EDITORIAL

VISION THERAPY IN THE OPTOMETRIC CURRICULUM—PART I

Many of you are aware of the ability of optometrists with special interest in vision training/therapy (VT) to communicate electronically with membership in VTOD-L@LISTSERVE.INDIANA.EDU. This is possible because of the efforts of Dr. Bill Rainey at the School of Optometry at the University of Indiana. The members form a discussion group who can communicate with each other by e-mail. Hardly a day goes by without some type of communication. Generally, the messages can be divided into three groups: consultation regarding the care of patients, opinions on various topics, and practice management issues. What I find to be particularly valuable is that the group is composed of faculty at the various schools and colleges of optometry and optometrists in group or solo practices who are able to communicate easily with each other.

On July 6th of this year the following message was sent by Dr. Kenneth Koslowe:

> *It has been my impression for a number of years that visual training in all its forms has been consistently de-emphasized in the USA curriculum. Do you agree, agree strongly, disagree or disagree strongly?*

Dr. Koslowe's message created a deluge of responses. Few answered according to his scale although there was no doubt that they agreed strongly with the statement. Respondents ranged from current students, to recent graduates, to optometrists whose offices served as externship sites for various optometric educational institutions, to faculty at these institutions. Many of the responses went from moderate to strong "bashing of optometry schools and colleges". This is not a new topic, and I had addressed it some eight years ago in an editorial entitled "Blame It On The Schools—Déjà Vu."[1] By the middle of the next week some more moderate opinions were made individually by Optometric Extension Program President Glen Steele, Secretary Treasurer Gregory Kitchener, and Executive Director Robert Williams. While it was evident that they were at the "agreed strongly" on Dr. Koslowe's scale, they implied that school bashing would accomplish little.

I propose that Dr. Koslowe's question is the tip of the iceberg. The underlying and more important issues can be phrased as "why aren't there more optometrists practicing vision training ?" and "why don't more optometrists who don't actively practice vision training diagnose more functional/behavioral vision dysfunctions and refer them to optometrists who do?" Indeed, some ten days after Dr. Koslowe's original e-mail the communications focused on the latter question.

The answers to all the questions raised are complex. They involve the transformation of optometry, particularly over the past decade, and the mission of the schools and colleges of optometry.

While I am unaware of hard data indicating that visual training has been de-emphasized in the curriculum of each of the schools and colleges of optometry, many of the members of the LISTSERVE feel that it has, and that cannot be ignored. Nevertheless, as someone who was intimately involved with optometric education in general and VT in particular for some 30 years I should like to point out several things.

During this time span there were always certain schools and colleges that emphasized VT in their curricula, while others emphasized the diagnosis and management of ocular and systemic disease. My impression that the "VT" institutions were the Southern California College of Optometry (SCCO), the State University of New York, State College of Optometry (SUNY), Pacific University, College of Optometry (PUCO) and the College of Optometry at Ferris State University (FSU); the remaining institutions were in the "ocular disease" camp. I propose that during the 1980's and into the 1990's both categories moved toward a more middle position. I have first hand knowledge that at SUNY the didactic and clinical curricula in VT were decreased because students felt that they

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were getting too much in that area. This must be put in the context that this was the era when virtually all states were granting diagnostic pharmaceutical agent privileges (DPA), and the advent of therapeutic pharmaceutical agent privileges (TPA) was not a question of "if", but "when."

Coincident with the decrease was an increase of interest of VT in the curricula of the "ocular disease" institutions. My first hand experience is based on calls, letters and conversations with administrators at those schools asking me to suggest individuals to join their faculties for didactic and clinical teaching roles in VT. This must be put in the context of the impressive growth and success of VT related residencies. It is logical to assume that the desire to recruit more VT faculty was based on strengthening rather than weakening that area of the curriculum. And the need for qualified VT faculty continues to this day as evidenced by ads in the various optometric publications.

I believe that the question raised by Dr. Koslowe is valuable and he should be thanked for bringing it to a wide audience for what has become a healthy discussion. At this writing, some two weeks after the original e-mail, I've counted more than 50 related communications. Two of these are particularly well done and represent views by individuals with completely different backgrounds. They accompany this article as guest editorials.

Reference

1. Suchoff IB. Blame It On The Schools—Déjà Vu. J Behav Optom 1994;5(3):58,68.

GUEST EDITORIAL
VISION THERAPY IN THE OPTOMETRIC CURRICULUM PART II

Being one of the few non-optometrists on LISTSERV, I will not cast an official ballot on the survey but did want to make some comments.

First of all this is not a phenomena of the past decade. The changing emphasis has been going on for some time and we, in the behavioral community, are at least partly responsible. I recall sitting in an Optometric Extension Program (OEP) Forum around 1978 and hearing the same song sung, while I was Alumni Director at Southern California College of Optometry (SCCO). School bashing has never and will never solve or prove anything. Stating from any platform that formal education is not valuable, a waste or time and money will not win support, and in fact will have the opposite effect. Fortunately I do not hear the bashing as much and very seldom over the past 10 years or so. I thought then and think now that all the schools and colleges of optometry provide a solid foundation upon which all future professional education and development rests.

At one of the Optometric Summit meetings of the early 90s one of the conclusions was that graduation was just as described: a commencement. The Summit further concluded that life-long learning is not an option but a requirement and that the OD degree represents the entry-level knowledge and skills to practice all aspects of optometry. If we want more optometrists to gravitate to binocular vision and vision therapy [BV/VT] we need to provide means, motive and opportunity. We have said for many years that one of the reasons relatively few optometrists choose the BV/VT 'specialty' is the time and effort it takes to become proficient. I liked Dr. Mary McMains comment about the difficulty of faculty who have been solely based in an optometric educational institution to understand the realities of practicing BV/VT in a private setting.

I greatly appreciated Dr. Ernie Loewenstein's comments about the new program at the New England College of Optometry (NEWENCO). He, Dr. Sol Slobins and their team proved that positive things can happen, with time, effort and resources. The Scholar In Residence program at NEWENCO can be viewed as a model and replicated at the various schools and colleges of optometry. I doubt that many administrators would resist such a program. It is a solid concept with a good educational foundation.

Further, as Dr. Glen Steele commented, we need to be talking about more than just VT. Lenses are vitally important and the behavioral use of lenses is just as important as a therapy program and for many more likely to be implemented in a practice setting that cannot or will not support an active in-office VT program.

Rather than being negative about the changing emphasis in a formal curriculum, why don't we look at other activities that can have a positive result? We would be better off, I think, focusing more on: inspiring practitioners to practice BV/VT; demonstrating the satisfaction both personal and financial of BV/VT; providing mentor and extern opportunities, formal or informal; and practicing full scope optometry.

And, as Dr. Lowenstein pointed out, there are positives in the profession. The NEWENCO is one. The efforts of Parents Active for Vision Education (PAVE) and the Neuro-Optometric Rehabilitation Association (NORA) to educate the public are another. The College of Optometrists in Vision Development (COVD) campaign on public information is another. All these and others deserve our support. OEP has produced some excellent tools for public information and professional development. The Baltimore Academy of Behavioral Optometry (BABO) courses provide a great foundation for real expertise in BV/VT.

OEP has published two volumes in recent years on practice development and management in this area. Developing the Dynamic Vision Therapy Practice, a multi-authored volume edited by Willard B. Bleything, O.D., M.S. was published in 1998 and another edited by Anne Barber, O.D., in 2000. Included is guidance from many who have experience and expertise. There are ways to attract new doctors to BV/VT once they have their basic education. Maybe we just need to be more approachable and accepting. And remember, each of you was once a new grad with only basic knowledge of BV/VT. But, with this basic foundation from optometry school and a desire to grow, develop and provide quality care to all, you became the practitioner you are, because that is what you wanted to do.

Others can do the same.

And, we need to help them.

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GUEST EDITORIAL
VISION THERAPY IN THE OPTOMETRIC CURRICULUM PART III

As a 'new' doc (Northeastern State University, College of Optometry, '98) I think Bob Williams' e-mail is very valuable. I have commented (and will continue to do so) on my desire to see the clinical experience in binocular vision/vision therapy (BV/VT) strengthened in the schools in any way possible. I sometimes rant on the topic to peers and anyone who will listen. But, no matter what we wish for, the fact that VISION is more complex than eyesight just makes it too difficult to give more than a basic foundation for future learning in the short time available to the schools.

In my practice, I am sometimes appalled at the scripts I find in my charts as my patients return for follow-up. My growth as a clinician from year to year is something of which I am very proud, especially in light of how skilled I thought I was when I graduated!

However, that clinical growth comes with a price and does NOT come from experience alone! The continuing education I have attended since graduation has so changed my clinical thinking that I sometimes feel I'm back in my first year!

It IS difficult to simultaneously meet my felt needs to (1) pay my bills, which are not inconsiderable following school, practice start-up, and later practice purchase), (2) 'treat the complaint' (stressed during school), and (3) learn to uncover visual inefficiencies which can change a person's life, when presented properly and subsequently treated.

I think more optometric physicians don't practice BV/VT because it IS difficult. I practice it because it challenges me, because I was genuinely interested in brain function before optometry school, and because our public and private schools, including those my children will soon begin attending , need my help to teach more children successfully. If I didn't have this desire and 'vision' for what my work can do (read: most of our OD colleagues), why would I make the effort to move from a comfortable place where I treat 'refractive disorders' and pathology, both of which respond to less involved treatment strategy and implementation?

Our job, as I think the College of Optometrists in Vision Development COVD) leadership realizes, is multifaceted. We must educate our individual patients concerning the services we offer. We must find in-roads to the media which can be used to create a stronger image of the optometric profession and of behavioral/developmental/functional/neuro optometric benefits. We must help our optometric educational institutions provide what is lacking in students' and young doctors' education in BV/VT. This approach is more productive than moaning and criticizing the perceived inadequacies of the schools and colleges. We must also help our colleagues want to do what we do.

On the last point, I think all of us, as doctors, want to be successful financially and professionally. If our colleagues are happy with the financial benefits they currently receive, then why appeal to them to make the great effort to change the way they practice?

Should everyone treat BV problems?

Yes.

Will everyone?

No.

Can everyone, given the opportunity to see the positive outcomes in THEIR patients lives, appreciate the need for treating BV problems?

Yes.

So, do they know how to refer?

Yes.

The refractive surgery boom would not exist without OD referrals. Our profession knows how to refer. We guarded and then developed those refractive surgery referrals every step of the way. Only the weakest spines allowed a second referral to go where a patient was lost to the referral.

We know to refer where our patients are returned to us. We know how to refer in ways that keep us 'in the loop'. We know how to talk up our M.D. surgeons' skills because we know that patients' perceptions positively (or negatively) effects treatment outcomes. We know how to make this work.

We need to find ways to show our O.D. colleagues how BV/VT can help their practices be better. Refractive surgery might be a model to examine. We need to help our O.D. colleagues find ways to be secure in knowing that a referral will absolutely not hurt their image or practice or patient base.

I know I'm 'preaching to the choir,' but I think it is good to remind each other (and myself) of our focus. If we expend our collective energies on solving the how-to for each of the goals above, I'm sure we, and our patients, will benefit much more than we can currently imagine.

Sincerely,

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P.S. The opinions expressed in this post are meant solely to relieve my feelings of guilt for my frequent forgetfulness in practicing what I preach. Should any thought contained in this post spark feelings of guilt in the reader, the post's author offers sincere apology for your discomfort, and recommends you join him in resolving to yourself to do something positive about it.

Thanks for the reminder, Bob.