CHAPTER 3

THE PROFESSION OF OPTOMETRY ASSUMES GREATER RESPONSIBILITY

INTRODUCTION

In spite of becoming the 44th state to enact an Optometry Practice Act in 1919, Alabama has had, in many respects, an illustrious history in terms of its legal and legislative activities. Nationally, the passing of the original optometry practice acts in each state, including the District of Columbia, required about 23 years. This era of passing optometry practice acts spanned a time period from 1901 to 1924 (1). Even before the legalization of optometry in every state, the profession had turned its attention to a variety of issues including exemptions given to physicians and opticians regarding the practice of optometry, licensure and self-regulation, commercial optometry, increasing optometry's professional stature, eliminating proprietary schools and colleges, implementing a professional program curriculum in its schools and colleges, as well as developing an accreditation process for the educational programs. This was an ambitious list that included very complex issues and would require many years of effort.

The following discussion has both state and national aspects in terms of their impact. The matter of improving education was perhaps the most important priority since many aspects of the profession were a direct result of optometric education. However, legal outcomes from state court cases helped establish precedents that had national implications. Two of these cases were tried in Alabama and involved optometrists with Alabama licenses. Underlying these issues was the matter of professional image that was extremely complicated and, in many respects, was largely dictated by the marketplace and not the profession.

THE EMERGENCE OF A PROFESSION

Education

In the very early years of optometry its educational enterprise was largely either on-the-job training or some form of apprenticeship in nature. Later short courses were offered by practitioners who had large practices, optical companies, or optical manufacturers. At the end of the 1890's and into the 1900's there were 60 such private schools, at one time or the other. These proprietary schools existed as businesses engaged in training physicians, opticians, and others as "refractionists" (2, 3). Typically, these were educational experiences that lasted from several days to several weeks in duration. It was from these meager beginnings that optometric education emerged, evolved, and matured into true professional programs.

Early Efforts to Elevate Optometric Education

During the same period of time that optometry practice acts were being passed, the profession began the long process of improving the quality of optometric education by implementing an accrediting process that elevated standards. This process achieved its intended goals by gradually resulting in decisions made to close proprietary schools and correspondence courses.

This process required many years, even decades, before it evolved into the accreditation process it is today. From 1902 until 1918 all matters concerning optometric education in the AOA were under the Scientific Section. When this section was discontinued in 1918, the AOA created a Department of Education. After 1919 one of the AOA Vice Presidents was made responsible for this department (4). Nevertheless, this Department of Education was not involved in accreditation. The International Board of Boards (IBB) was begun in 1913 when several state boards met in Rochester, New York to discuss plans for an organization consisting of state boards as members. However, the plans for this larger organization were not completed until 1919 (2).

The Beginning of Accreditation

In the decade from 1925 to 1935 optometry began to more urgently feel the responsibility of becoming a profession. As early as 1922, the stage was set for inspection of schools and colleges of optometry, when the AOA Department of Education, the newly formed International Association of Boards of Boards (IBB) (this organization would eventually become the International Association of Boards of Examiners in Optometry, or IAB, and later the Association of Regulatory Boards of Optometry, or ARBO) and the International Federation of Optometry Schools agreed to hold a meeting.

This meeting was held at St. Louis, Missouri in 1922 and called the First Conference to Establish Optometric Standards. The primary purpose of this meeting was to compile standards for the optometric curricula in the several university and private professional schools in the United States and Canada. Resolutions passed at this meeting included recommendations for the adoption of uniform standards by all states, discarding of the apprenticeship provisions of the various optometry laws, the discontinuation of recognition of correspondence courses in optometry, and the adoption of the Syllabi of Optometric Education prepared by Dr. Frederick Woll of Columbia University. This Syllabi was to be used as a guide for schools to follow or utilize in some manner pertaining to these topics. The report of this conference also provided criteria for establishing acceptance and classification ratings of schools (2). This was a significant undertaking and the beginning of the advancement or the elevation of optometric education by ensuring schools and colleges met certain standards.

At this time in the profession's evolution, most of the state optometry laws specified the nature and minimum degree of optometric education prerequisite to licensing. This created a situation where, in effect, the responsibility of each state board was to decide if the content offered by schools provided adequate preparation. The state boards of the individual states therefore had the immediate responsibility of accrediting schools and colleges of optometry when optometry laws were enacted. It was by this mechanism that the International Association of State Boards of Examiners, early on referred to as the International Board of

Boards (IBB), assumed the responsibility for accrediting optometric education programs or institutions. In all likelihood the AOA was still involved with the evolution of this organization and matters primarily related to legislation.

Accreditation of Optometric Education

In 1925, using as a guideline the Syllabi of Optometric Education developed by Dr. Woll, the IBB appointed a committee to survey, during 1925 and 1926, about 30 optometry schools. This evaluation system served to bring about standardization by eliminating apprenticeships and correspondence schools and encouraging proprietary schools to raise their standards or cease to exist. The rating system required that an optometry school must provide at least a minimum curriculum of two years of at least 32 weeks each year. Of those 30 schools surveyed, only 16 were considered worthy of inspection and only nine (9) of these were given a rating; six schools received an A rating, two a B rating, and one a C rating. Most of the schools that did not meet the standards were rated as "Unclassified" and eventually closed. Some of the schools were placed on probation. In 1927, the IBB published a pamphlet representing the official adoption of these Minimum Requirements for Classified Schools (2).

Proposal for the Formation of the Council on Education

On October 20, 1928 Dr. Arthur Hoare sent to the AOA Officers and other leaders of the profession suggestions in the form of a proposal for Policies of the American Optometric Association. Item four of this proposal recommended the creation of a permanent and representative Council on Education (COE) (4). In 1929, a Committee on Education was created under the AOA's Department of Education, to evaluate the status of optometric education and make appropriate recommendations. Dr. William M Kinney, as first Vice President of the AOA, proposed a coalition of agencies operating in the field of education. At the 1930 AOA Congress in Boston the Council on Optometric Education was created. Dr. Hoare was nominated Chairman, and represented the AOA. The other committee members were Dr. Sterrett Stitus, who represented the American Academy of Optometry, Dr. Walter Brown represented the Distinguished Service Foundation, and Dr. Harold Doane, represented the International Association of State Board of Examiners in Optometry (2-4).

One of the purposes of this Council was to perform a three-year study of optometric education. It was to assume the responsibilities of the IBB in accrediting and rating schools (2, 4). However, this plan was not implemented due to a lack of agreement as to the purpose of the organization. During 1931 through 1933 there were long discussions concerning the Council at the AOA House of Delegates as well as Pre and Post Congress meetings of the AOA Board of Trustees. The central issue was the scope and function of the COE and whether it should be an independent organization or remain under the umbrella of the AOA. If it remained under the

AOA, in which department should it be? Some were against the proposed coalition, since the AOA was entirely funding the functions of the COE. As a result of these unresolved issues, the COE proposed at this time did not become active. However, each year the Council appeared before the House of Delegates seeking a definite policy and making various proposals.

In spite of these issues, the decade between 1925 and 1935 had shown a steady advancement in optometric education. Until about 1925, admission requirements for most schools did not include completion of high school training (3). Therefore, it was not uncommon for a student to quit high school and instead enroll in an optometry school. Beginning in 1923 Dr. Woll served as Chairman of the IBB inspection team for several years (5). During this period of time, the IBB did not grant accreditation to some 20 schools. These schools were closed due to poor ratings (5).

Council on Education and Professional Guidance

Finally, in 1934, the AOA House of Delegates passed Resolution 18 which called for the official recognition and change in structure of the Council on Education with funding being allocated for support of the Council. The AOA President was to appoint seven members to the Council on Education and Professional Guidance and it was to conduct a three-year study related to the problem of optometric education (3). Dr. Charles Sheard served as its Chairman for the next 10 years. According to Dr. Borish, this Council, however, was never implemented (5). Nevertheless, the Council on Optometric Education (COE) considers the year 1934 as its beginning (4).

In 1935 Dr. Frederick Woll edited the First Revision of *Optometric Syllabuses and Standards for the IBB*. By 1936, Dr. Albert Fitch submitted to a joint meeting of representatives from the AOA, IBB, AAO, and the various schools and colleges his *Proposal for the Standardization of Optometric Education Courses*. This proposal included a suggested optometry curriculum whose educational requirements were four years in length at all accredited schools or colleges of optometry (2).

Although the IBB carried out accreditation activities related to optometric education for more than a decade, it was apparent that this process was not rigorous enough, its members not qualified to evaluate schools, and the process was lacking integrity. At the conclusion of the IBB meeting, that occurred in conjunction with the 1940 AOA meeting, Dr. Irvin Borish stood to criticize the processes utilized by the IBB. After a closed meeting of the officers of both organizations, it was decided the AOA would assume responsibility for accreditation with the provision the IBB would have representation on the Council. By 1941, the AOA's Council on Education and Professional Guidance (CEPG) published its *Manual of Accrediting Schools and Colleges of Optometry* (2, 3). This Manual was prepared by Drs. Irvin Borish and Gene Freeman

but was presented by Dr. William Needles. This marked the first time Borish was assigned a role in these accreditation proceedings (2,5). By 1941 the Council listed eight schools in the U.S. as accredited and in 1945 added one more (2).

Over the two decades from 1935 to 1955 optometric education made steady and maturational growth with a pre-professional and professional curriculum that was truly professional in nature (4). By 1935, ten optometry schools required a three-year curriculum after graduation from high school. In 1946, eight schools required four years of study and by the end of this year there were seven schools requiring a four-year curriculum and three requiring a five-year curriculum (3). Many optometry students may have had at the time of admission to an optometry program more than the two year's required pre-professional education. However, the professional program degree curriculum remained three years in length until the late 1960's. It was in 1969 that schools and colleges began to graduate students who had completed a four-year professional program curriculum. Almost all programs began to require at least three-years of pre-professional educational and most students had four years of education or a bachelor's degree on admission to an optometry program by the 1980's. The Pennsylvania State College of Optometry had become the first educational institution to grant the Doctor of Optometry degree in 1923. It had been granted approval to do so by the Pennsylvania Legislature that same year.

COE Recognized by USDE

In 1952, the United States Office of Education (now the USDE), recognized the COE as an accrediting agency for professional optometric degree programs. In this same year, after many years of being denied membership, the first representative of the Association of Schools and Colleges of Optometry (ASCO) was added as a member of the COE, and a second member of ASCO was added in 1955 (3). ASCO had been formed in 1941 to serve as an organization representing the schools and colleges of optometry. Although members from optometric education had been included as far back as 1922 in discussions on accreditation, membership in the COE had been repeatedly denied and kept ASCO representatives from being appointed until 1952 (3).

In 2001 the name of the COE was changed to the Accreditation Council on Optometric Education (ACOE). The ACOE continues to periodically review standards and publish guidelines for all of the programs it accredits. These programs include professional, residency, and technician programs.

There are currently 21 schools and colleges of optometry in the United States and Puerto Rico. The existing schools or colleges or their predecessor institutions or educational entities are the Illinois College of Optometry (1872), the New England College of Optometry (1894), Southern

California College of Optometry at Marshall B. Ketchum University (1904), The Ohio State University (1914), Salus University Pennsylvania College of Optometry (1919), University of California, Berkeley, (1923), Southern College of Optometry (1932), and Pacific University (1945). Indiana University began its Division of Optometry in the College of Arts and Sciences in 1952 (this program became a school in the 1970's) and the University of Houston, College of Optometry began the same year as the Indiana program.

It would be 15 years before another School of Optometry was established. On January 23, 1967 the Alabama Legislature approved a Joint Interim Legislative Committee to study the need for a School of Optometry in Alabama during the legislatures Organization Session. The Committee determined on June 23, 1967 there was a need for a School of Optometry in the State of Alabama (3). During the Regular Session of the Alabama Legislature that same year the Legislature authorized the expenditure of $50,000 for each of two years to begin planning for the operation and maintenance of a School of Optometry. This bill was signed by Governor Lurleen Wallace on September 6, 1967. On May 5, 1969, the 16th day of the Special Session, the Alabama Legislature approved an Education Appropriations Bill that included funding for a School of Optometry as part of the University of Alabama Medical Center in Birmingham. This bill was signed by Governor Albert Brewer on Wednesday, May 14, 1969. This school, subsequently to be known as the University of Alabama in Birmingham (UAB) School of Optometry, officially began on September 1, 1969. The history of the legislation establishing this school is provided in detail in chapter 4.

Since the establishment of the UABSO several more schools or colleges began optometry programs in the 20th century. The State University of New York, State College of Optometry (1971), Ferris State University, Michigan College of Optometry (1975), the University of Missouri at St. Louis, College of Optometry (1980), the Northeastern State University, Oklahoma College of Optometry (1981) the Inter American University in Puerto Rico, College of Optometry (1981) and the Nova Southeastern College of Optometry (1989).

Several more educational institutions began optometric schools or colleges of optometry as this trend has continued into the 21st Century. These include the Western University of the Health Sciences, College of Optometry (2007), Midwestern University, Arizona College of Optometry (2008) and the University of the Incarnate Word, Rosenberg School of Optometry (2009). In addition, three more schools have begun optometry programs in this decade – one as part of the Massachusetts College of Pharmacy and Health Sciences (MCPHS), School of Optometry (2011) the University of Pikeville, Kentucky College of Optometry in the eastern part of Kentucky (2016), and the Midwestern University, Chicago College of Optometry (2017) in Downers Grove, IL. There are other programs in the planning or accrediting process.

PUBLIC IMAGE AND PROFESSIONALISM

Public Image and Perception of the Profession of Optometry

Public Image

In 1932, a committee headed by the Chairman of the United States Department of the Interior, was appointed to survey the cost of medical care. Unfortunately, there was not one optometrist appointed to this committee. The author of the study was critical of optometric education but acknowledged the profession's efforts to raise its standards (2).

Of greater damage was the series of three articles published in 1937 in the then very popular magazine, *Reader's Digest* (2). In these articles, optometry was severely criticized by the author Roger William Riis, for the quality of the level of care, much of it provided by exempt optometrists, who were men with a trade school education practicing in stores. In this era optometry was partly business and partly professional. To the public, or anyone surveying the profession, what they were likely to find were practitioners who advertised to attract patients by using window displays, newspapers, shop windows, street cars or buses.

Claims were made that optometrists were not competent to perform vision examinations, sold glasses unnecessarily and perhaps, most insulting, were the eye physician's claims that optometrists could not diagnose eye disease. Riis claimed to have collected cases where the diagnosis of glaucoma, brain tumors, or other diseases had been missed by optometrists. He criticized the profession for lacking standards. He also emphasized the great need to raise the standards in optometric education and practice, if optometrists expected to enjoy the public's confidence. While Riis' article was unfair and lacked comprehension, it did garner the attention of the profession's leaders. Nevertheless, such negative publicity did affect the profession's public image for years to come (5). It also served to lower the morale of the members of the profession for several years thereafter. To make matters worse, the profession did not have an effective manner in which to address the situation.

Countering Claims Through Public Education

In 1935 the AOA developed its first official Code of Ethics and distributed copies both in brochure and an attractive format suitable for framing. In spite of the leader's efforts to promote some interest these efforts were met with general lethargy by the ranks of the profession. As a result of the negative publicity, by 1939, there existed in the AOA administrative structure a subdivision known as the Public Health Bureau. The goal of this Bureau was to provide a long-range program of public relations and public education to acquaint the public with the function and aims of optometry. In 1942, the AOA set-up a permanent and strongly supported plan known as the Professional Advancement Program. This

plan included a Department of Ethics and Economics. In 1944 a new Code of Ethics was adopted and supplemented in 1946 (6). This Code of Ethics is, to this day, periodically reviewed and approved by the AOA House of Delegates.

A comprehensive public relations program was also initiated in the 1970's by the AOA. However, in spite of its cost this program was not a great success and many members failed to pay their special assessment assessed by the AOA House of Delegates.

The public image of the profession has vexed the profession for years. This was a multifaceted problem due in part to the commercial aspects of the profession, criticism of specific services rendered, especially in the area of vision therapy, and lack of professional settings for those optometrists not affiliated with a commercial entity. In 1928, the Oklahoma Optometric Association developed a plan for membership education that would subsequently evolve into the Optometric Extension Program (OEP). This organization published monthly study papers that could be used by small groups of optometrists for discussion. OEP also encouraged the development of professionalism within the profession such that practices gradually evolved into models used by other health professions (2). The profession continues to produce public service announcements but national marketing programs have not proved to be effective.

Movement to Professionalism

The matter of not only being a profession but providing services in a professional setting has been of great importance to the profession. The specific issue of optometrists practicing in a professional environment and separating the image of independent practitioners from those associated with commercial establishments, was of great concern to those in organized optometry during the 1930's and forward. Contributing to this was, of course, the matter of optometry dispensing or "selling" a product as part of its professional services. The complexity of these issues made it difficult for the public to distinguish between the three "O's" of opticianry, optometry, and ophthalmology. Ultimately these issues were decided to some degree in the marketplace.

First, the lack of growth of opticianry as a licensed profession contributed to its stagnation. As the American Academy of Ophthalmology dropped its ban on ophthalmic dispensing within the ophthalmology practice in 1955, the slow decline of the Guild Optician ensued (7). Many opticians were gradually forced to become employees of independent optometric or ophthalmologic practitioners or commercial entities.

Second, optometry began to expand its scope of practice in the 1970's by eventually passing laws in all 50 states and territories to allow the use drugs for diagnostic and therapeutic purposes. This expansion of scope of practice permitted the optometrists to provide services they had heretofore been unable to provide. It also served to make medical eye care more

accessible to patients, especially those patients in rural areas. Additionally, made it more difficult for ophthalmologists to attack the competency of optometrists in the diagnosis and treatment of disease. The expansion of the scope of practice has, perhaps, accomplished more than any public relations effort in elevating the perception of the profession in the public's view.

Finally, in 1978 the Federal Trade Commission struck down the ban on organization memberships and advertising. Great efforts had been expended by the state optometric associations during the 1950s, 1960s and first half of the 1970s, to eliminate the commercial aspects of optometry. The case of *Gibson v. Berryhill* was one of three such cases that eventually established the right of all professionals to be members of an organization regardless of practice affiliation. This case involved the Alabama State Board of Optometry and the Alabama Optometric Association in its efforts to enforce regulations related to unprofessional conduct. It also served to remove the barriers of advertising that professional organizations opposed (8, 9).

Marketing has become commonplace in all health professions as a result of the FTC ruling and economic necessity. It has also had an impact on other professions such as the legal profession. In the contemporary health environment, marketing or advertising, is commonplace even for many professional practices including those in medicine/hospitals, dentistry, optometry, pharmacy, as well as other health care professions.

LEGAL RESPONSIBILITY

Standard of Care and Product Liability

It was also during the late 1930's and early 1940's optometry encountered issues that served to signify its uneasy transition from business to profession. Among these issues was the aforementioned negative national media coverage as evidenced by the series of articles in *Reader's Digest,* the involvement of the AOA in the development of a Code of Fair Competition for the Optical Trade and its attendant implications of being a trade instead of a profession. In addition, were the issues that optometrists were excluded from efforts to expand social security legislation (Wagner Bill) and the fact that optometrists served as non-commissioned officers in the military while other healthcare providers, including nurses, were commissioned as officers (2, 3).

In addition to this list of challenges, was the fact that optometrists were beginning to be held to the same standard of care as expected of other professionals. Specifically, optometrists could be held liable for failure to refer patients to medical or other practitioners (9-11). The first of these malpractice cases occurred in Alabama in 1939 (10). Although neither of the following cases involved the Alabama Optometric Association (ALOA), they involved optometrists

licensed to practice in Alabama and both originated in the same city and the same year. Clearly the issues of malpractice and product liability have been a part of the legal history of optometry across the nation for many years.

Malpractice/Standard of Care

In the sense that one of the following cases was the first reported case of optometric malpractice in the United States, it served as the beginning or foundation for the eventual establishment of optometrists being held to a medical standard of care. This standard evolved over several decades of trial law which continues to evolve as the optometrist's duties and responsibilities have increased.

Hampton v. Brackin's Jewelry and Optical Co., Inc.

In this case, a patient complained her eyes had been hurting her for some time and she was experiencing difficulty in performing her work. After seeing the defendant's advertisement in a local Birmingham newspaper, the plaintiff visited the optometrist in charge of the optical department at this establishment for an examination on May 17, 1935. The defendant, Brackin's Jewelry and Optical Co., Inc., a Florida Corporation, operated an optical department in Birmingham. She was examined by an Alabama licensed optometrist who was in charge of the department. In this department, eyes of patients (referred to as customers in the legal brief) could be examined and glasses prescribed and fitted.

In this particular instance, the optometrist examined the patient's eyes and prescribed lenses. The prescribed lenses, however, failed to relieve the condition (patient's symptoms). The patient, according to testimony introduced on her behalf, returned to the optometrist on several occasions and complained that the glasses caused her eyes to hurt. She was assured the glasses would remedy the ailment once she became use (adapted) to them.

On November 2, 1935 the patient (plaintiff) returned again to the optometrist and complained that she could not see out of one of her eyes. The optometrist again examined her eyes and found the sight in one of the eyes was "completely gone" and she was advised to consult with a physician. The physician with whom she consulted discovered she was suffering from glaucoma which had caused a detached retina in her right eye and, which was at that time, affecting her left eye. Subsequently the right eye was removed and the left eye treated in order to save it. She then brought suit against the Florida Corporation, Brackin's Jewelry and Optical Co., Inc., and the optometrist, Dr. P. H. Tyler, in Circuit Court of Jefferson County, Birmingham, Alabama. The date of the Circuit Court trial was not stated in the Supreme Court judgment. However, it seems likely that the suit was filed in either 1936 or perhaps 1937.

Circuit Court

Before this case was given to the jury, the case against the optometrist was dismissed and thereafter the trial court gave judgment to the defendant corporation. The plaintiff, Priscilla Hampton, appealed to the Supreme Court of Alabama.

Appeal to the Supreme Court of Alabama

This case was taken up by the Supreme Court on January 12, 1939. On appeal, the first question discussed by the Supreme Court was whether the relationship of master and servant existed between the corporation and optometrist. The court was of the opinion that when an optometrist undertakes to make an examination of the eyes with a view of determining whether glasses will be of aid to the patient, he must exercise professional or scientific skill, knowledge and judgment, and cannot be directed by an employer who has no such knowledge. This does not mean, however, the employer, whose business the optometrist is conducting, is not answerable for the negligence of the optometrist resulting in injury to a third person who has gone to the employer's place of business for an examination of her eyes and to be fitted with glasses.

It was true that it was the defendant's business, under the control of its optometrist, but the defendant undertook for a pecuniary reward to render competent and proper optometric services. For all practical purposes, the defendant was engaged in rendering optometric service to the public. The defendant cannot, therefore, escape liability because of the independent character of the agent's or the servant's business. The defendant was bound to see that those who sought examination of their eyes and fitting of glasses received proper attention and service. Any injury or damage to the defendant's customers, proximately caused by the want of skill or negligence of the optometrist, can make the defendant liable (10, 11).

After reviewing several definitions of optometry, the court concluded that the optometrist in this case was not required or even authorized to diagnose and treat diseases of the eye. The Optometry Act of Alabama prohibited any optometrist from administering drugs in any form, from practicing or claiming to practice, medicine or surgery in any sense, or from using any title or appellation intended or calculated to indicate the practice of medicine or surgery.

Clearly, in the opinion of the Supreme Court, the duty resting on the optometrist was to examine the plaintiff's eyes for the "purpose of ascertaining any departure from normal (having reference to vision), measuring its functional powers, and adapting mechanical means for the aid thereof". If, however, in the performance of those duties, it would be apparent to a skillful optometrist that there existed in the eye a disease or malformation, the Court inferred that it would be the optometrist's duty to advise his patient in order that the proper medical or surgical treatment might be had (provided). The evidence in this case, however, convinced the court that the disease of the plaintiff's eyes was not such a disease as should have been

detected by a skillful optometrist. The corporation's optometrist, therefore, was not negligent in failing to detect it. Since there was no breach of duty owed by the corporation to the plaintiff, the judgment for the defendant corporation was affirmed (8-10). A rehearing of this case was denied by the Supreme Court of Alabama on February 9, 1939.

Outcome of this Litigation

Classe referenced this case in the chapter in his book entitled "Optometry - A Legal History of Optometry" (7). However, he discussed it in greater detail in the chapter on "A Short History of Liability in Optometry" (12). In this latter source, he notes that the Supreme Court of Alabama established several important guidelines to be applied in future cases. These guidelines were: 1) expert testimony would be necessary in order to determine the standard of care expected of an optometrist; 2) under this standard an optometrist could be held responsible for the detection of disease; and 3) if disease were detected, an optometrist was required to refer the patient to the appropriate practitioner for treatment (9, 10).

All of these important guidelines emerged from a case in which the optometrist was dismissed by the Jefferson County Circuit Court before the case was sent to the jury and the Circuit Court ruled in favor of the defendant corporation. This decision was upheld on appeal by the Alabama Supreme Court. In affirming its decision in favor of the defendant doctor, the Alabama Supreme Court noted the state optometry practice act did not require or even authorize the diagnosis and treatment of eye disease by an optometrist. In addition, there was no evidence to establish that the glaucomatous condition of her eyes should have been detected by an optometrist in the performance of his professional duties.

What did emerge from this case, however, was that even though liability was not proven by the evidence, the case established that failure to adhere to the prevailing standard of care expected of optometrists under the circumstances would result in liability for damages legally caused by such conduct. This is the rule of law for professional liability that stands throughout the United States for negligence claims against optometrists.

Classe' has, perhaps more than any other optometrist, made the profession aware of its duty to render the best diagnosis possible, but above all, regardless of the diagnosis, there exists a duty to refer (9, 10). The leading cause of professional malpractice claims against optometrists is from misdiagnosis which inevitably leads to allegations of failure to refer (9, 10).

In order to establish that an optometrist is liable for malpractice, evidence must be introduced to show the optometrist did not perform to the standard of care expected of an optometrist under the circumstances. Proof for the standard of care is established through expert testimony, and traditionally only practitioners of the profession or "school" have been considered to be competent to offer this testimony. According to the traditional criteria only

optometrists would be allowed to testify as to the standard of care applicable to other optometrists. Over the years, however, the rules of evidence have become more liberal and physicians have been allowed to testify as to the standard of care to be applied to optometrists (10). This has left the optometrist to be in the unenviable position, in some situations, of having the ophthalmologist encouraging a patient to file suit and having an ophthalmologist testify as to the standard of care. Over the past 50 years or more, it has become evident that a medical standard of care would be applied to optometrists. As the scope of practice of optometry has increased there is no doubt that optometry is held to the same standard of care as medicine, or more specifically ophthalmology. Complete and accurate record keeping is the best defense against this type of litigation.

Product Liability

Since optometrists also are involved in fabricating, dispensing or "selling" a product they are also at risk for product liability. By coincidence the first reported case of product liability involving an optometrist also occurred in Birmingham, Alabama in 1939.

Gilbert v. Louis Pizitz Dry Goods Co.

On July 2, 1936 Kathryn Gilbert, visited Pizitz Department Store in Birmingham, Alabama. This department store also had an optical department and the plaintiff was examined by an optometrist, who prescribed and fitted her with glasses. Approximately two months later, on September 17, 1936, while wearing the glasses, she tripped down the steps of her house and severely injured herself. The patient then sued the department store for damages alleging that the glasses had been negligently fitted nor were they suitable for the purpose for which they had been sold (13).

Circuit court

The trial court dismissed her claim. She appealed to the Alabama Supreme Court for damages. This action was then brought against the Louis Pizitz Dry Goods Company.

Alabama Supreme Court

In discussing the basis for the woman's claim, the court observed that whenever a buyer makes known to a seller of goods, either expressly or by implication, the particular purpose for which the goods are required, and relies on the seller's skill and judgment as to their selection and suitability, there arises an implied warranty that the goods are reasonable fit for the purpose for which they are sold. The court held that this implied warranty of fitness, could be applied to the glasses sold by the optometrist and to the optometrist employer. The decision of the trial

court was reversed and the case was remanded to the Circuit Court for further legal disposition (12-14).

Outcome of this Litigation

This action by the Supreme Court of Alabama set a precedence based on implied warranty of fitness. As a result, not only could the manufacturer of a frame or spectacle lens be held responsible but so could the designer, fabricating optical laboratory, or seller (optician, optometrist, or ophthalmologist). Over the past several decades another cause of action based on the product liability law has established that any of the above entities may be held strictly liable for injuries cause by a defect in the product.

The preponderance of professional liability claims against optometrists has involved ophthalmic materials. In the past, the majority of these claims were due to injuries from spectacle lenses and frames, but now the largest cause of litigation is contact lenses. The increase use of hard resin ophthalmic lenses has decreased claims resulting from glass lenses. As regards the optometrist, the greatest risk is from fitting or dispensing an unsafe ophthalmic lens. Product liability theory has not been extended to the fitting and dispensing of hard or soft contact lenses since the optometrist is not involved in extrinsic factors such as their design, manufacture, or sale. However, the optometrist may be liable for negligence based on the professional judgment required and information provided in the fitting or proper care of contact lenses.

SUMMARY

Optometric Education

The challenges the profession faced during the 1920's through the 1950's were remarkable. Perhaps first and foremost were the changes necessary to develop a credible educational program in terms of prerequisite courses, criteria for admittance, curricular content, program length, degree granted, and an accreditation process that would ensure a high quality optometric education. This resulted in moving from correspondence or short term courses to a four-year professional degree program curriculum in a period of 40 years. Considering the complexities involved and the differences in philosophies between university and private institutions the change is even all the more astounding. Of course, the changes in scope of practice have further changed optometric curricula over the course of the last 40 or more years. A list of the optometry schools that existed at one time or the other in the United States is quite revealing. Goss has reviewed this history and estimates that 60 schools existed from 1870 to 1901, 42 between 1901 and 1914, 36 from 1914 to 1922, 30 from 1922 to 1926, 10 between 1926 and 1936 and eight from 1936 to 1946 (15).

Public Perception

The public image of optometry has likewise changed significantly. Optometrists are a respected member of the health care professions. Part of this change has occurred because of the increase in the scope of practice delivered and part is due to changes in the marketplace. The public is used to seeing advertisements in all forms of media for almost every health care specialty as well as other professions. Their view of such marketing is much different than a professions view of such marketing. Optometry is not perceived as being the only health care specialty with a product or special service. Many physicians now have products of some nature they sell directly to patients. In fact, some of the billboard or television advertisements for other groups are much more blatant than those utilized by optometrists.

Legal Aspects

There are many facets to legal cases that deserve consideration. Of course, when viewed from the perspective of 2018, the clinical knowledge and education of the optometrist is much different and certainly greater than in 1935. Nevertheless, the courts have recognized that in terms of malpractice, historically optometrists were in a difficult dilemma in that they were prohibited from using drugs to facilitate diagnosis. In the specific instance of Alabama, the Alabama Optometry Practice Act did not require that disease be diagnosed. In the particular case of Hampton vs. Brackin Optical Co., the details of the examination findings are not contained in the summary. There is an overlap of visual or ocular symptoms that may be related to functional conditions or ocular or systemic disease. The complaint of ocular discomfort, or the eyes hurting, could be related specifically to such conditions or diseases as uncorrected or under corrected refractive error, binocular vision in-coordination, dry eye, anterior segment disease and beyond. Most cases of glaucoma are open angle in nature and do not cause discomfort or pain. Likewise, retinal detachment does not result in a complaint of pain. Patients with angle closure glaucoma may experience pain and ultimately vision loss from optic nerve damage.

However, during the next 40 years as case law became more clearly established and the responsibility of the optometrist increased, there was a confluence of circumstances which occurred that would redefine the profession of optometry. Among these was the increasing quality of optometry school applicants, the length of the undergraduate education of applicants to optometry schools or colleges, the increasing length of the optometric educational curriculum, a desire by young graduates to assume more responsibility commensurate with their education, the availability and adoption of instruments such as the bio-microscope, monocular and binocular indirect ophthalmoscope, sophisticated ocular imaging and, of course, the threat of legal action if proper care was not delivered and documented. All of these factors,

and more, influenced the profession to take the steps necessary to provide a broad scope of practice.

The important aspects of the malpractice case, however, were not related to the specific findings of the case. However, for the first time the court found optometrists could be held liable for failure to refer patients to medical practitioners when the history and examination findings so dictated. Even though in this particular case the court found in favor of the defendant, the opinion implied that optometrists had a duty to refer patients in whom they suspected or detected diseases of the eye (9-12). This was a prelude to increasing legal responsibilities to come and it occurred in Alabama. These duties would be more clearly defined as more cases came to trial. This in turn, led to a greater desire on the part of the profession, to be authorized to use drugs for diagnostic purposes. The lack of drugs utilized for diagnostic purposes placed the optometrist at a distinct clinical disadvantage.

Proper chart documentation remains a problem even today. In the midst of a busy schedule it is easy to overlook documentation by the technician or optometrist. This problem is not unique to optometry. However, timely referral for diseases or conditions beyond the scope of practice or comfort of the optometrist, are a well understood aspect of contemporary optometry. As it became increasingly clear that optometrists were being held to the same standard of practice as ophthalmologists, or other physicians engaged in such practice, it stimulated the profession to act accordingly.

Product liability has become less of an issue as improvements in technology have resulted in safer ophthalmic lens materials. However, it is still possible that the optometrist may be named in a claim in which injury was sustained as result of the frame or spectacle lens. Negligence in care is more likely to become an issue in the proper fitting of contact lenses.

SUMMARY

The time period from the 1920's through the 1960's was a time of continual growth of the profession. Optometry emerged from being a business, to becoming a profession, and then a health profession. All of these changes occurred before the expansion of scope of practice. Unique to Alabama were the two law suits involving optometrists related to standard of care and the legal responsibility of the optometrist and product liability. These topics are of increasing importance as the optometrist, assisted by advances in medical technology, assumes greater responsibility for patient care.

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