

it is advisable to have the accommodation acting slightly—that is to say, see that the spherical portion of your correction is not quite full.

I would say that the most valuable of these tests are the Jackson cross cylinder, the presbyopic, and the double cylinder method, in that order. The Jackson can be used to check both the power and axes of the correcting cylinder, no matter what method you use in determining these factors. The presbyopic test can be used in all cases of presbyopia and suspected presbyopia, with the great advantage that you will never again ask a maiden lady of dubious age how many summers have passed since she arrived on this planet. Furthermore, you can test each eye separately for its presbyopia addition, where a difference of addition is suspected or both together,

as is usual. This test can also be used to check the spherical factor in those cases among young people where you rather suspect you have not quite squeezed out the full Hypermetropic element by the fogging method.

The double cylinder method quickly gives very accurate information of the power of the cylinder, which, of course, can then be fined off exactly with the Jackson.

Some, or all of these methods, can be used in every case, and the results obtained will help you to feel confident of your work. In testing children, mutes, illiterates, bad observers, and foreigners, the static cross cylinder methods are invaluable, as you can use any letter or figure as a test object, while the chart for the presbyopic test is so simple that any client can readily understand it.

Oculist or Physician?

To whom should you refer your Patient?

By

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I am invited by my friends to move: "That this conference advise optometrists to recommend clients needing medical attention to general medical practitioners in preference to sending them to oculists. In advising your clients you naturally desire they should receive the best attention but have you ever thought of the very small proportion of cases that are really local or ocular pathology as distinct from systemic. Possibly not less than 75 per cent. of the cases optometrists are accustomed to refer to the oculist for "specialist" attention, require only ordinary skilled medical attention, such as is within the scope of the average family doctor. How many different kinds of eye cases can you think that need the attention of the oculist. I can think of very few. As a matter of fact, the real need of the expert services of the oculist seem limited to remarkably few cases, such as glaucoma, keratitis, serious injuries, and the operative treatment of cataract and certain cases of squint.

This has been forcibly impressed since studying one of the latest Oxford Medical Publications, entitled "Clinical Ophthalmology for General Practitioners," by Dr. Maitland Ramsay, Lecturer on Ophthalmology at Glasgow University and Ophthalmic Surgeon at Glasgow Royal Infirmary. The keynote of this book by an eminent oculist is to emphasise that many of the so-called serious eye diseases are best treated by the general practitioner. For example, on page 170, referring to Diabetic Iritis—which to the optometrist is simply Iritis—he says: "Prudent restrictions in the kind of food that the patient is allowed to take are essential; but that is a matter more for the

consideration of the general practitioner than for the eye specialist." Again, on page 108, referring to Phlyctenular Conjunctivitis: "It is necessary always to bear in mind that the very essence of the disease lies in the malassimilation of food, and that most, if not all, cases arise as a result of improper feeding." On page 389, referring to optic neuritis, we are informed: "That it ought never be regarded as a disease, per se; it is always a sign of serious disease in some other part of the body."

On page 397, "Arterio Sclerosis may show itself very early in the retinal blood vessels and give rise to haemorrhage long before there is any manifest renal inadequacy. It is prudent, however, to regard those cases as prealbuminuric; because, by regulating the patient's diet, and wisely supervising his whole manner of living, much may be done to prolong life as well as to preserve vision. Haemorrhages detected in the fundus oculi may, of course, be local in origin; but their presence ought always to suggest the propriety of carefully examining the heart, kidneys, and blood pressure; of treating any pronounced diathesis—such as gouty or rheumatic—and of rectifying constipation, etc." Surely these quotations when supplemented by the first paragraph of the preface: "The author spent ten years in general practice before he specialised in eye diseases, and that experience has greatly influenced his outlook on ophthalmology," support the contention that many eye conditions commonly referred to oculists are within the scope and skill of the general practitioner. The aim of the book is to indicate as far as possible those cases, which the general practitioner can treat on his

own responsibility. The principal causes of ocular diseases are gout, rheumatism, syphilis, tubercular and toxia.

Most scotomas and paraesis are due to general health conditions within the knowledge and domain of the family doctor. Even in cataract cases, where the skill of the oculist does not appear to have discovered any certain cure, the general practitioner may, by improving general health and giving special attention to systemic disorders such as gout, rheumatism, diabetes, indigestion, toxia, retain useful vision for a longer period than if no attention had been given to these.

Having demonstrated the ability of the general practitioner to successfully treat the pathology of most eye cases, let us next consider the professional policy of optometrists referring patients to their family doctor rather than the oculist, when medical attention is necessary. First, the family physician in his general practice, has to recommend many patients for optometrical attention and the reciprocal medical-optical exchange is one of the happiest professional relationships that may be evolved. Each can render valuable professional service to the other, the optometrist in detecting eye-strain conditions that are the cause of puzzling and obscure nerve and other disorders, in cases referred to him by the physician, and similarly the physician diagnosing defective health conditions as the cause of obscure visual conditions in the patients of the optometrists. The optometrist referring pathologic cases to the oculist, is simply referring his patients to a rival, as after attending the case medically, the oculist will further proceed to prescribe the optical needs so that the optometrist is dethroned from his professional status as the true visual specialist, and becomes simply the dispenser where he should be prescriber.

In your relationship with the general practitioner your position as visual special-

ist is retained and the case after medical attention is referred back for you to prescribe for the visual needs. When you refer a patient to the oculist you also do the family physician an injustice, as most ocular pathology is really systemic pathology, and, therefore, you are diverting the patient of the family physician from his legitimate, and often, best qualified medical advisor. He is induced to spend guineas on specialist's fees when the ordinary professional fees of his regular advisor would be productive of more beneficial results, as the family physician, from prior attendance is already aware of the family and personal health history and idiosyncrasies of the patient. These are often of supreme importance in diagnosis and treatment.

Had optometrists made a regular practice of recommending patients to their family physicians instead of oculists, when medical attention is necessary, we should have gained the support of the majority of the general practitioners representing at least 90 per cent. of the profession, and this support would have been of inestimable assistance in gaining legal recognition. As it is the pernicious effect of diverting patients from our "truly logical" friends, the general practitioner, to our candidly-expressed rivals, the oculists, has tended to alienate the one without gaining the support of the other.

Even in many of the more serious eye affections, in which the skill of a specialist is indicated, it would probably be wiser for us to first refer the patient to his medical advisor as a matter of courtesy, instead of ourselves sending the patient direct to the oculist. Who is to determine the family physician is not himself competent to treat the case successfully—most of the older school of eminent specialists commenced practice as family physicians. And surely it is the right of every family physician to have the opportunity of attending his patients when they require medical attention.

Fusion Sense and Binocular Vision.

At a meeting of the Medical Science Club of South Australia, held at the University of Adelaide on August 5, 1921. Dr. R. H. Pulleine drew attention to some phenomena dependent upon binocular vision which were not usually apprehended. A large part of the total field of vision was actually monocular and the proportion of monocular vision was increased when the eyes were prominent and decreased when they were deeply sunken. The diplopia in planes other than the plane of convergence was eliminated by the "fusion sense," which also eliminated imperfections of binocular vision due to the admixture of monocular field, slight inaccuracies of convergence and so forth. The fusion sense was readily disturbed by interference with the normal correspondence of vision in the two eyes, as by causing one eye to view the field through red and the other through blue glass. Advantage was taken of this in the near vision

phorometer. By its means slight defects of convergence were readily demonstrable, which would be imperceptible in the fusion sense were active.

Dr. W. Ray drew attention to the utilisation of the fusion sense in the stereoscopic X-ray screen, an arrangement by which the rays from two X-ray tubes placed in the relative positions of the eyes were alternately thrown upon a fluorescent screen at the rate of 200 alternations per second. The fusion sense of the observer created a stereoscopic picture of the shadows thrown upon the screen.

Professor J. B. Cleland and others drew attention to the fact that if in the use of a microscope the unaccustomed eye was employed, illumination appeared to be much enhanced, but definition was correspondingly poor.

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