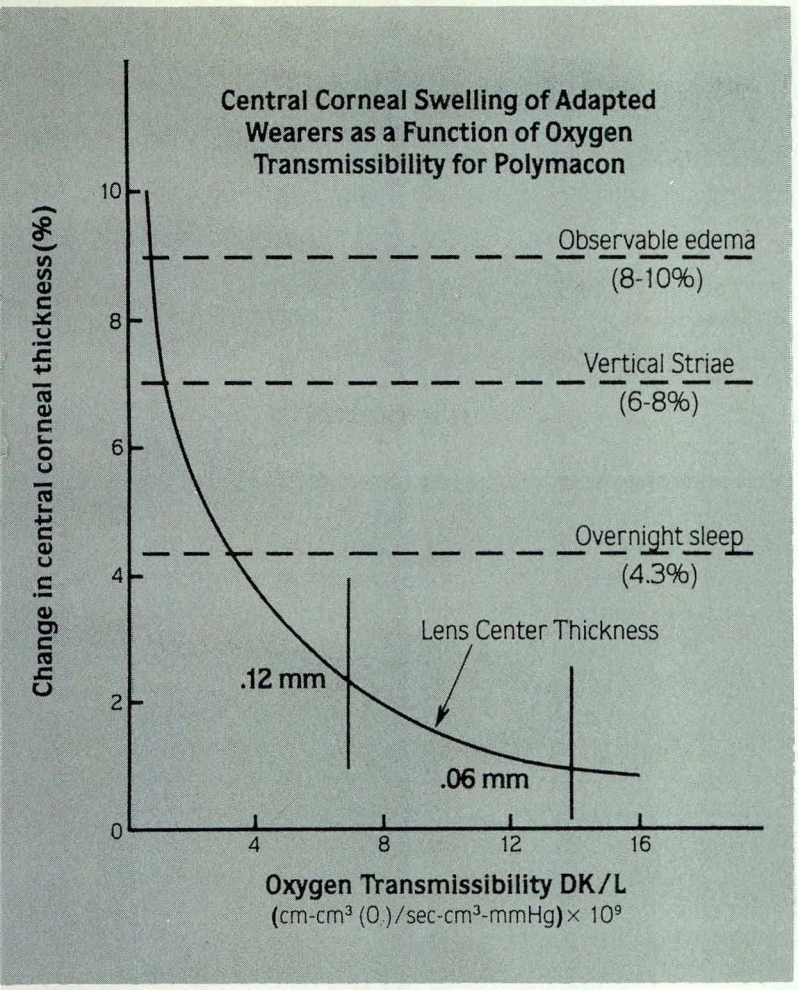

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OPTOMETRY AND THE HALL REPORT

On September 3, 1980 the Report of Chief Justice Emmett Hall entitled "Canada's National – Provincial Health Program for the 1980's" was released in Ottawa. There have been numerous summaries and commentaries on the Hall Report appearing in the media that have undoubtedly served to make every optometrist aware of the Report's major recommendations. But as usual, the media has ignored the comments of Mr. Hall that relate to vision care or the position of the optometrist in the health care delivery system. We will therefore attempt to relate the Hall Report to the concerns of optometry as a fee for service health care profession.

CAO's involvement with the federal government efforts to analyze the problems of Medicare began with President Jack Huber submitting a brief on February 15, 1980 to Mr. Hall at the Saskatoon public hearings of the "Health Services Review '79." The CAO brief put forward 26 recommendations that focused on problems associated with the accessibility, availability and cost of the vision care services required by the Canadian public. In response to the CAO submission, Mr. Hall stated within his final report that "the Canadian Association of Optometrists submitted an excellent and well-documented brief." He then made the following direct comments as taken from pages nos. 97–98 of his report.

The initial part of his section on optometry reviews our national status in health insurance programs, the ratio of optometrists to population, our educational process, and the profession's desire to create a third school of optometry in Western Canada. He points out that "there is discussion underway at this time which may lead to the establishment of another school at the University of Calgary which would be supported by the four Western Provinces. This sounds like a sensible arrangement to meet an obvious need." Mr. Hall's statement supports the intent of Recommendation No. 23 as presented in the CAO brief. We are very pleased that he endorsed our position and will now proceed to take action in Western Canada that will allow us to capitalize upon his statement.

In his report Mr. Hall referred to the fact that a number of our recommendations concern "areas of vision care common to ophthalmology as well as optometry." As a reference he cited Recommendations 6, 8, 12 and 13 from the CAO submission:

6. "Provinces that do not currently have a statute regulating ophthalmic dispensing be encouraged to develop them and existing provincial acts be reviewed and made consistent with the tenets of Health Care Legislation and public protection. To that end: The definition of dispensing opticians be specified, their relationships to ophthalmologists and optometrists be codified with conflict of interest defined and regulated."
8. "That a joint committee of optometrists, ophthalmologists and orthoptists consider, with respect to optometric and medical legislation, the future status and educational requirements of orthoptists as its relates to the appropriate delivery of vision care."
12. "There should be a comprehensive study by Federal and Provincial Government agencies of occupational vision standards in industry with respect to visual demands and potential eye hazards for all common occupations. The study should be funded by both the Federal and Provincial Governments and involve their respective Ministry of Health, Ministry of Labour, as well as the Canadian Standards Association. Worker's Compensation Board and National or Provincial Association of Optometry and Medicine."

And in respect of sports:

13. "A comprehensive study by appropriate Sports, Medical and Optometric Associations should be undertaken in order to identify and establish appropriate vision care standards for amateur sports and recreational activities."

This section as written does not offer a clear indication of whether or not Mr. Hall is supporting the spirit of our recommendations. We will therefore be contacting him in order to request further clarification on his intent in citing these specific recommendations.

Mr. Hall concludes his direct commentary on the CAO brief by pointing out that our Recommendation No. 14 "merits attention in respect of blind and partially-sighted persons:

> "The Canadian National Institute for the Blind, as the national center for services to the blind and partially-sighted, be urged to implement without further delay the following recommendations contained in the "Vision Canada" report:
> 1. Registration of blind and partially-sighted persons;
> 2. CNIB low vision clinics and mobile eye care services;
> 3. Multi-Disciplinary surveys."

We are encouraged by the fact

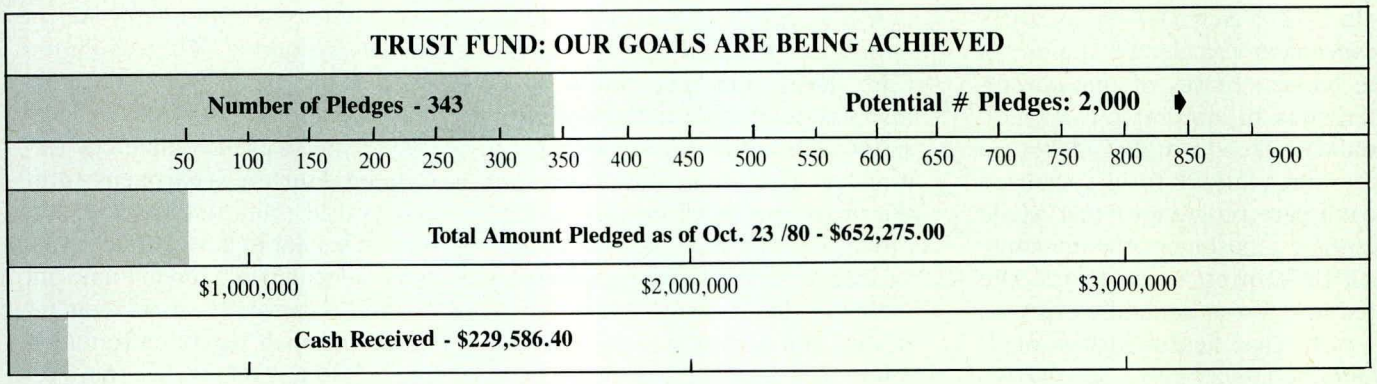
that Mr. Hall has joined with us in advocating that the CNIB become more responsive to the vision care needs of the partially-sighted through changes in their outdated service delivery policies that are routed in a medical bias.

Throughout the remainder of the Hall Report the following additional comments were made that although addressed to physicians could apply equally to all fee for service health care professionals such as optometrists:

- Binding arbitration should be used to settle disagreements over payments for services that arise between the providers of care and provincial governments.
- Providers of care should not be allowed to bill patients more than the maximum fee paid by the provincial health care plan.
- The Income Tax Act should be amended to give health care professionals tax relief in terms of continued education cost, deduction of a spouse's salary as a business expense and removal of the sales tax on medical supplies.
- Health care professionals should not be placed on salaries. Mr. Hall points out that the salary system is contrary to Medicare's founding principles of "free and self-governing professions."

CAO and provincial associations are now faced with the problem of anticipating the extent to which the various recommendations contained in the Hall Report will be acted upon by provincial and federal governments. The issues of balanced billing, binding arbitration, medical manpower, portability of benefits, salaried professionals and block-funding as discussed in the Recall Report are all topical political issues. The Report has certainly served to give the various governmental agencies a focus for their future discussions and problem-solving action on the important issues. Since it is as much the responsibility of the providers of care as it is the government to implement the required positive changes, CAO and our provincial associations will now begin to integrate the positive aspects of the Hall Report into our various association activities.

*Summary by Donald N. Schaefer



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THE SEVENTIES IN REVIEW

The British Columbia Optometric Association Report

The decade of the seventies has for British Columbia optometry been a period during which great changes were seemingly close at hand. Expectations ran high and, then, hope of those expectations faded, and, in the end little had changed. Nonetheless, a gradual movement of the profession forward and upward has been maintained thanks to the patience, determination and dedication of many members of the profession.

Eighteen months before the decade began the government of British Columbia passed legislation to provide an optometric benefit through the Medical Services Act. A yearly benefit was to be the entitlement of every citizen and a fee of thirteen dollars was to be paid to the optometrist per examination.

The decade was barely seven months old when, without warning, consultation or explanation, the government slashed the fee by ten percent and reduced the entitlement to a biennial rather than an annual one. This same axe did fall on some other professionals as well but left medicine untouched. The effect of this action altered the economic position of optometry such that, even as the decade ends full recovery has been barely achieved.

In 1972, a New Democratic Party government was elected and one of the earliest moves of this government was to appoint Dr. Richard Foulkes to head a study and prepare recommendations for a socialized health care programme that would see the establishment of community health clinics throughout the province. It was generally expected as well, that health professionals would be moved into a salary basis rather than the fee-for-service concept. Optometry was invited to submit a brief and recommendations to the Foulkes Commission. A very extensive and intensive study was prepared and a seemingly healthy rapport was established between the Foulkes Staff and optometry's spokesman.

The report was eagerly awaited with some hope that perhaps the position of optometry would be strengthened by the recommendations. The report was finally received by the government, and one or two health clinics were established but the bulk of the report was shelved. The importance of the Foulkes report was soon forgotten.

Of some importance and impact, though not necessarily a direct result of the report, was the decision of the minister of Health, Honourable Dennis Cocke, to all but command that Optometry and Ophthalmology begin a team approach to vision care on the Queen Charlotte Islands—off the north coast of the province. Six years later the team, one ophthalmologist, one optometrist, and one optician still visit the islands twice a year. The optometrist and ophthalmologist receive a fee for service remuneration with the Department of Health covering expenses.

A further government venture aroused optometric hopes again late in 1976 when the Minister of Health, now of a Social Credit Government, appointed a Task Force in Vision Care. His action appeared to be a response to optometric pressure for support for a Western School of Optometry. The intent was to review the provisions of vision care in the province, determine the role of the various persons involved and to recommend the training, and training facilities for each as with the Foulkes Study. The Task Force of eleven persons-two optometric appointees and two alternate appointees—embarked on a long, intensive assessment. Medical personnel outnumbered the optometric and the resulting recommendations were not all agreeable to optometry.

The Task Force provided an opportunity for optometry to enter in the public record for its scope of service, its extensive training and education and its sound legislation while medicine's presentations were weak by comparison. The report was completed—presented to the Minister of Health and as of the end of 1977, it remains buried away with none of its recommendations implemented.

Legislation was expected to come forward to provide for education, qualification and regulation of the opticians of the province who continue to function without any control or limitation at all.

In response to the Canadian Association of Optometrists' plea for new legislation that would provide for dual administration and control of the profession and to include lay representation on regulatory and disciplinary committees, a new Optometry Act was drafted and presented to the government but no action followed and none seems to be in the offing.

During the mid-seventies the Board of Examiners succeeded, after some seven years wait, in having amendments made to the regulations under the Optometry Act of British Columbia. The regulation that has had the greatest impact on the profession dealt with the location of practices in commercial surroundings such as department stores and optical retail outlets. The regulation sought to have all such practices re-located in a limited time but reaction against the regulation resulted in much legal confrontation and, while several practices have relocated the majority of such operations remain in their original surroundings.

The impact of Health Insurance

on the profession of optometry can not have been other than beneficial. Certainly the fact of inclusion of optometric benefits have made services available to almost the total population of the province and as the cost of the diagnostic service is removed, so to is the patient better able to afford the treatment service necessary to meet the vision care need.

Perhaps, but not necessarily, the average fee for covered services may be lower than if no insurance was available or the reverse may be true. Certainly the absence of any practitioner of optometry, and very few in medicine, opting out of the agreement with the Medical Services Commission speaks loudly of the value of such insurance.

Initially the coverage was for one eye examination each year. This, as has been noted already, was reduced to one every two years. Minor examinations were added for myopia and, in 1973, all time restrictions were removed and the responsibility of substantiating the need of such services rested with the practitioner. A wider range of services was covered late in the decade to include tonometry and visual field examination.

The percentage of funds allotted towards optometric services is not great and probably will not change to any great extent. Health Care costs in the province reached one billion dollars at the end of the decade, approximately 25% of the total government expenditures of these optometric services which cost in excess of four million dollars.

In general, vision care in the province is made available to the total population. The influx of new ophthalmologists into practise has made medical eye care available in many smaller centres than was the case ten years ago and, as a consequence, the increase of these means more and more are practising a form of optometry rather than medicine. Co-incident with the increase in medical practitioners and the current business interest in the optical field has been a mushrooming growth in dispensing outlets. Since no government regulation controls opticianry, untrained and poorly qualified persons man these outlets. Public reaction to the situation has prompted considerable media attention—particularly as pertaining to inadequately trained persons fitting contact lenses.

The latter years have seen an increase in third party contracts. Ten years ago the profession had, at the most, three third party contracts in the business field and some very loose "arrangements" with the government departments of welfare, Indian Affairs and Veterans' Affairs, none of which were very satisfactory from the practitioner's point of view.

Within the last half of the decade very firm and satisfactory agreements have been concluded with the Department of Human Resources (Welfare) of the provincial government. Federal government policy has resulted in the same contracts being automatically accepted by Veterans' Affairs and Indian Affairs departments. One large and influential health care benefit carrier has recently concluded an optometric agreement. This agreement is looked for in increased volume in the near future.

Much of the interaction the profession has had with the provincial government during the past ten years has been covered in the above paragraphs. One other and significant relation concerned the acquiring of a mobile vision clinic. A government grant of $20,000 was received towards . . . acquisition and fitting of such a clinic.

It was operated over a period of years with staffing by senior students from Waterloo University with optometric practitioners in charge. Wherever the clinic was located ie; isolated communities, special care homes etc. it provided a great service which was well received.

Continued functioning of the clinic was thwarted by lack of financial support on a regular basis from government sources leaving the optometric association to carry the burden.

The contrast between the relations with government departments during the 'seventies compared to the previous decades has been marked by a willingness to receive optometric input, consider association requests and a demonstration of an understanding and appreciation of the profession and the contribution it can make to the health of the people of the province.

During the last ten years the British Columbia Association has demonstrated a great deal of confidence in the future by expanding its one room office facilities to a four room suite, well equipped to effectively communicate with the membership and well staffed by competent and responsible executive secretaries who have contributed much to the administration.

The objective of B.C.O.A. has been, and continues to be, simply to represent the profession effectively, to further the post-graduate education of its members, to enhance its image in the public view and to secure recognition of the services of the optometrist. Much of the effort during these years past has been to promote a school of optometry in the west. Whatever the outcome of this quest it will have a great effect on shaping the future of the profession.

Active public relation programmes of the late 'sixties involved much more expenditure of funds and more areas of activity than evidenced after 1970. Presently there is a great expectation of results from the proposed "Western Public Relations Programme."

If there is one single worry on the minds of leaders in the B.C.O.A. as 1980 begins—it must be the concern over the possibility of decreasing manpower in the province. In the mid 1960s (1964) practitioners had decreased to 132 from 162 in the 'fifties. Present registrations numbers 165—170 of whom 25% are 55 years of age or over and moving to retirement. If a western school is not forthcoming the replacement inflow will be insufficient to maintain adequate optometric services for the people of British Columbia.

Norman Armstrong O.D.

The Alberta Optometric Association Report

The end of a decade is a logical time for the profession to reflect, review, and reassess before proceeding further. Alberta Optometry has taken some dramatic steps forward in the 1970s. Some philosophical approaches have changed and even completely reversed over the past ten years. Some of the battles being waged in the 1970s are still ongoing. How determined we are to learn from our mistakes and build on our triumphs will mark our success in meeting the challenges of the decade ahead.

The 70s began with great promise when several significant changes to the Optometry Act and Bylaws were brought into being. Legislative confirmation of the "fee-for-service" concept of optometric remuneration, as opposed to the retail merchandising of optical goods, was introduced and passed as the decade began. Optometrists were legally required to calculate all fees according to specific values for specific services rendered. The wholesale laboratory cost of the ophthalmic materials dispensed were passed on to the patient without mark-up.

A continuing education bylaw, the first in Canada, was enacted in 1970. A minimum of 12 hours of approved post-graduate education was, and still is, required each year in order to maintain a license to practice Optometry in Alberta. Although far from ideal, it was a pioneering attempt to cope with the problems facing the professional practitioner who must keep current in an age of accelerating scientific advances.

Other legislative changes included more specific advertising restrictions. In publications such as the telephone directory yellow Pages, bold print box listings, etc. were expressly prohibited. It is interesting to note that, although in the 1980s advertising by professionals may well be viewed in a more tolerant light, very restrictive advertising legislation in the early 1970s was considered essential to the best interests of both the public and the profession. Several discipline "prosecutions" and "convictions" resulted from breaches of these bylaws throughout the decade.

In 1972 a Legislative Committee on Professions and Occupations, which became known as the Chichak Committee, was given a very broad mandate to investigate and recommend future government policy on legislation regarding all professional and occupational groups. The establishment of the Chichak Committee resulted in a "freeze" on almost all such legislation with the exception of housekeeping changes to existing acts and bylaws which was to last until its report was tabled in the Legislature in 1974. In fact, the "freeze" continued for the rest of the decade. Although many special resolutions requesting progressive changes and additions to the Optometry Act and Bylaws were passed by the A.O.A., almost none were enacted into law.

The first sign of a "thaw" came in 1978 when the government issued a White Paper entitled "Policy Governing Future Legislation for the Professions and Occupations". Alberta Optometry has since studied the White Paper and entered into a very positive dialogue with the government. As a result of this White Paper, two Bills - The Health Occupations Act (Bill 30) and The Architects Act (Bill 31) were presented to the Legislature at the 1979 Spring sitting. Since The Architects Act was meant to serve as a model for other new acts governing professions, and since The Health Occupational Act was umbrella type legislation with power to bring under its jurisdiction any health care occupation not already governed by its own act, these two bills sparked a great deal of public input from other professions and many organizations representing health care occupations.

While the A.O.A. made a number of specific recommendations for amendments, it was felt that for the most part both bills were forward looking legislation. Apparently, however, this was not the general reaction and there was sufficient concern and lobbying to cause the government during the 1979 Fall sitting to withdraw both bills prior to second reading. It is anticipated both acts will be back in revised form for first reading during the current (Spring 1980) session of the Alberta Legislature.

Meanwhile the A.O.A. is engaging in philosophical exchanges with government representatives, submitting constructive detailed criticisms of the proposed model acts and preparing specific recommendations regarding the new Optometry Act which might become a reality as early as the Fall of 1981. The separation of what might be seen to be public interest and self interest activities of the profession (College/Association concept) is being considered by the A.O.A. This may not yet be practical because of the relatively small number of practitioners in the province and it is not being requested by government to date.

A priority of new optometric legislation will be the setting of stronger, more specific minimum standards of practice with fair but effective methods of monitoring and enforcing such standards.

Legislation enabling optometrists who have completed appropriate educational requirements to use diagnostic pharmaceutical agents will certainly be a major objective in upcoming discussions regarding the new Optometry Act.

Specific parts of the new Optometry Act dealing with the "academic" optometrist and the optometric student are being discussed. Such discussions confirm Alberta's quiet op-

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†Fichman, S; Simplified Cold Disinfection Procedure for Hydrophilic Lens. Contact and Intraocular Lens Med. J. 5: 38-39, 1979.

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timism that, after all the efforts throughout the 1970s by Dr. Hugh MacKenzie and his committe (and specifically Alberta's Dr. Walter Mitson and Dr. Ken Armstrong), Alberta may soon be the site of a new University Faculty of Optometry. In 1980 one thing seems certain, optometric legislative affairs in Alberta appear headed for exciting times.

By 1970 Albertans had for four years enjoyed receiving a benefit from the provincial medi-care plan for an optometric "refraction". Freqency of eligibility was complicated and restrictive. By 1973 it was relaxed to allow payment of one benefit within the plan's fiscal year for any registrant. The optometric service eligible for partial coverage was restricted to a "refraction". This was later redefined as an "oculovisual assessment including refraction and the provision of a written prescription for glasses". The benefit amount has never been negotiated. Optometry has not pressed for, nor received, any offer to participate in the process of determining how much the health care insurance plan will contribute towards an optometric service. The health care insurance contribution has been viewed as a benefit to the patient, not a fee to the optometrist. Therefore it was not felt appropriate to negotiate what the health care insurance plan would contribute to or on behalf of the patient. The autonomy of the practitioner to set his own fees and, should they exceed the health care insurance benefit, to bill the patient for the balance has been a very basic and precious premise to Alberta Optometry's approach to health care insurance during the 1970s. As a result, with very little pressure to raise the patient benefit, it remained unchanged at $12.50 until 1976. Each year since then, the A.O.A. has been informed on January 1 that the benefit amount had been arbitrarily raised by an amount which reflected either the Anti-Inflation Board guidelines when relevant, or a percentage increase approximating that given to the Medical Association in their "negotiations". It rose to $18.05 on January 1st, 1980.

In 1974 the provincial government announced the establishment of the Extended Health Benefits Program for all Alberta citizens over the age of 65 and their dependents. Recipients receive benefits for a wide range of health care needs such as dentures, hearing aids, and eyeglasses. Both optometrists and ophthalmic dispensers were paid fees based on 80% of the 1972 Suggested Schedule of Optometric Fees for the dispensing services, plus laboratory costs of lenses and a small amount toward the frame cost. No diagnostic services were included. Eligibility was not guaranteed due to a three year frequency restriction and so most optometrists opted to bill their patients directly and allow the patient to recover the benefit amount from the government. Benefit amounts continue to be arbitrarily increased by small percentages corresponding to the increase in basic health care coverage.

Annual meetings with Alberta Health Care Insurance Plan administrators have essentially been amicable, but unproductive. Suggestions for broadening the scope of optometric services eligible for benefits, eliminating the frequency restrictions, recognition of the professional referral, and observations about the inadequacy of the benefit amount provided by A.H.C.I.P. are the topics of discussion year after year. Aside from these annual meetings, the main communications between A.H.C.I.P. and the A.O.A. has been via the "Profile Committee". This committee is comprised of three optometrists appointed by the A.O.A. who investigate and advise A.H.C.I.P. on questions raised by the plan administrators when the computer detects that an optometrist's claims profile deviates greatly from the norm. Seven such investigations have been undertaken since 1974.

Balance billing by health care professionals became a high profile political issue in Alberta and across the country in 1979. As a result, the A.O.A. reassessed its position on the matter and, although it feels strongly that more money should be paid in the form of benefits toward more optometric services, the right of the practitioner to set his own fees according to his own economic circumstances, quality of service rendered, etc. is a right that must be preserved. Belief in this principle was made unequivocally clear in a carefully prepared brief submitted in the Spring of 1979 to the Conservative Government's Caucus Committee on Balance Billing chaired by the Rev. David Carter, M.L.A. It would appear that the mood reflected in the Federal Anti-Combines Legislation of the late 1970s supports such a right. And so the 1980s begin with Albertans receiving benefits to help offset the cost of optometric examination fees - a concept unchanged throughout the past decade, but perhaps unique in Canada.

The greatest philosophical change undergone by the A.O.A. in the past decade has been in the area of third party contracts. In the early 1970's one of the main objectives and certainly one of the greatest single expenditures of the A.O.A. time and energy was devoted to negotiating contracts with various government agencies. No formal agreement existed between the A.O.A. and the Indian Affairs Branch of the National Department of Health and Welfare, D.V.A., Workers Compensation Board, or the Department of National Defense when the decade began. The provincial government paid a flat $10.00 for treatment services to welfare patients and contracted with laboratories directly for ophthalmic materials. After first achieving recognition of the relative value of optometric services (both basic diagnostic and basic treatment) through contracts paying low monetary amounts, by the mid 1970s the A.O.A. had negotiated contracts with all of the above noted government agencies. These were the envy of other optometrists across the country, reaching 90% of

current suggested fee schedules.

An attempt at global budgeting for optometric fees in the provincial welfare program proved to be an extremely cumbersome and frustrating experiment. It succeeded in establishing a fee for service concept with government, but failed to provide prompt and adequate payment to practitioners. The government decided upon a lump sum payment to a fund administrator each year who in turn paid optometrists' claims originally at the rate of 30%, then 60% and finally by 1974, 90% of the 1970 Suggested Schedule of Fees.

Another interesting innovation introduced in Alberta was a flat per diem payment to optometrists who visited Indian reserves. When the last contract with National Health and Welfare was signed in 1976 the per diem rate was $300.00.

By 1976, however, all other government agencies had decided to follow whatever agreement was achieved with the provincial government for social service recipients. As 1976 negotiations began, it became evident that the government was unwilling to pay the balance of the diagnostic fees not covered by the A.H.C.I.P. benefit. This change in government policy did not represent a dispute as to Optometry's right to balance bill, but was strictly an administrative decision. However, the A.O.A. felt that the principle of an adequate remuneration for diagnostic services, coupled with the "benefit" concept for A.H.C.I.P. payments, was vital to Optometry's survival and growth. To subsidize inadequate diagnostic fees by inflating treatment fees, as the government offered, would set the profession back decades to the days when optometrists were essentially purveyors of spectacles. Consequently neither side could abandon its principles and the era of third party contracts between government agencies and the A.O.A. came to an end.

Government wards are now seen as private patients and optometrists have the autonomy to determine what fee they will charge for their services. Government agencies will pay "benefits" to the practitioner or the patient based on unilaterally set increments to the fees paid according to the last contract. In general, after some initial concerns, both the profession and the government are satisfied with the new concept, although government admits administration is more complex. The autonomy Alberta optometrists have cherished so much remains intact and practitioners are again free to exercise their professional right and duty in choosing who to donate their services to and to what extent.

During the early 70s when hard and sometimes bitter negotiating represented much of the time spent in dealing with government, it became evident that, as health care professionals, optometrists could not behave like the hard nosed, hired negotiators they faced across the table. It was realized that the optometric members of a negotiating team could function more effectively if their ranks were augmented by lay people hired for the purpose of negotiating. Our able Legal Counsel and eventually our Executive Director began to play key roles in the negotiating process. When negotiations with the provincial Department of Social Services broke down in 1975 the Minister refused to meet with the President of the A.O.A. because he had sat at the negotiating table. The lesson was learned and the President removed himself from negotiating in the future.

Since the end of the "contract era" in 1976, government relations have become much more positive and less adversarial in nature. Input to elected officials and bureaucrats alike has been far more constructive and a greater mutual respect is gradually developing.

Until 1974 the A.O.A. functioned in much the same manner for many years. The bulk of the workload fell on the shoulders of the President and the Secretary-Treasurer who was paid a modest honorarium. Finally it became evident that the workload was steadily increasing and the executive of the A.O.A. was no longer made up exclusively of older, established practitioners who could devote more and more of their productive time to the Association administrative affairs. On September 15, 1974 the A.O.A. took the first of several steps to come to grips with the problem and an A.O.A. office was opened in the Tegler Building in downtown Edmonton and staffed by our capable Executive Secretary Miss Bonnie Werner. A year and a half later Mr. Adrian Berry, of Calgary, was hired as an Executive Director on a part-time basis. Mr. Berry still serves in that capacity, devoting about half of his working time to A.O.A. duties. These include administration, preparation of briefs, contacting and building liaisons with government, industry and other groups. Thus the A.O.A. executive officers are more able to devote their time to policy matters.

The new organizational structure has allowed the development of one of the most comprehensive occupational vision care and eye safety programs in North America and has allowed us to keep step with other professional groups of far larger membership and resources.

In December, 1979, with the pending demolition of the old Tegler Building, the A.O.A. office moved out of Edmonton's downtown area and into a bright new office with double the space and an image befitting a vital primary health care profession.

Such increases in sophistication as well as the inflation which typified the 1970s resulted in the operating budget for the A.O.A. rocketing from under $50,000 in 1970 to a predicted $180,000 in 1980. Annual membership dues were $250 ten years ago. At the Annual Meeting held in December, 1979 the members approved a budget and annual dues of $970 amending the $870 amount requested by Council! A significant amount of the increased expenditures are being aimed at developing new methods of communicating Optometry's message through the institutional advertising of the Western Communications

Program, Occupational Vision Care Programs, and the National Advisory Committee on Vision Care Benefit Plans. Optometry's growth, and perhaps its survival, depend on the success of such programs.

In 1970 the late Dr. Stan James of Medicine Hat took over the Public Information Department of the A.O.A. and ran it from his office for several years. The A.O.A. was recovering from an expensive and relatively fruitless experience with a professional PR firm and Dr. James' efforts at very little cost provided far more in the way of T.V. coverage, dissemination of printed material, the drafting of press releases, etc. than did his professional predecessors. The A.O.A. office and Executive Director now serve much the same function as co-ordinators of public information projects. Optometric career material and promotion were a sizeable part of Public Information Department projects in the early 1970s but the difficulty students found in gaining acceptance into a Faculty of Optometry forced a slow down and eventually almost a complete cessation of these activities.

The number of optometrists registered and licensed to practice in Alberta rose from 124 in 1970 to 184 (including 8 out of province registrants) by the end of the decade. The net gain in optometrists practicing in the province has been steadily increasing since 1974. On the other hand a recent survey indicates that 35.4% of all Alberta optometrists plan to retire in the next 10 years.

In 1978, 40% of optometrists practiced outside the two major urban centres of Calgary and Edmonton which hold 50% of the province's population. No comparable figures were available for 1970. Almost all optometrists practicing in rural Alberta continue to provide a complete and "unified" range of optometric services. By mid-decade approximately 15% of optometrists practicing in urban areas had opted to provide diagnostic services only, a trend which appears to have remained approximately level in the past few years.

The 1970s saw Alberta Optometry conduct the most comprehensive economic survey and study ever carried out for the profession in Canada. A course for optometric assistants was born, floundered for two years, and died at an Edmonton Community College. With A.O.A sanction and help, the Alberta Optometric Assistants Association was formed and had been only moderately active until the 1970 C.A.O. Congress in Edmonton included an assistants education program for the first time. Strange as it may seem, in 1976 the Board of Examiners in Optometry and the Association decided to break a long standing and mysterious tradition and began to communicate with one another.

The maturity, strength and wisdom gained by the optometric profession in the 1970s allow us to anticipate the challenges of the coming decade with confidence. In retrospect, each experience, each leader, each philosophical shift of the A.O.A. policy in the past ten years contributed to the growing up of the professional body. Optometry has done well. If it continues to remember and build on past experience it will continue to do so.

Scott Brisbin, O.D.

The Saskatchewan Optometric Association Report

In Saskatchewan in the early 'seventies 74 optometrists served the needs of the Saskatchewan citizens and in 1979 ninety two optometrists served the needs of approximately 1,000,000 persons. The percentage of female to male practitioners was 3% in 1970 as well as in 1979. The trend in establishing a practice in Saskatchewan is for the new member to join in an associate or group practice setting; the last solo practitioner office was opened in 1971. Important to the geographical distribution of the population there has continued to be a good urban-rural distribution of new practitioners.

The greatest thrust of public relations has been for the individual optometrist to become involved in community affairs, such as local governments, service clubs and community sport directors. In Saskatchewan the future lies in extending the optometrist's expertise outside the office and to become involved in community health planning, occupational and institutional delivery of vision care services.

The administrative affairs of the Saskatchewan Optometric Association has been handled very effectively by a seven man council which has responsibly served the regulatory and disciplinary functions of the public as well as the fraternal well being of optometrists. The two major areas which occupied the Association's time in the early 70s, namely Medical Care Insurance Commission activities and legislative changes, remain dominant in recent council activities. If further expansion of council activities are to take a broader base it is forseeable that paid administrative assistance will be necessary. In 1970 the annual license fee was $200.00 and in 1979 the annual license fee was $500.00.

Optometry enjoys an open door relationship with the Department of Health and thus the communication network is there. Basically the government in the early 70s accented

restorative health measures but now expends energy and finances on preventive health programs as well as maintaining basic diagnostic and restorative services. The Optometry profession is well suited to play an active role in preventive vision care services. This apparent void could be easily filled by capable optometrists working within government agencies and extolling the virtues of early preventive vision care services.

With the dawning of a new decade Saskatchewan is predicting a bright economic future; along with this future is anticipated growth and development. International and national companies are bringing in new ideas of job security. Job security no longer means big paychecks, but rather more comprehensive employee benefits. These benefits may take the form of pension, deferred incomes or accident and sickness benefits. In the early 70s occupational welfare was low key but now government departments have created and enacted laws to protect the occupational and health needs of Saskatchewan's workers. There is little doubt vision care benefits will be soon at the top of the list of worker benefits to be negotiated. The underwriter of these benefits may be either government or private insurance carriers. Saskatchewan optometry is aware that vision care services for the senior citizens is an area where government would like to lighten the financial burden. It is important that optometry keeps abreast of these developments.

In 1968 Optometry entered into agreement with the Saskatchewan Medical Care Insurance Commission for the delivery of socialized health care to its citizens. Today the Optometric services covered by the Saskatchewan Medical Care Insurance Commission is for one diagnostic service only, namely refraction. Other diagnostic services are considered non-insured services. The rate of payment in 1970 was $10.20 and in 1979 it was $19.00. Negotiated contracts for both diagnostic and treatment services are available with various government agencies such as Social Services, National Health and Welfare and the Department of Veterans Affairs.

Although the outcome of the negotiations with the Saskatchewan Medical Care Insurance Commission is paramount to Optometry and the public in terms of their budget, optometric services account for 2% of services and 3% of payments. Overall there is little doubt that the inclusion of Optometric services within the provincial health care system has enhanced the prestige of Optometry.

One challenge before Optometry in the next decade will be to encourage the Saskatchewan Medical Care Insurance Commission to promote Optometric services in their literature.

Saskatchewan's Optometrists have obtained the confidence of the legislators by being diligent in their work and sincere in their actions. We feel this is important for when we approach government for legislative changes to reflect professional and educational maturity we can assure delivery. We are confident that by moving positively and logically we can gain the confidence of other professions as well as way lay the fears of skeptics—principally in medicine. We have seen flexing of political muscle by ophthalmic dispensers in their intentions within their new Act and by medicine in their attitude regarding the regulating of ophthalmic drugs. However, if perceived from outside the fast ever changing mode of delivery of health care services, it is not immodest to say Optometry has caused the biggest waves.

Saskatchewan hopes that the 1980s permit all providers of health care services to exercise their professional skills at their highest possible levels so that the health care needs of the citizens may be better served.

James A. Krueger, O.D.

The Manitoba Optometric Society Report

Manitoba shares with Quebec the distinction of having the first Optometry Act in Canada in 1907.

The Optometry Act of 1957 contained a clause stating that the University of Manitoba Senate must determine whether an optometrist may use the title Doctor. In 1968 in response to the request for a ruling from the Manitoba Optometric Society and the University of Manitoba Senate refused to rule on this clause, stating that it was not qualified to do so and referred the consideration back to the government of Manitoba.

In 1969 Bill 49 proposed to remove the restrictive clause regarding the Doctor title and eliminate the one year preceptorship. The Bill received first and second reading and died on the order paper when an election was called. In 1970, Bill 10 (previously Bill 49) eliminated the preceptorship. In 1971 the Bill was returned to the Legislature in the form of Bill 21 and was referred to the Professional Acts Committee.

Bill 30 finally received Royal Assent June 23, 1972. Bill 30 repealed the previous restrictive clause and provided authority for each person practicing as of May 1, 1972 to use the prefix or title "Doctor" or the abbreviation "Dr" provided the word "optometrist" precedes or follows his name. At that time this Manitoba Optometry Act was the only act in North America which stated that the title "Doctor" may be used and included a grandfather clause. This legislation was mainly due to the outstanding efforts of the Chairman of the Legislative Committee Dr. Roy Brown, with assistance from Dr. Jim McQueen and Dr. E.J. Spearman.

In 1979 changes in the Optometry Act were proposed to the Manitoba government. The changes included general housekeeping changes plus a section which would allow the use of pharmaceutical agents.

Presidents who served the M.O.S. in the '70s are as follows:
Dr. Roy Brown 1967–1970; Dr. Jim McQueen 1970–1972; Dr. Neil McCaughey 1972–1974; Dr. Rod Small 1974–1976; Dr. Bruce Rosner 1976–1978; Dr. Harry Basman 1978–1980; Dr. Keith Letts elected President in April 1980.

Our Secretaries for this same period were:
Dr. Neil McCaughey 1967–1970; Dr. Rod Small 1970–1974; Dr. R.J. Stanners 1974–to the present date.

In 1970, 55 optometrists were registered in the province, in 1975 63 were registered and in 1980, 70 optometrists were registered. However due to the decreasing number of Manitoba students at the School of Optometry and the expected retirement of the post World War II optometrists, it is projected that only 40 optometrists will be in practice in Manitoba in 1990. This shortage of manpower will result in the loss of optometric services to many communities. In particular, many rural communities will no longer have optometrists to provide vision care services to school children or the increasing geriatric population. For instance, in the Westman area, 14.4% of the population is over 65 years of age – this percentage will rise to 21.9% in 1986. More manpower is presently needed for out reach programs to health care institutions.

The need for an additional School of Optometry in Western Canada was recognized at a meeting of the four western provinces in 1967. Several meetings during the '70s were held with the University of Manitoba, optometry being represented by Dr. Brown, Dr. Spearman, Dr. McQueen and Dr. Moore. In addition, Dr. Brown and Dr. Spearman met with Education Minister Saul Miller in 1973.

The Manitoba Vision Conservation Program was instituted in 1975 with representation from optometry, ophthalmology, Department of Health, Department of Education and the C.N.I.B. Optometrists serving on the Committee were Dr. Bruce Rosner, Dr. Don Porter and Dr. E.J. Spearman. The Vision Screening Program was approved by the Manitoba Optometric Society in September 1979. As a result, screening is now carried out by Lay Personnel annually in every school division in Manitoba.

A pharmacology course was proposed for Manitoba optometrists in 1979 as prepared by the School of Optometry, University of Waterloo.

A continuing education program was proposed by the M.O.S. Council in 1979. This program would include for each optometrist, a practice profile file relating to hours attending continuing education lectures, course content, optometric journals and articles written or presented. In April 1980 the Manitoba Optometric Society established such a file for each member.

Reviewing Manitoba's record for Social Allowances, the M.O.S. provided free optometric welfare care to all residents of Manitoba from 1950 to 1960. The Provincial Medicare Program came into effect in June 1960. At that time the Manitoba government offered an examination fee of $3.00 and treatment service fee of $3.00. In February 1960, the Manitoba government proposed that a recipient of Social Allowances seen by an optometrist would have a certificate from a duly qualified medical practitioner that the patient "is free from systemic or ocular disease." In March 1960 the M.O.S. passed a resolution accepting the fee schedule out of concern for welfare patients but protested strongly the necessity of direct authorization from another profession. The problem was referred to the

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University of Manitoba Senate which appointed an Ad Hoc Committee to bring in a report. In February 1961 the Ad Hoc Committee reported "optometrists are not thoroughly qualified to recognize pathological conditions of the eye." The Committee presented no evidence that they had either contacted or visited the College of Optometry of Ontario in Toronto in order to make a knowledgeable and unbiased judgement. In addition, physicians refused to sign any certificates stating that a patient was free from systemic or ocular disease.

Representations by Dr. Roy Brown during his Presidency of the M.O.S.resulted in the elimination of the need for the certificate by Minister of Health and Social Development, the Honorable Jack Carrol.

The Federal Medicare Act provided the option for provinces to include optometric examination. In April 1969 the Manitoba Medical Association issued a policy statement on optometric services to the Manitoba Health Services Insurance Corporation. In brief the M.M.A. recommended that the inclusion of optometric services as insured services be predicated on the practitioner undergoing re-training and upgrading of skills. (There is no evidence of any indepth study of optometric education.) Another condition would be that optometrists would provide spectacles and ophthalmic appliances to their own patients at cost. Further, that all services for eye care be reviewed by a committee which would include M.M.A. representation. And finally that legislative power be given the M.O.S. to establish a review or discipline committee in relation to methods of practice and regulation of members with respect to ethics etc. Such an M.O.S. Committee had been functioning through legislation for many years.

Optometric examinations were included in the Manitoba Health Services Program in September 1969 without any of the additional restrictions suggested by the M.M.A. The inclusion of optometry in the provincial plan was one of the goals of Dr. Roy Brown when he accepted the Presidency of the M.O.S. in 1967.

The initial fee for optometric examination was $8.50, the frequency of the examination determined by the age of the patient, in some cases once every three years.

Presently, the examination fee is $17.45. A subsequent examination fee of $9.80 qualifies under several headings including changing myopia, changing hyperopia, changing presbyopia, cataract, systemic diseases (diabetes, M.S.), glaucoma, amblyopia, muscle imbalance, headaches, high astigmatism, prescription breakage or loss, referral from M.D. or public health nurse, progress evaluation of visual training by report.

Guidelines for a Peer Judgement and Review Committee were authored by Dr. Roy Brown and Mr. R. Guy of the M.H.S.C. in 1971. For several years Dr. H. Basman has capably chaired this committee.

As of April 1, 1982 the examination fee is $19.00, subsequent examination $10.65. In addition a further insured service is the initial fitting of contact lenses following congenital cataract surgery, presently $305.00 and on April 1, 1982 will be $332.00. Dr. Bruce Rosner and Dr. Harry Basman were responsible for M.H.S.C. negotiations and the achievement of this long term contract.

In Industrial Vision, particularly the Manitoba Telephone System – an agreement with the M.O.S. was in effect for several years allowing a treatment service fee of $10.00. The M.T.S. refused to increase this fee in 1977 and since that time no official agreement is in force with the M.T.S. With few exceptions M.T.S. employees are treated as regular patients.

Since 1978 the Department of Veterans Affairs has discontinued the practice of tendering through labs. All treatment services are handled by the optometrists with a payment of 90% of the usual fee schedule. The Department will allow up to $15.00 for a frame with an additional fee of $15.00 for R.C.M.P.

As for the Workman's Compensation Board the Fee Schedule approximates usual fees. In areas like Manitoba Hydro, C.N.R. etc. there are no official agreements with M.O.S. and the patient pays practitioner's fees. Social Allowances' treatment service fees for single vision are $20.70, $26.50 for bifocals and a maximum frame cost of $10.00.

Manitoba's C.A.O. Delegates during the seventies have been Dr. E.J. Spearman 1963–1973; Dr. Roy Brown 1971–1980; Dr. James McQueen 1977–1979.

Our relationship with the Motor Vehicle Branch is as follows. For several years it has been compulsory for an optometrist to report to the Motor Vehicle Branch any person who is suffering from a condition that may make it dangerous for that person to operate a motor vehicle. The optometrist may request a second opinion, optometric or medical, regarding the withdrawal or reinstatement of driving privileges. A standard of $^{20}/_{40}$ minimum acuity is stated – special consideration of lower acuity may be considered with certain restrictions i.e. no night driving, radius of travel.

The Department of Northern Affairs treatment service fee in 1970 was $8.00. Present fee for single vision is $19.80 and for bifocals $24.10.

In conclusion, the 1970s have proven to be a decade of growth and challenge and change for the optometrist of Manitoba. We look forward to the continuation of these trends in the 1980s and remain confident that the Manitoba Optometric Society will continue to serve the best interest of the optometrist of Manitoba in dealing with issues confronting the profession.

Roy Brown, O.D.
E.J. Spearman, O.D.

The Ontario Association of Optometrists Report

The Ontario Association has undergone a series of major changes and has witnessed continued growth in many areas throughout the seventies.

At the beginning of the decade there were 360 members out of the 503 optometrists practicing in Ontario for a 71.5% membership rate, and at the end of the decade there were 568 of the just-over 600 practicing optometrists for a 92.5% membership rate. In addition, all but two of the school faculty and a number of out of province practitioners have kept up their membership in the OAO.

Our name was changed to the Ontario Association of Optometrists from the former cumbersome Optometrical Association of Ontario. This was felt to be particularly appropriate since the operative word in the mind of the public is OPTOMETRIST.

In terms of finance our yearly operating budget of $50,000 in 1970 rose to $150,000 in 1979.

We are pleased to note that our Congress attendance has almost tripled from 130 optometrists in 1970 to the 1980 total of over 375 members.

With respect to payment for services the previous decade saw a $7 examination fee with a $15 dispensing fee. In the early '70s this became $15 and $10. On-going negotiations produced a more uniform fee for service approach with OHIP paying a fee on a negotiated basis. In 1980 the fee OHIP pays is $19.50 for an examination, $13.90 for a reassessment and $8.30 for a partial assessment.

Other significant advancements included the addition of a second optometrist to the Advisory Board of the Dispensing Optician course at Georgian College. Also, a board of optometrists representing the School, College and Association now plays an advisory role to the optometrical secretarial course at Conestoga College.

Moving into a Group Insurance Program, we changed from a small group insurance life policy underwriter to a major company and brought in a program of greater protection for coverage, for alleged malpractice cases, as well as protection for families through income protection, office overhead costs while ill and term life insurance.

These have continued to be updated with both improvements in cost and service and in increased benefits when surpluses accumulate. Another major accomplishment was the development of a handbook which was replaced by the Policy manual. This was in keeping with the goal of establishing a more uniform approach for all practitioners in offering their various services to the public.

In another move the Maybee Memorial Fund which was developed in the previous two decades to assist veterans and other needy students was turned over to the School of Optometry for scholarship purposes.

The Information, Library and Assistance Centre, a new service to members and the public went through its development stage in the '70s.

In an effort to improve interprofessional relations, the OAO Newsletter was developed as an informal means of disseminating information originated by members, the board of directors, or from the School and/or the College. It became a means for exchanging information and encouraging members to present papers and comments both on an informal basis and as scientific papers. New sections for assistants, auxiliaries and students have also been added as required.

In the area of systems development, our representatives assisted in developing patient reporting cards, invoicing and recording as well as offering assistance in developing the use of computers for improved office-patient services.

Continuing education, always a concern of associations, resulted in the development of a very strong committee which maintained an ongoing dialogue with the College to ensure that realistic attitudes would prevail. The College has encouraged the Association to take the responsibility for administering approved programs which qualify under the College Regulations of the Health Disciplines Act.

In terms of its organization, the OAO organization and committee structure has gone through two major changes in order to keep up with the changing times, changing needs and the interests of the members.

During this period the new name "Auxiliary to the OAO" changed from "Women's Auxiliary" and a new province-wide rather than the previous Toronto only organization appeared. New avenues were opened in the public relations field, all of which contributed to the good of optometry.

Mid-way through the decade, when the College of Optometrists took on a more aggressive role toward the responsibility of meeting the "public interest," the Association accepted the need to be stronger as a combined force to represent the membership in every sense, and the addition of Mr. Bill Maxwell as legal counsel was initiated. This segregation of role responsibilities followed the pattern of the other major health disciplines in recognizing the need for independent leadership to be given by the elected delegates.

A new outlook every few years was established by the assembly to participate in group dialogue ses-

sions in order to see where the profession is going in relation to its desired future, updating programs as planned or when the need arises.

Mid-way through the decade we were able to convince the Department of Veterans Affairs Treatment Services that its previous attitude toward veterans was not in keeping with entitlements of veterans. It was also recognized that Optometric services were a provincial matter and the previous Canadian agreement was not acceptable. It paid $6.00 for fitting and $10 for an examination.

Consequently, an agreement for members only was signed for 90% of our fee schedule to be automatically charged and accepted whenever our annual meeting by vote changed the fee schedule.

The previous "ophthalmologists whenever possible" attitude was replaced with "vision practitioner of choice" and it was also agreed that the recommendation of the optometrist using professional judgment would be the criteria for the lenses and frames, with the right of the veteran insured whereby that person could, if desired, choose a frame in excess of $10 and pay the difference.

New negotiations during this decade resulted in a recognition for accepting the Indian patient as a citizen and not a welfare case. This means recognizing our fee schedule whether the native patient pays or whether the government pays for professional services performed.

Talks with the Workmens Compensation Board brought about our policy to deal with the patient directly as a more acceptable manner of meeting that patient's needs at the time of his accident. The responsibility for payment now rests between the practitioner and the patient and the responsibility relating to the accident remains between the patient, the employer and the WCB.

A number of practitioners have become active in their district CNIB chapters but the Ontario Division still refuses to recognize the existence of an optometrist for participating services.

In motorist vision, a decisive role was played by optometry with clinics and seminars held throughout the province at which optometrists lectured to the driver examiners and driver teachers.

During the '70s there were six conferences dealing with "Co-operation in the Provision of Health Services" at which the optometric viewpoint was well represented.

A new emphasis was placed on the need for closer liaison with other associations and practitioners which has developed on an ongoing sharing basis. This applied to not only improved interprofessional relations with medicine, but also with others interested in vision care such as nurses, opticians, pharmacists, health workers, teachers and health clinics.

Ongoing meetings are now held with the Ontario Association of Nurses, the Ontario Medical Association, the Ontario Dental Association and the Ontario College of Family Practice.Periodic meetings are held with opticians, ophthalmologists, public health, and other associations and agencies associated in the health care field.

Finally after years of planning the last part of the decade saw positive action which resulted in the formal establishment of the optometric Centre.

A commitment in support of the Centre has now been made by three groups—Association, College and School for action, finance and manpower.

An ongoing public relations program materialized during this decade which included two large donations made to the CAO to contract from P.R. spots for Ontario TV.

News releases prepared in the office in recent years have maintained a steady usage and contact source for newspaper stories and TV interviews.

In addition our direct public contact through releases to schools, teachers, and school boards in addition to the public (through inquiries and clinics) has increased public awareness of both the optometrist and a need for optometric exams.

More recently the CAO P.R. program has been integrated into the OAO program for a better overall coverage.

To assist in accomplishing all of these advances, costs were shared by all from dues of $175 in 1970 to $275 through 1979, and so when asked "What does your association do for us?" the answer now is "And what do you do for your association?"

Mr. Cal Peppler
OAO Executive Director

1981: International Year of Disabled Persons

The United Nations General Assembly has proclaimed 1981 as the International Year of Disabled Persons. The theme for the year is "Full Participation and Equality." The year will promote the enjoyment by disabled persons of rights and opportunities which are available to other persons in society.

The official logo to be used in connection with the year of disabled persons (IYDP) represents two people holding hands in solidarity reflecting equality, hope and support. The leaves around the logo show a part of the United Nations emblem.

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The New Brunswick Optometric Society Report

The year immediately preceding the decade of the seventies in New Brunswick Optometry began on a somewhat discouraging note. But this was not to set the tone for the years to follow.

The N.B.O.S. had introduced a new Optometry Bill in March 1969 which was later withdrawn as we had not discussed it first with the Department of Health. We were told at this time that the definition of optometry provided in our draft was too broad and we were told to qualify our position in the use of drugs.

Although future meetings were held with the Department of Health and an attempt was made to prepare a 'Memo on the Use of Diagnostic Drugs' we postponed the planned introduction of our Bill until 1978 when we felt the climate would be more receptive. As there had been many changes occurring nationwide – the new N.B. Provincial Government in the fall of 1970, the Report of the Commission on Healing Arts, Ontario coming out in favour of optometrists using drugs, new legislation in Quebec and Ontario establishing new concepts for our position, the University of Waterloo becoming recognized in training optometrists in the use of diagnostic drugs – we waited and worked these developments into a stronger base to lead from in future actions.

Where the sixties emphasized the need for training of negotiating teams, the seventies brought forth the necessity of training lobbyists (keymen) and legal councillors for our cause.

In the spring of 1970 we managed to have the Optician Bill defeated in our province.

The National Legislative Conference held in Toronto April 1972 similarly gave us confidence and direction in building a stronger platform in our province to combat all phases and types of government agencies in the preservation of the best interests of the profession.

Throughout the late sixties N.B.O.S. had presented oral and written briefs to the Medicare Study Committee and Law Amendments Committee for our inclusion in Medicare. In 1968 the Medical Services Act for N.B. was passed and our services were not included due to a lack of Federal Government funds.

Although continued pressure was applied to the government for our inclusion in Medicare through '68 and '69, the Honourable N. Theriault announced prior to the election in the fall of 1970 that "refractions primarily to fit eyeglasses would not be covered for either optometrists or ophthalmologists as these examinations might be discriminatory against the optometrical profession."

A new Conservative government was elected that fall and in January 1971 the present Medicare plan was started with the exclusion – "refraction for prescribing eye glasses."

We maintained pressure on the government emphasizing the fact that this was no solution for the future development of eye care in our province and that this represented a backward step for the professional image of optometry in N.B. compared to the rest of Canada.

We were again reassured that if federal funds became available our services would be included. To date there has been no change.

By 1972 we were able to negotiate a new few schedule with Social Services (1967 Exam – $8.00, Dispensing – $3.00) for a 63% increase and an 80% increase with DVA. With this basis established we were able to have the Department of Indian Affairs fees increased to DVA's levels.

These were major increases for us to obtain and although the fee schedule format required hard negotiating on our part, it established a better image for optometry in presenting our professional services.

Our involvement with government agencies occurred largely as a result of three factors: the Equal Opportunity Program in the late '60's, the Optometry Bill 1969, and the introduction of Medicare in early 1971. These developments demanded the training of legal councillors and keymen for lobbying. Negotiating teams for handling fees and services along with the development of an active PR program were also requisite to meet the changing times.

Optometry as a result of these changes and demands became a voice that otherwise would not have been heard. The N.B.O.S. Presidents who offered leadership during this transitional period were Dr. G.C. Ross, 1969–73, and Dr. Ray Corbin, 1973–76.

One of the most gratifying developments during this period of the N.B.O.S.'s history was the high level of participation by all its members. The 1973 annual meeting was held in Moncton with 75% of the membership in attendance. At the next two meetings in Fredericton, attendance was even higher.

N.B.O.S. also became bilingual during these years. The membership, composed of both anglophones and francophones determined that meetings would be held in both English and French, with members using the language of their choice.

The attack on optometry from various quarters seemed to subside during these years and we were able to progress without undue outside pressure.

A brief was presented to the Health Services Advisory Council in February 1973 but there was still no

change in their attitude. With the advice from our membership our council decided to suspend further plans to promote our inclusion.

Our position has not seriously affected us monetarily but as one of the five health disciplines, being on the outside and looking in, our image is suffering. The area of referrals poses problems as the patient is charged by us and yet the ophthalmologist is paid by Medicare. The situation whereby a hidden examination is paid for by the province and all referrals by G.P.'s are made knowing that they (medical doctors) will be paid under Medicare is far too loosely controlled. And the criterion supporting the fact that examinations are paid to ophthalmologists where "medical reasons exist" are far too broad.

With respect to third party contracts our approach and position has evolved gradually over the years. In the mid-sixties our government approached us and initiated discussion about supplying vision care service to recipients of Social Assistance. This was our first exposure to the thoroughness of government departments. The lack of negotiating experience and proper organization on the part of Optometry left us at a distinct disadvantage in this encounter. Later in April 1970, after a review of the CAO Fee Schedule format stressing fees for diagnostic services and assessing treatment cost, not on a retail basis but on a fee for service basis plus lab cost of materials, we updated our own Fee Schedule demands on the same basis.

Major highlights during the 1973–76 period included developments in the area of third party contracts. N.B.O.S. met with government in fall 1973, 1974 and 1975. Each time we were able to obtain more recognition for optometry from our government, both for services and fees supplied to Social Services recipients. We also became better negotiators and we got to know our politicians much better which was of great value for the three main events to come: the Opticians Act, the Optometry Act and the use of diagnostic drugs. It should be noted that everytime we made head-way with government, it was followed through by developments with D.V.A., D.I.A. and Workman's Compensation.

With respect to the Opticians Act, opticians did not have an Act in N.B. and were still under the Optometry Act of 1946. Both groups felt that opticians should have their own Act. For the first time both Optometry and Opticianry sat down together and after much heated debate agreed on an Act which was accepted by the Dept. of Health and the Dept. of Justice. In 1976, the New Brunswick Legislature passed the N.B. Optician Act.

C.A.O. meetings during this period continued to offer an excellent opportunity to meet and exchange views with other provincial association's officers. Both the President and Secretary of N.B.O.S. attended C.A.O. meetings during these years, held respectively in Winnipeg and Halifax. During all these years the C.A.O. delegate from New Brunswick was Dr. Hervé Landry.

In September 1976, Dr. Hervé Landry was to become President of N.B.O.S. but Dr. Garson Lecker, then C.A.O. President, requested that Dr. Landry go on to the C.A.O. executive. This request was granted by N.B.O.S. Dr. Ronald Harding was then elected President with Dr. Wayne Lenehan as Secretary-Treasurer.

The priorities for the next two years were then established with more involvement in the Society by more people as the main objective. To this end, an "every office visitation program" was established and carried out. This provided a personal contact with members that normally did not attend meetings and also gave the executive sound knowledge of where our profession stood around the province on various issues.

One major concern during this time was the entry of optometrists into the Sussex Health Centre, a first for our province. Since these optometrists did not dispense, they rented space to a private optical firm. Council tried in vain to have this reversed. The result was a short term lease so that opticians could be removed if possible.

Other concerns during this period included Direct Referral to ophthalmologists and the C.N.I.B. Medicare continued as a major concern.

In May 1977, a new Health Minister was appointed, the Honourable Brenda Robertson. Council met the Minister soon after her appointment and it became evident she knew very little about the profession of optometry. She expressed a willingness to learn more and was subsequently invited to tour the School of Optometry at the University of Waterloo. The acceptance of this invitation drastically altered the future of N.B. optometry . . . for the better.

At the annual meeting in 1977, Dr. Roy Brown C.A.O. President spoke to our members and provided a great deal of inspiration.

On October 21, 1977 Mrs. Robertson, Dr. Harding and Dr. Lenehan visited the University of Waterloo School of Optometry. Needless to say, she was impressed with the people and facilities she saw there. The Minister said that while the N.B.O.S.'s entry into Medicare would depend on a new Act with better mechanisms for control of the members, she would actively assist in making that Act a reality.

The next eight months were fully consumed by the writing, editing, lobbying for and presenting our Act. The new Act would include a new definition of the practice of optometry, compulsory continuing education, diagnostic drug legislation, peer review and lay representation on the discipline committee.

The spring months were intensely concentrated on various drafts of our Act and yet another visit to Waterloo by the Assistant Deputy Minister of Health, Dr. Wylie.

Our Act received first reading in the House on May 7, 1978. Our Corporation Committee meeting was

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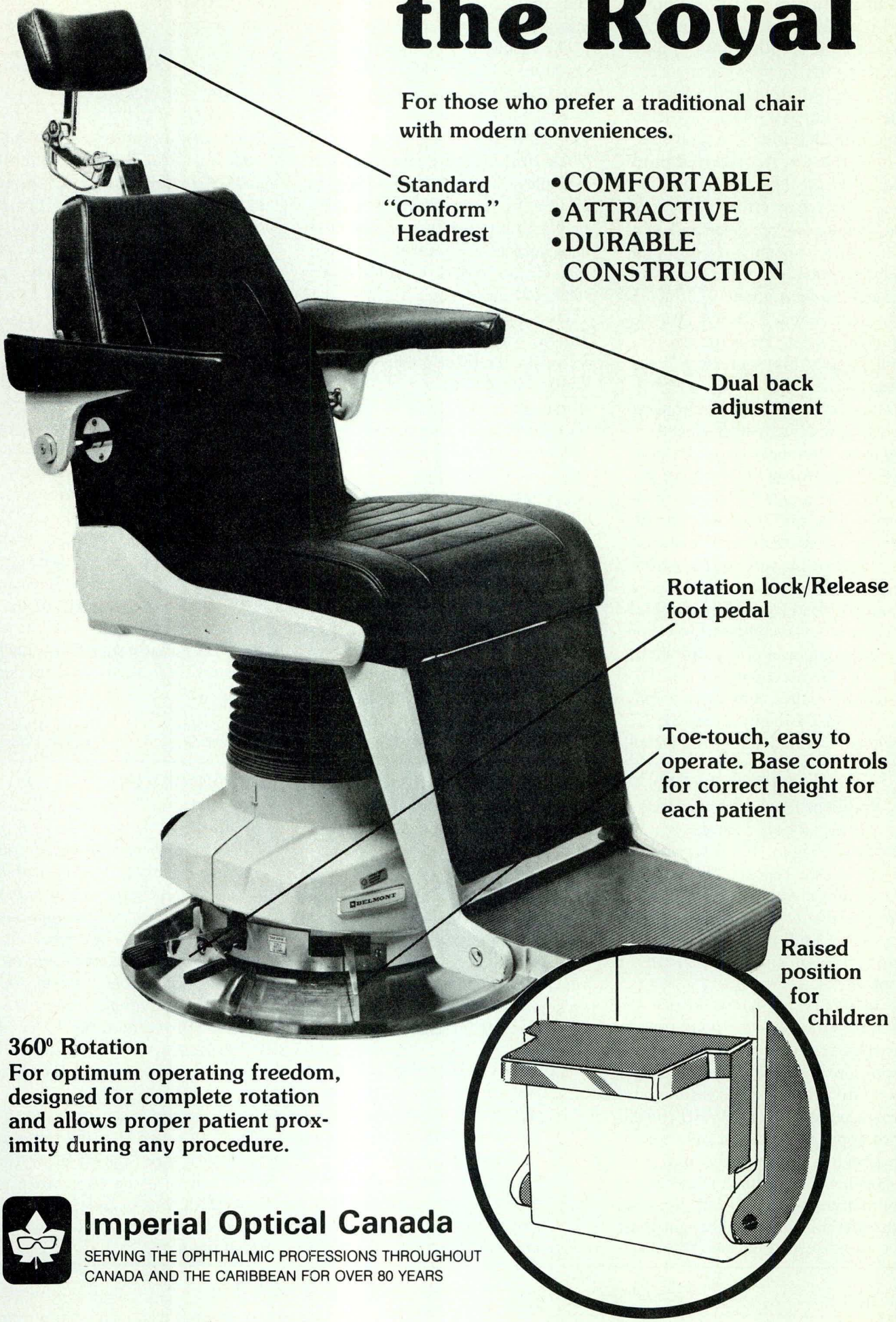

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held the 28th of May and attended by all optometrists in N.B. along with Dr. Woodruff, Dr. Lyle, Dr. Andrews and Dr. Roy Brown. Many people spoke in opposition to the Act, mainly Medicine and opticians. The Act did pass the Committee stage with all this help and on June 8, 1978, the new Act received third reading in the House and became law. It was a team effort all the way and a number of factors contributed to our success, mainly, the devotion and determination of the executive to keep the fight going.

In September, 1978, Dr. Wayne Lenehan became President and Dr. Tom Hickey his Secretary-Treasurer.

The next major task confronting N.B.O.S. was the by-laws which now had to be formulated and submitted to the Department of Health for approval. The major by-law was concerned with the diagnostic drugs. The act stated that the Minister of Health would determine which drugs would be permitted using whatever resources they deemed necessary. A committee was appointed composed of two optometrists, Dr. Wayne Lenehan and Dr. Woodruff. Other committee members included two physicians, Dr. C. Lythgoe, Ophthalmologist, Dr. Neil Graham, Internist, and a Pharmacist, Mr. Landry, all under the chairmanship of Dr. Robert Tonks, Dean of the Faculty of Health Sciences at Dalhousie University in Halifax. The Committee met in Fredericton several times and travelled to Waterloo before reaching their decision. They decided to permit certain cycloplegic and mydriatic drugs to be used by those optometrists who met qualifications for an optometric drug license. The Minister accepted the unanimous decision without any further changes.

Dr. Lenehan then entered negotiations with the University of Waterloo to set up a qualifying drug course. By the spring of 1979 approximately 75% of N.B. optometrists had taken a drug course of over 100 hours, including a week of clinical trials at Waterloo, all of which was concluded by June 1979. Dr. Lenehan was re-elected President in September 1979 with Dr. Hickey taking the post of Secretary-Treasurer again.

Concerns for the next period centred on Medicare again and a Mobile Vision Van. Briefs were prepared and presented to government on both issues as it was felt they were tied as one program. There were numerous discussions on this subject over a period of six to eight months and a vision care plan for children and seniors was seriously considered.

A local service club was approached for funding for a Van and offered support if the government would give its approval. It then became a political decision. Opposing groups organized protests and blocked the proposal. At present neither issue has been resolved.

Third party negotiations and liaisons with other professions continued to occupy much of the time of the N.B.O.S.

As the decade drew to a close it was apparent by the progress we had made that the N.B.O.S. was in a much stronger positon than ever held previously. It is hoped that Medicare and a Van, and a voice in the planning of health delivery in New Brunswick will become a reality in the Eighties!

At this time the N.B.O.S. wishes to take this opportunity to congratulate Dr. Hervé Landry's dedicated efforts on the behalf of New Brunswick Optometry and assure him of our utmost support during his term as C.A.O.'s national president.

by
Dr. G.C. Ross, Dr. J.R. Harding,
Dr. Raymond Corbin, Dr. Tom Hickey

IOOL SEEKS WORLD HEALTH ORGANIZATION RECOGNITION

President-Elect L.D. Pickwell of the International Optometric and Optical League (IOOL) expressed concern in his report to the May 1980 Delegates meeting in Japan that the World Health Organization (WHO) does not understand the League's purpose in the promotion of optometry.

In this report he noted that the IOOL welcomes an invitation to truly become involved in WHO sponsored eyecare schemes, but that despite IOOL presentations and correspondences, the WHO still did not appear to recognize the role of optometry. "They recognized opticians and ophthalmologists but not optometrists." As a result, he said, the first priority of the League must be to make certain that WHO understands that optometry is the primary source of eyecare in all countries and that the IOOL is an optometric organization.

He suggested that all members and delegates who have contact with WHO should circulate the following statement to explain the League's position and to emphasize that any scheme for eyecare which did not include optometry would invite criticism.

. . . *"The IOOL policy is that optometric service is essential to full eyecare for the public of all countries. Without optometry, development of full eyecare in underdeveloped countries would be very much slower and never reach the best possible in the public interest. Where optometry is fully developed, early detection of disease and prompt and proper prescribing of optical appliances is very widely available. Optometric examination is an appropriate approach to the provision of optical aids. The dispensing service is immediately available from the optometrist. This has proved to be the most economic way of providing optical aids and screening for eye disease and eye signs of general disease."*

Pickwell stated that the status of the IOOL's recognition by the WHO will be reviewed at the next General Meeting of Delegates and a further course of action determined at that time.

NOVA SCOTIA
HEALTH SERVICES AND INSURANCE COMMISSION
OPTOMETRIC SERVICES

Payment and Utilization Summary

	1973-74[1]	1974-75	1975-76	% Change	1976-77	% Change	1977-78	% Change	1978-79	% Change
Payment Summary										
- Payments to Optometrists in Nova Scotia	$109,615	$719,661	$768,872	6.8%	$761,029	−1.0%	$881,343	15.8%	$962,330	9.2%
- Out-of-Province Services	—	1,701	1,896	11.5%	2,852	50.4%	3,110	9.0%	4,358	40.7%
	$109,615	$721,362	$770,768	6.8%	$763,881	−0.9%	$884,453	15.8%	$966,688	9.3%
Utilization Summary										
- Services Rendered	9211	60,622	64,773	6.8%	64,196	−0.9%	66,343	3.3%	71,802	8.2%
- Persons Insured	793,000	802,000	814,000	1.5%	823,000	1.1%	825,000	0.2%	831,000	0.7%
- Persons Receiving Services (Beneficiaries)	—	59,625	63,500	6.5%	63,300	−0.3%	65,600	3.6%	70,800	7.9%
- Percentage of Persons Insured	—	7.4%	7.8%	—	7.7%	—	8.0%	—	8.5%	—
- Services Per 1,000 Insured	12	76	80	5.3%	78	−2.5%	80	2.6%	86	7.5%
- Expenditure Per 1,000 Insured	$ 138	$ 899	$ 947	5.3%	$ 928	−2.0%	$ 1,072	15.5%	$ 1,163	8.5%
- Services Per 1,000 Beneficiaries	—	1,016	1,020	0.4%	1,014	−0.6%	1,011	−0.3%	1,014	0.3%
- Expenditures per 1,000 Beneficiaries	—	$ 12,098	$ 12,138	0.3%	$ 12,068	−0.6%	$ 13,483	11.7%	$ 13,654	1.3%
No. of Optometrists (in-province) Paid	34	37	37		38	2.7%	37	−2.6%	41	10.8%

[1]Part year only. Optometric benefit became effective December 1, 1973.

highest number in the decade. The increase in the number of optometrists and the enthusiasm of the younger practitioners has had a stimulating effect on the profession.

The past ten years have seen a gradual increase in association activity whereby the profession has assumed a high public profile. With greater involvement in public related projects, the Nova Scotia association hired an executive director for greater efficiency and to improve internal communication.

The Nova Scotia Optometry Act and by-laws have not been revised since 1961 and much effort has been directed toward rewriting the Act and up-dating the by-laws. Hopefully, with the latest proposed changes Optometry may present the Act to the Legislature at its spring sitting in 1981. Legislation is indeed necessary to achieve the goals set out by the CAO for all Canadian Optometry in 1977, in Toronto.

With a more healthy manpower situation Nova Scotia optometrists are hopeful of expanding their role in low vision and public screenings. Increased manpower will provide Nova Scotians greater access to optometrists as areas not served in the past will now have practitioners at their disposal. In addition the optometric role can be expanded to more fully meet the goals we have set for ourselves.

Garson Lecker O.D.

The Prince Edward Island Association of Optometrists Report

Our situation in P.E.I. is unique in that we have only six optometrists to form an association and man the relevant committees. Because of this situation our association normally functions in an informal manner. However, we do meet on a regular basis and make a sincere effort to keep well informed as regards optometric matters, in both the political and educational field.

For the past four years we have been endeavoring to have a new optometric act approved. This act would be more relevant to modern day optometry and would allow the use of diagnostic pharmaceuticals for optometrists qualified in this field. Our new act has been drafted for some time but its enactment has been delayed during the past year by a change in government, and prior to that, by several changes in health ministers. However, our association is hopeful that 1980 will see our act brought before the legislature and approved.

As optometrists, we are not part of the government medicare insurance program. For the most part our members have been less than enthusiastic about medicare. We have made approaches on occasion to the government, but have never lobbied with the determination necessary to have the government accept us in their program. If more ophthalmologists were to establish in P.E.I. it would become economically necessary for our members to become part of medicare. At present, we are aware that this is a real possibility and so it seems likely that we will start the eighties with a campaign to become part of medicare.

As our province has no large industrial firms we are seldom engaged in bargaining with third parties. Most of our third party contracts are with government agencies, and generally speaking, they accept our schedule of fees without undue objections.

During the past several years our association administration has become more businesslike, and our meetings although informal are guided by parliamentary procedures. Our dues have been gradually adjusted upward from $100.00 in 1970 to the present $275.00. The greater part of this assessment is forwarded to C.A.O. with the remainder left to take care of administration expenses.

Our association has never entered any promotional schemes, and public relations has been on an individual basis with members accepting speaking engagements and being involved with community work.

In 1970 we had six members, and today our membership remains at six. During the decade we lost three members through death and have had three members join our association. Of these, two were trained in Scotland and one in Ontario. In 1970 all our members did their own dispensing and now just three. Two members are associated in practice and the rest operate solo. During the 'seventies, we have watched retail optician outlets multiply from one or two in 1970 to twelve or more today.

It would appear that P.E.I. will remain essentially a rural community in the foreseeable future. For this reason it is unlikely there will be any major change in the number of optometrists in P.E.I. or their mode of practice.

B.F. Hunter O.D.

The Nova Scotia Optometrial Association

The past decade has seen many changes in all aspects of social behavior and with these have come many alterations to previous patterns usual to the conduct of the professions. Optometry has not been immune to these changes and as a result has assumed the position as the primary profession in vision care. This all began prior to the advent of health care insurance when the Canadian Association of Optometrists organized optometrists across Canada into a political lobby and succeeded in changing the Medical Insurance Act so that the services provided by optometrists could be covered.

Optometry in Nova Scotia began to respond to the winds of change early when it endeavored to have optometric services covered by Medical Services Insurance. It was a unifying experience and was a successful endeavor when visual analysis by optometrists was insured as of December 1, 1973. The payment amounted to $11.90 but optometrists have retained the controversial benefit of balance billing their patients. Unfortunately, visual analysis remains the sole benefit paid and the number of patients on the average has not increased substantially (see appendix). In 1978–79 the cost to Medical Services Insurance for optometric (vision) care was less than $1,000,000 with 41 optometrists participating (not all active for the year and two with recently opened practices). There are now 44 optometrists registered in this province, the

The Newfoundland Optometrical Association Report

Optometry as an organized profession in Newfoundland and Labrador is still very young. During the 1970s, Newfoundland's concerns out of necessity have been more basic than many other parts of Canada. Central to our continued existence and development, has been the need for an increased number of Optometrists. This problem is bound up with the lack of training institutions in Canada. It is little more than 30 years since Newfoundland was closely tied to the U.K. as a consequence of which we entered Confederation with a number of British trained Optometrists. We have accepted British graduates for licence examinations ever since 1949, and as long as a shortage of Canadian trained Optometrists exists, we will probably continue to do so. This mixture of variously trained personnel is rare in Canadian Optometry but has worked well for us.

As recently as 1964, there were only 7 Optometrists in the whole province. Although the number of practitioners began to increase in 1964, due to deaths, retirements, etc, there were only 12 licenced practising Optometrists in 1970. By 1980, the number had increased to 27 with 25 practising. Much of the increase was due to more Newfoundland men and women entering the profession and returning home after graduation.

Optometry was and still is governed by the Optometry Act 1928 (Revised 1952) and though a good act for its day, it was out of date by the 1960s. Starting in 1966, a group of Optometrists began with their lawyer to draw up and present a new act to govern Optometry and legally establish the Newfoundland Optometric Association. This act has been through many drafts and changes over the past twelve years, and has seen several governments and many Ministers of Health come and go, but is still not passed.

The road that the act has travelled reflected the changes in our society, both provincially and nationally during these past ten years. Strong opposition has come from the Newfoundland Ophthalmological Society and the Canadian Ophthalmological Society as Ophthalmology tried to move into the primary vision care field, and as Medicare tried to refine and improve its public image during the latter part of the decade. What the final form of the Act will be is still not clear. We know want we what and have strongly presented our ideas to our government, but we also know where our opposition comes from. Until the new act becomes law, we must abide by the 1928 act. This act has many loopholes and vague areas which still allow less control over our profession than we would like. This makes Optometry less structured than in some of Canada's more populated provinces.

The Newfoundland Optometric Association was formed in St. John's in 1968 and membership was voluntary as was payment of yearly dues. It says much for the Optometrists of the province that dues have always been paid by everyone even though legally the relicencing fee is still $10.00. Since the new Optometry Act appeared to be in the offing in 1968, nothing was done to legally incorporate the Association and that is the way it still stands. What the future will be in this regard only time will tell.

The Association was officially made a corporate member of the Canadian Association of Optometrists in 1973 (?) and has tried to contribute its fair share to the Canadian Association of Optometrists since that date. It has paid its full dues and taken part in P.R. projects such as the very successful eclipse project. Until the past three years the Newfoundland Optometric Association has been handicapped by lack of members with the result that two hats, sometimes three, had to be worn by all. Until 1980, the President of the Optometry board was also the president of the Newfoundland Optometric Association. This year, that has been changed and the two functions separated (anticipating the Optometry Act) due to a doubling of our membership. The increased membership argues well for increased activity in Provincial P.R. Programs, bulletin production, Canadian Association of Optometrists committee participations, etc.

The progress of Optometry during the, '70s can be traced to the arrival of new graduate Optometrists in the mid 1960s and the increased demand for Optometric services by the general public due to the advent of Medicare in 1967. The fledgling Newfoundland Optometric Association presented a brief to the Newfoundland government for the inclusion of Optometrists in Medicare, but was unsuccessful. While most of the other provinces have seen fit to include Optometrists, even by 1980, the Newfoundland government still had not done so. Although this initially put Optometrists at a disadvantage, vis a vis Ophthalmologists, especially in St. John's, the freeing of the average Newfoundlander's funds from medical expenses and the advent of prepaid insurance plans covering vision care allowed more people to seek Optometric services.

During the early to mid '70s, a number of General Practitioners, following little or no proper training, began refracting. MCP paid them the non-specialist's fee for this service. They were usually involved with some form of optical dispensing and advertised free eye-examinations. This was another and more potent threat to Optometry in Newfoundland. Unfortunately, this

trend was encouraged by some Ophthalmologists and the Canadian Ophthalmological Society. In St. John's, several of our members were temporarily hurt by these people. However, as the decade progressed, the public began to see through these "eye specialists", and their impact began to wane. The Newfoundland Optometric Association is still vigorously pushing for Optometry's inclusion in Medicare and there is some hope that this goal may be reached shortly after 13 years effort.

During the '70s, the Newfoundland Optometric Association has made every effort to make its presence known to Departments of Government. We have, I think, raised the consciousness of the Department of Health with regards to Optometry quite significantly. Payment for our services on a fee basis, with realistic fees and materials at cost was established and maintained throughout the decade. Parallel with this and based on our Department of Health agreements have been agreements with D.V.A. and the R.C.M.P. These agreements are updated yearly.

The province of Newfoundland like many of our less densely populated parts of the country offers a special challenge to practising Optometry. There are few large communities and the population is scattered over 390,000 square kms and along 16,000 kms of coast line. Branch offices are a necessity for many Optometrists, especially those building their practices. Some of our more remote communities have to be serviced by travelling Optometrists. As our numbers increase and transportation improves, these will disappear from the scene.

Although some members of our Association have opposed increasing the number of Optometrists in the province, more reasoned consideration indicates that only by increasing our numerical strength can we continue to prosper and improve services to our patients. The eighties decade should see continued improvement in our profession in this province and I hope it will be as lively and interesting as it has been in the past ten years.

John A. Snow O.D.

CAO Congratulates the University of Waterloo's School of Optometry 1980 Graduates

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James Agnew O.D.
Bradley Almond O.D.
Joh Astles O.D.
Sondra Berman O.D.
John Bruno O.D.
Lois Calder O.D.
Paul Chapman O.D.
Lesia Ciz O.D.
David Dobbelsteyn O.D.
Randall Dyke O.D.
Ian Edmison O.D.
Arnold Eitutis O.D.
Alexander Erdie O.D.
H. Steven Garrett O.D.
Steven Gold O.D.
Grand Goodes O.D.
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Melvin Haché O.D.
David Hampton O.D.
Richard Hareychuk O.D.
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Julia A. Holterman O.D.
Surrinder Mahil O.D.

M.Sc. Physiological Optics
Pamela Earle

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The Executive Committee of the Canadian Journal of Optometry wishes to acknowledge all those scientific referees who contributed generously of their knowledge, expertise, and time to review and to evaluate the suitability of transcripts submitted for publication to the Canadian Journal of Optometry for the years 1979 and 1980. The Executive Committee is ever mindful of their contribution to the integrity and accuracy of the Journal.

COMING EVENTS

DECEMBER

11-16
American Academy of Optometry Annual Meeting
CHICAGO, IL

Contact: Dr. J. Schoen
115 W. Broadway
Box 365
Owatonna, MN

MERRY CHRISTMAS

International Year of Disabled Persons
1981
Année internationale des personnes handicapées

JANUARY

24-26
The Skeffington Symposium - Vision, Development and Training
WASHINGTON DC

Contact: Robert A. Kraskin
4600 Mass. Ave.,
N.W. Washington, DC
20016

FEBRUARY

4-6
Course - Current Thinking in the Management of Ocular and Adnexal Tumors
SAN FRANCISCO, CA

Contact: Extended Programs in Medical Education
(415) 666-4251

6-8
Interdisciplinary Conference on Learning Disabilities
SAN DIEGO, CA

Contact: Richard B. Elliott
Southern California
College of Optometry
2001 Associated Road
Fullerton, CA 92631

11-16
Optometric Winter Carnival
SUN VALLEY, ID

Contact: Richard B. Elliott
Southern California
College of Optometry
2001 Associated Road
Fullerton, CA 92631

20-22
Heart of America Contact Lens Congress
KANSAS CITY, MO

Contact: Dr. Rex Ghormley,
Suite 310,
10004 Kennerly Rd.
St. Louis, MO 63128

MARCH

8-10
Optifair East 1980
NEW YORK, NY

Contact: Christine Grande
500 Summer Street
Stamford, CT 06901

14-18
59th Annual NECO Congress, Optometry in the '80s
BOSTON, MA

Contact: George Syby
101 Tremont Street
Boston, MA 02108

17-23
Around the World Contact Lens Congress
TAJ MAJAL, BOMBAY, India; TOKYO Japan; SINGAPORE

Contact: Dr. Allen Prechtel
National Eye
Research Foundation
18 S. Michigan Ave.
Chicago, IL 60603

21-22
Third Annual Review of Contact Lenses
LOS ANGELES, CA

Contact: Richard B. Elliott
Southern California
College of Optometry
2001 Associated Road
Fullerton, CA 92631

26-29
Annual Educational Congress
DALLAS TX

Contact: Pierce M. Allman
P.O. Box 8482
Dallas, TX 75205

MAY

23-29
'33rd Jahreskongress der WVAO
BERLIN, West Germany

Contact: H.J. Helle
Adam-Karrillon-Str.
32 D6500 Mainz/
Rhein

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INDEX '81
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Surname_____ First Name_____ Initials_____

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Postal Code_____ Telephone Number_____ Area Code ( )

School(s) attended_____

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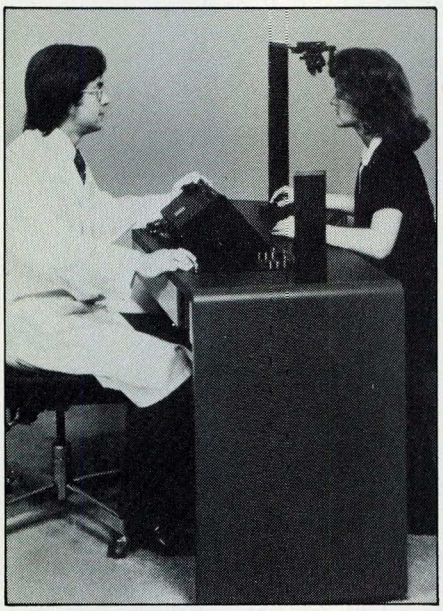

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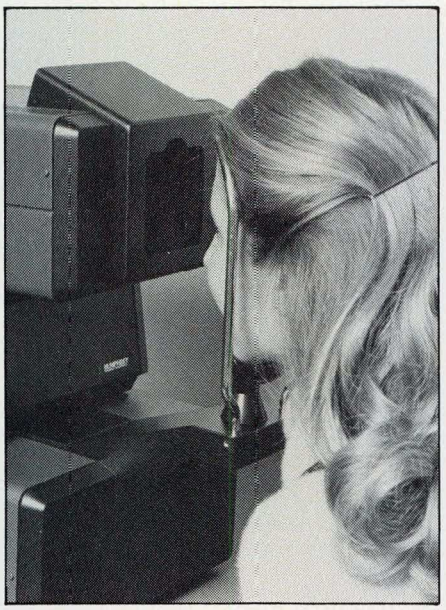

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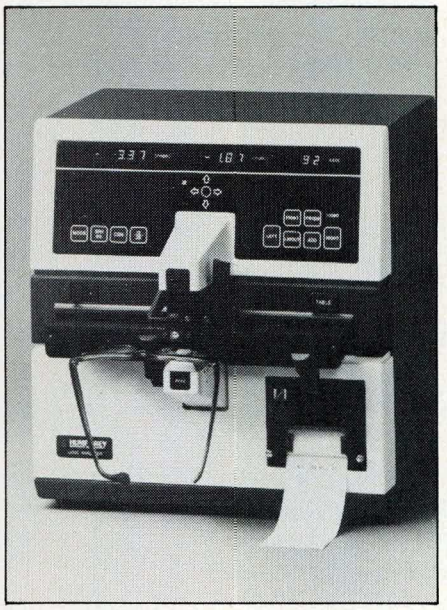

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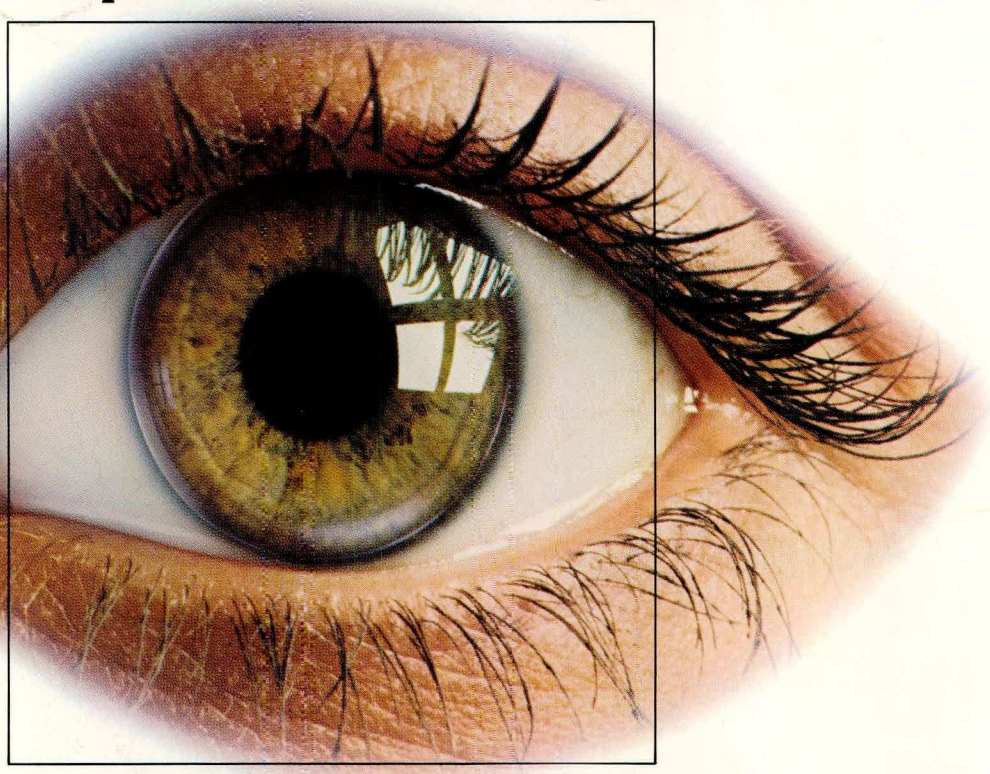

that prevents protein build-up

Hydrocare® Protein Remover Tablets

Weekly use of these tablets containing stabilized papain removes and prevents build-up of protein and diminishes the frequency of inorganic films. Starter Pack: 12 tablets with mixing vials. Refill Pack: 24 tablets.

Allergan Preserved Saline Solution

A sterile, buffered, isotonic solution for daily rinsing and heat disinfection.

Hydrocare® Cleaning/ Soaking Solution

Daily use of this sterile, preserved, buffered, isotonic solution hydrates, disinfects and removes oily contaminants with one solution.

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