
EDITORIAL

THE PATRICIA LANCE LECTURE

In 1987 the Council of the Orthoptic Association initiated an annual lecture to be given at the opening of our Scientific Meetings to honour Patricia Mary Lance on her retirement from her position as Head of the School of Orthoptics at Cumberland College of Health Sciences.

Miss Lance completed her training in 1941 in the second training course in Australia. She was a founding member of the OAA and has held the office of President for a record six terms, in addition to her continuous contributions in other capacities and her presentations at Scientific Conferences. She was made an honorary member of the OAA in 1965, and this was converted to that of Fellow when this award was introduced in 1973. She assisted in the formation of the International Orthoptic Association and became Australia's first representative on its Council of Management. Following a long involvement in orthoptic education she was appointed in 1973 as the first Head of School of Orthoptics at the New South Wales College of Paramedical Studies (shortly to be renamed Cumberland College of Health Sciences). She was honoured in 1979 with an MBE for her services to orthoptics.

I was given the honour of giving the inaugural address in Sydney in 1988, which is included in this edition as an Editorial. Alison Pitt's lecture, given at the 1989 meeting in Brisbane, is also printed in this issue. It is hoped to publish future lectures in subsequent editions of this journal.

Occasionally Pat has described me as one of the few Orthoptists in NSW who was not one of 'her' students. I really think that this is no longer the case. Whereas most of the others were her students for only two or three years, I have had the opportunity to be with her and learn from her for eleven years.

Pat's career in Orthoptics has spanned many developments, and, whilst it has been popular at recent conferences to look to the future, with themes such as 'Orthoptic Horizons', I feel that a great deal can also be learned by looking at our past. What were our origins, why were we needed, what niche did we fill?

Clearly, we were specialists in binocular vision, or, more particularly, in the use of exercises to treat amblyopia and squint. Orthoptists were needed not only because of the many hours needed for treatments in those days, but also because of the complexities of the sciences of binocular vision and ocular motility. To be frank, many ophthalmologists were only too happy to direct responsibilities for the management of these cases to the orthoptist.

However, times have changed, ophthalmologists are now well educated in these areas. This has helped us by providing a more equal base of respect and understanding, as is evidenced by our conjoint scientific meetings. But I feel that this understanding has not always extended to the potential for orthoptic treatment in the management of many patients, and alternatives to surgical treatment are not always considered seriously. This means that the skills of the orthoptist working, as is often the case, in an ophthalmic setting, may be confined to routine measurement.

Certainly this situation has evolved to fit the common pattern, but the question remains, who will give the eye exercises?

We now have a well educated public, educated not only through formal schooling but also through the often more effective media. The status of the medical profession is not as hallowed as it was a generation ago, and patients are more likely to question the doctor and look for alternative methods of treatment, particularly if the treatment involves surgery on their child's eyes. There is also a concomitant and not unrelated rise in the popularity of 'alternative medicine' as orthodox management does not always give the patient what he wants, be it a cure or just a sympathetic ear. Who will provide the alternative to squint surgery, or treatment for symptoms arising from accommodative problems or decompensating heterophoria if the orthoptist doesn't? Others, without the orthoptists education, will, and are doing so already.

But will we still have the skills to provide this treatment, other than a few simple convergence

exercises? We may look to other areas of ophthalmology to provide directions for our future, yet the developments of technology mean that the skills of refraction and visual field assessment may become redundant in the future. What technology is there that will replace the skills of teaching a person with an intermittent exotropia to control his deviation, or the newer areas of therapy such as rehabilitation of the low vision patient? The role of eye movement training has now extended beyond that directly related to squint or heterophoria into the management of visual field problems, eccentric viewing training and null point training.

Before I am branded a complete reactionary, let me make two things quite clear:

- I am in complete agreement with the development of orthoptics into areas of general ophthalmology. This has meant that the graduating orthoptist has a wider knowledge of the eye, its anatomy, physiology, optics and pathology, and of the whole body that the eyes serve. It has meant that orthoptists can choose to specialise in other areas of vision and research if they wish, and there are several examples of such people in our profession. Indeed, a broader education may be one of the answers to the issues I am addressing.

- Secondly, I am not advocating a blinkered return to orthoptics of the past. Certain treatments have been found to be ineffectual, unnecessary and a waste of time and money. There is no doubt that surgery is the only form of effective treatment in many cases of squint. Modern research into the neurology of binocular vision has shown us why it is pointless to attempt to restore binocular single vision in squints where it has never developed. Indeed, I am anxious that we don't fall into the methods of others that we criticise, and dress up unfounded, even quack remedies, in the guise of professionalism. The time has passed when we could give treatment and demand payment (or expect the taxpayer to support us in a publicly funded institution) just because we think that it works. The public has a right to demand evidence of the efficacy of our skills, a concept now known as accountability.

For this reason, we must direct more of our time to systematically evaluating our treatments. Other professions do it, it is one of the hallmarks of professionalism. For 15 years orthoptic

students have been studying statistics and research methods as part of their college based education, but why is it that, when final year students are carrying out research projects, I see a reflex dilation of the pupils, a blanching of the skin when I suggest that a statistical analysis of their results may be appropriate? Most submit, resigned because we hold the power of marking the assignment, but I get the distinct impression that many, freed at last from college control, would not consider using simple research methods and statistical applications to their clinical findings. Why is this so, why is it that so much of the research in orthoptics is found outside our profession?

It is hoped that the new degree courses in orthoptics may help some of these issues, but I also feel that a major problem is a lack of a strong professional identity, that is, a lack of identity in what we do, rather than what we are. Are we specialists in our own area, or are we technicians. We started as a profession with admittedly a very narrow focus, but have we blurred the focus by broadening our role?

I started by looking back, and I will close in the same way. My first day as an orthoptic student involved turning up at 127 Collins Street in Melbourne in the early 60s. Those of you privileged to have also been to this address, now unfortunately engulfed in a modern hotel, will know that Beverly Balfour ran her practice there from her delightful flat on the top floor.

The main consulting room was a wonderful mix of orthoptic equipment, Persian rugs and all kinds of bric a brac, including a magic monkey that children looked at if they wanted to see a few extra letters on the vision chart. But the best feature was a large table piled high with old Christmas cards, nail polish, cellophane, scissors, coloured pins and many other bits and pieces. Each patient had a carefully designed exercise made to suit his or her particular needs, to inhibit or stimulate convergence, to discourage suppression or overcome amblyopia. This was my first impression of orthoptics, and I feel that it still represents the core of our identity. Although the methods we use may change with changing knowledge and technology, the skills of orthoptic treatment will always be needed. We can do it, we can do it well, and if we don't, others will.

Elaine Cornell