SIU G. WONG, OD, MPH: A PIONEERING CAREER IN PUBLIC HEALTH OPTOMETRY

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ABSTRACT
This memoir, written by Dr. Siu G. Wong, chronicles her early influences and education, and profiles her first career as a public health optometrist and her second career as a community activist and public historian. Dr. Wong graduated from the University of California, Berkeley with her doctorate in optometry in 1970 and received her master’s in public health in 1973. Her first position as an educator at the University of Houston (UH) included pioneering an interdisciplinary community health program in a low-income neighborhood as well as coordinating the first externship program for UH optometry students with the United States Public Health Service-Indian Health Service (USPHS-IHS). Dr. Wong joined the USPHS in 1978 where she was the first female commissioned officer assigned to the Indian Health Service (IHS), the first chief optometrist of an administrative region, and eventually the first woman to hold the position of chief optometric consultant to the IHS. During her tenure, she spearheaded quality assurance programs and was active in both the American Optometric Association (AOA) and the American Public Health Association (APHA), serving in leadership roles in the AOA’s Council on Clinical Optometric Care, Hospital Privileges Committee, the QA Committee, and the Multidisciplinary Practice Section. She also became a member of the APHA’s Vision Care Section and the Armed Forces Optometric Society. After retirement, Dr. Wong continued her role in public service, serving as the Clinical Director for the Special Olympics Opening Eyes program and as a clinical consultant. She became active also in public history, joining the Chinese American Citizens Alliance where she works to raise awareness of the contributions of Chinese Americans to American history. This article was annotated by Kirsten Hebert.

KEYWORDS
Siu G. Wong; United States Public Health Service; Indian Health Service; public health; optometry history; University of California Berkeley; University of Houston; Albuquerque, New Mexico; Quality Assurance; Asian-American history; Chinese-American history; American Optometric Association

A Tradition of Service
When President John F. Kennedy, said: “Ask not what your country can do for you—ask what you can do for your country,” this statement resonated with me. In the 1960s, altruism propelled many individuals to enter the health professions. Truthfully, this was an easy way to meet one’s moral obligation to help others, to give back to the community, and to make a difference in people’s lives. Since childhood, I planned to help others and a career in health care or social work was always an option. My maternal grand-uncle was a physician, my maternal grandfather was a lay-minister, and my parents supported me and were pragmatic in encouraging me to pursue a career that could support me.

My father was bilingual and well-educated and the role as patriarch of our extended family fell on his shoulders. He took this role seriously with the goal of helping his family and community. He was active in the Sacramento, CA Chinese-American community as president of the Wong Family Benevolent Association during the late 1960s, and was the chair of the campaign to build the Wong Center, a low-income housing complex. While not preached, it was demonstrated that our life would be happier and more fulfilling if we gave back to our community.

My parents were born in China in the early twentieth century. My father came to the United States in 1914 to attend school. In the 1928, he received a bachelor of science degree in ceramic engineering from The Ohio State University and a master of science degree from Penn State University in 1930. Though unusual for the time, my mother, who came from a wealthy, educated family, also received an education and was an elementary school teacher prior to her marriage. My parents lived in Shanghai under Japanese occupation (1937-1941) before and during the Second World War (1941-1945). As American citizens, my family resided in the American concession—one of several areas within the city reserved for foreign nationals. My father worked for General Electric Company, and my mother was in charge of the household. At the end of World War II in 1945, they were repatriated to United States on a troop ship and settled in California.1 (See Figure 1, page 54)

My three brothers and two sisters were born in Shanghai. With my birth in San Francisco, CA, our family of six children was complete. My parents planned to return to China and help rebuild the country after the devastation of the war, but eventually decided to remain in the United States, settling in Sacramento, CA. Unfortunately, we were “dirt” poor because we had lost everything, but the Chinese culture values education, and so it was instilled in all the children that college was the only way to change our lives. In our high school, there was one track for college-bound students, and other tracks for those who were not. All six of us children went to college—a target that was unquestioned and understood, but rather unique for the 1950s and 1960s.
I began pursuing my undergraduate degree at University of California at Berkeley in 1964, a radical time of the Free Speech Movement. In my sophomore year, I went to the counseling center and decided to become a social worker, but by in my sophomore year I had changed my major to optometry since there was a school on campus and was told this would be a great profession for a woman. A bonus was that I could be licensed to practice independently, and not be reliant on referrals or orders from another professional.

I received a bachelor of science in physiological optics in 1968 and my doctorate of optometry in 1970. My class at Berkeley was the first to receive the doctor of optometry (O.D.) degree—previous graduates received a master of science degree. My class had fewer than 50 students, which included eight women. Attrition was about 15%, which would make women approximately 20% of the class, a rather high percentage in the 1960s. All the women graduated, and all went into practice.

I do not recall being treated differently than my male colleagues. We had a dress code which required women to wear dresses and men to wear a tie when examining patients and attending classes. We also had a project for our doctor of optometry degree, and since it was the 1960s, my project was on L.S.D. (lysergic acid diethylamide) on eye movements. After graduation, I took six months off and traveled through Europe, and when I returned I was not able to find a job but did not want to start my own practice. As they say “When you can’t find a job, return to school”!

Community and Public Health: Providing Quality Care for the Under-Served

This turned out to be the best decision of my life. I decided to study for a master’s in public health degree (M.P.H.) The M.P.H. was a great degree—while optometry was too focused, the M.P.H. allowed me to expand my understanding of health care and how it is affected by multiple social determinants: environment, education, culture, crime, housing, politics, etc.

I graduated in 1973, when doctors of optometry with a M.P.H. were still unique. This opened doors for me and being a woman with these two degrees was unusual—there were perhaps only a handful in the nation. I thought I would enter academia and was offered three teaching positions. I accepted the offer from the University of Houston (UH) College of Optometry and started as an assistant professor in charge of public health and the external community clinical programs. At UH, one of my teaching goals was to provide quality clinical rotations which had a racially diverse patient population, multiple clinical conditions and numerous patients. I was able to do this by developing the first United States Public Health Service-Indian Health Service (USPHS-IHS) externship for the college.

Because of my public health background, another one of my goals was to institute an interdisciplinary health care class. It was important to have optometry students interact with students studying other health care professions, since the traditional teaching model, including optometry, was to educate students in these programs in isolation from one another. I was awarded a grant from the Department of Health, Education and Welfare to have optometry, nursing and pharmacy students in a joint class where they collaborated to design a community project in the Houston Heights neighborhood.

After five years at UH, I decided to join the USPHS-IHS. Fortunately, I had had the foresight to invite Lester Caplan, O.D., the first optometric consultant to the IHS, to speak to my public health class—little did I know that I would need his service as he was the recruiter for the IHS! I was hired and assigned to the Albuquerque Area Office in 1978, which is the administrative office for New Mexico, Colorado and part of Utah and Texas. This clinical region is also identified as the Albuquerque Area (AA). I was the first USPHS female commissioned officer to be assigned to the IHS and the first to become chief optometrist of an administrative region. In the 1990s, I became the first woman to hold the position of chief optometric consultant to the IHS, which is equivalent to the chief optometrist of IHS.

The optometry program was in its infancy when I was recruited. My responsibilities were broad with emphasis on program and policy development with some clinical care. Throughout my IHS career, I was fortunate to have supervisors who trusted me to do my job with minimal oversight. Early on my guiding principles for the IHS optometry program were to develop programs that were good for patients (delivered quality eye and vision care) and good for optometry (position optometrists as primary care providers who delivered care commensurate with their training and clinical

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privileges). Using these guiding principles, it was my job to build a robust, comprehensive eye and vision program that eventually became the foundation of the IHS optometry program.

From the start, I knew patients did not know what quality optometric care was. Patients expected good care, but how would they know they were receiving it? When I started in the Albuquerque Area, there were 20 frames available: five for men, five for women, five for girls, and five for boys. While it may be difficult for patients to know if the doctor is providing good care, patients know if they like their glasses. Therefore, a quick and easy improvement which patients could immediately appreciate was increasing the selection to almost 100 different styles.8

One of the first programs I initiated in the early 1980s was the IHS Optometry Quality Assurance (QA) program, which may have been the first system-wide governmental QA optometry program in the nation. At that time, quality assurance programs were neither common nor popular. Who wants someone looking over your shoulder and telling you what to do? Nevertheless, QA was my strategic tool to improve the delivery of optometric care. If optometric care was compromised, QA provided the leverage needed to correct the deficiencies. There was power in using the term “quality assurance.”9

For example, one of the optometry clinics was in a tin shack located on mound of dirt. When the winds blew, which was constant, dirt and sand collected on the instruments, the chair, the clinical equipment and throughout the office. In another clinic, the grey, metal government chair was used instead of a proper ophthalmic exam chair. If a child was the patient, telephone books were used as a booster seat to allow the child to see through the phoropter. These deficiencies underscored the challenges facing the optometry program, and the neglect the program had faced over the years from lack of funding.10

The QA program was primarily conducted through survey and audit—first generation QA. The IHS hospitals were surveyed by the Joint Commission on Accreditation of Hospital (JCAHO), but optometry’s non-binding accrediting body was American Optometric Association (AOA) Council on Clinical Optometric Care (CCOC, now defunct), as JCAHO did not survey optometry clinics. I requested CCOC survey the Albuquerque Area optometry clinics with the objective of having structural and clinical deficiencies identified and eventually corrected.

Another arm of the QA program was the audit of doctors’ records. At an American Public Health Association (APHA) meeting, I attended a birth control audit form and then adapted a birth control audit form to create an optometric audit form. The Albuquerque Area optometrists determined by consensus the test procedures and clinical guidelines deemed to assure a quality exam. Audits were a critical element of the QA program, and it was clear that it changed the behavior of the doctors—one doctor of optometry even posted the audit form above the desk so it was easy to view!

The IHS was a primary care health delivery system and so doctors of optometry were primary care providers. We provided school screenings, exams and treatment either with glasses, monitoring or drugs or a combination. All the optometrists, employed or contracted, were credentialed to use therapeutic pharmaceutical agents (TPAs) and their privileges were

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**Fig 1. Act of December 17, 1943, Public Law 78-199, 57 STAT 600, to repeal the Chinese Exclusion Acts, and for other purposes.**

As American citizens the Wongs were allowed to repatriate after the war, but other Chinese people fleeing the devastation of war were not welcomed into the U.S. Even after the 1943 repeal of the Chinese Exclusion Act of 1882, new immigration of ethnic Chinese people was restricted to 105 persons per year regardless of country of origin.1
determined by QA audit findings and training. The IHS primary care model was ideal for optometry to flourish. There were very few ophthalmologists in the IHS, and patients were referred to the private sector if needed. Consequently, optometrists were credentialed to examine and treat the majority of patients, assuring doctors of optometry were providing primary eye care.

The practice of optometry in the IHS also helped optometry in the private sector. In the 1980s in Colorado, the IHS contracted with a private optometrist to provide care in a small, remote clinic at the same time that Colorado optometrists were seeking to expand their scope of practice by gaining privileges to use TPAs. Our contractor was able to testify before the Colorado legislature that he was credentialed to use drugs in the IHS clinic, but in his own private practice a few miles away, he was denied this treatment modality. Was he a different doctor? No—and this was clearly understood by the Colorado state legislators.11

The IHS was the first to require doctors of optometry to have hospital clinical privileges. While the JCAHO does not credential and grant clinical privileges for optometrists, the IHS developed a credentialing program grounded in JCAHO principles but tailored for optometry. I also introduced this program to the AOA, and one of the first AOA hospital privileges handbooks included IHS credentialing requirements.12 (Figure 4)

In 1973, I joined the American Public Health Association (APHA), a great career development organization for me. The APHA annual meetings were attended by thousands of APHA members with over 100 competing, concurrent, diverse sessions. The APHA was also one of the first organizations that welcomed optometrists with open arms in the mid-twentieth century. In the 1970s, the AOA decided to become more involved in public health and encouraged more doctors of optometry to join the APHA. To ensure a seat at the table, the AOA strategy was to establish an independent section within the APHA. I was one of two optometrists involved in defending and debating the approval of the Vision Care Section on the floor of the APHA. The APHA and the AOA were my primary professional organizations, and I served on a number committees that were not optometry-centric. Being the first optometrist on these committees helped broaden my interest and knowledge in health care.2,13

Concurrently, I was also member the New Mexico Optometric Association and the Armed Forces Optometric Society and I was active in the AOA volunteer structure. I served as an officer and member of committees that aligned with my professional work in the IHS, including the Multidisciplinary Practice Section, the Quality Assurance Committee, the Hospital Privileges Committee and the Council on Clinical Optometric Care. This work allowed me to share the IHS model of optometry, which treats optometrists as primary care providers, with the AOA. For example, IHS optometrists work at the intersection of interdisciplinary care and clinical privileges in the treatment and monitoring of diabetic patients. The high numbers of diabetic patients in this population require many follow-up visits from numerous providers, including optometrists who are necessary to provide education and monitoring of eye and vision changes due to diabetes. It was the Special Diabetes Program for Indians (SDPI) that proved the value of optometrists as primary care providers, and we became indispensable members of the healthcare team.14 (Figure 5)

From Public Health to Public History

My career as an optometrist and Public Health Service officer prepared me for my next career as a community activist. I didn't think this would be my second focus (no pun intended) in life, but after a number of volunteer efforts, I was drawn to the intersection between historic preservation and social justice. In fact, my life after optometry has been quite exhilarating with unexpected challenges which, at times, seemed daunting and made me aware of how unprepared I was for my next career.

Upon retirement, I volunteered for a number of organizations, some based on personal or professional interests, and others based on my activism. I continued to practice optometry in a limited way. For example, I was the New Mexico Clinical Director for Special Olympics Opening Eyes program for ten years and continued to provide QA consulting and auditing service for Davis Vision. I also became a docent for the city-owned Albuquerque Art and History Museum.

While busy with my optometry career and living in New Mexico, a state with a diverse ethnic population, it was easy not to see the racism that continued to exist in United States. However, upon retirement in 2006, I was inspired by book written by Helen Zia, *Asian American Dreams: The Emergence of an American People* (New York: 2000). This book transformed the second chapter of my life. Zia wrote about racism against Asians in the twentieth century, which continues today. Consequently, my interests gravitated to researching and educating the public about Chinese Americans in New Mexico and the nation. This community activism also reflects my heritage and family social consciousness instilled in me by my parents.
My activist platform is the Chinese American Citizens Alliance (C.A.C.A.), Albuquerque Lodge. The C.A.C.A. is the oldest Asian civil rights organization in the United States, established in 1895. One of C.A.C.A.’s goals is to educate, correct and update American historiography to reflect and include the numerous contributions Chinese Americans have made to American life and society. For example, Chinese Americans were approximately 80% of the workforce on the Central Pacific Railroad, which was the western line of the Transcontinental Railroad in the nineteenth century, but the story of the Chinese people who built the railroad is often overlooked or discounted in the classroom and public history. When I started researching Chinese Americans in New Mexico, there was scant information. The research typically covered Chinese Americans in California, Arizona and Texas. I knew this was incorrect—because of a truism I heard in my twenties: “where there is water, there are Chinese.”

My original idea was to gain recognition of a significant New Mexico Chinese American building, event, or incident. With the help of a local public librarian, Eileen O’Connell, I was able to identify a forgotten landmark civil rights case that commemorated a decision by the New Mexico Territorial Supreme Court. In the case Territory of New Mexico v. Yee Shun (1882) the Court allowed the testimony of Chinese Americans to testify, challenging the prevailing legal doctrine of the time which disallowed Chinese testimonies in civil and criminal cases. This case was a breakthrough in the developing relationship between race and law in the United States, establishing a precedent for other states.

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Lessons Learned by Looking Back

There is a connection between the organizational skills I learned at the AOA and from my optometry career: the C.A.C.A. Advocacy Program was modeled after the AOA’s legislative advocacy program. The C.A.C.A. Past National President, Carolyn Chan, was also the president of the AOA Auxiliary in 1978, and her husband Tony Chan, O.D. was the first Asian-American AOA Trustee. Because of the success and the grass roots elements of the AOA Lobbying program, Ms. Chan modeled the C.A.C.A Advocacy program after the AOA program. Another lesson I have learned during my career in optometry is to recognize and embrace positive change. The profession was on the cusp of a revolution when I began my career. The huge influx of optometrists trained under the GI Bill after World War II were willing to expand the scope of optometric practice, especially in the monitoring and treatment of eye disease. When I started college and optometry school in the 1960s, optometrists detected eye diseases and referred patients to ophthalmologists, we did not diagnose and treat disease. Optometrists in the private sector and in the IHS were eager to move forward and to provide the best care to patients. As it turned out, what was good for the patient is also good for the profession. I was lucky to be part of the evolution of optometric clinical training, and to fulfill the mandate that optometrists become members of interdisciplinary health care teams.

My career also spanned the second wave of the feminist movement in the late 1960s and 1970s. One of the consequences of the movement was the idea that we could become "superwomen" who could multitask and "do it all." While this was invigorating, sharing the workload is superior to shouldering all of the work. My only advice for women optometrists today is to
balance your personal and professional lives. You can’t do it all, and you don’t have to!

Annotations


2. The Regents of the University of California approved the granting of the terminal professional degree, Doctor of Optometry, on June 18, 1965 (Morgan MW, Peters HB. Optometry at the University of California. J Am Optom Assoc 1965;36(12):1059). Admission to the new four-year doctorate of optometry program began in 1966. Recent graduates of the Master of Optometry (MOpt) program as well as current students were allowed to complete additional requirements to obtain the “O.D.” See: Fiorillo J. Berkeley Optometry—A History. Berkeley, CA: University of California, Berkley: 2010: 739 p.

3. Original paper copies of the project papers produced by optometry students are held at the University of California, Berkeley Optometry and Health Sciences Library in the series RE14.02 entitled “O.D. Papers” 1969-1972. For access see: http://oskicat.berkeley.edu/record=b12912681~S1


5. After acquiring her M.P.H., Dr. Wong was a research associate at the St. Louis University School of Medicine, Department of Community Medicine and vision care analyst under the vice president’s office of the St. Louis University Medical Center—positions that provided experience she would later apply at the University of Houston. See also: Wong SG. Continuing education for independent health professions. J Am Optom Assoc 1973;44(5): 503. She also earned a Doctor of Ocular Science degree from Southern College of Optometry in 1995.

6. Dr. Wong wrote a series of articles for the J Am Optom Assoc under the 1975 DHEW Special Project Award grant #07-D-000105-01 and 02: Interdisciplinary health care: Part I. (JAOA 1978;49(7): 803), Part II (JAOA 1978;49(8): 895); and Part III (JAOA 1978;49(9): 1001). The series discusses the rationale and plan for the interdisciplinary training pilot program at UH beginning with the interdisciplinary project team, the pilot program and the community study in 1974 as well as the development of elective courses on Interdisciplinary health teams in 1975 with optometry, pharmacy, nursing, theology, and allied health students. In the first year, students did both traditional didactic coursework and field work. In the second year, the program expanded to include social work and dietetics. In recognition for this work Dr. Wong received a U.S. Public Health Service Traineeship Award 1971-’72, Beta Sigma Kappa Noteworthy Practitioner Award in 1977, and was named Diplomate by the National Board of Examiners in Optometry.


8. Dr. Lester Caplan also noted the poor selection of frames available to people served by the IHS and believed that the unattractive frames made children in particular unwilling to wear corrective lenses. Caplan, Lester, interview by Kirsten Hebert and John Amos, O.D. April 24, 2014, Archives & Museum of Optometry, St. Louis, MO.OH 507.

9. For a look an evaluation of optometric care provided by the IHS Albuquerque Area at the beginning of Dr. Wong’s tenure see: Toya JL. Reid KL. Evaluation of the Albuquerque Area Indian Health Service Optometric services provided to 19 Pueblo Indian communities. Indian Health Service, Staff Office of Planning, Evaluation and Research, Rockville, MD 20857 (E-30). 1979. Available from: https://digitalrepository.unm.edu/cgi/viewcontent.cgi?article=1004&context=nhid. While QA was welcomed within the IHS, acceptance by private practitioners was harder to win. Dr. Wong continued to promoted QA to those in group practice in her capacity as a member of the Multidisciplinary Practice Section (JAOA 1992; 63(4): 276).

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13. In 1978, Dr. Wong was elected to the APHA’s governing Council of the Medical Care Section (Potpourri. JAOA 1978; 49(1): 102). In 2005 She received the APHA Vision Care Section Distinguished Service award.

14. Dr. Wong joined the AOA’s Multidisciplinary Section in 1977, serving as chair in 1979-1980 (JAOA 1977; 48(10): 1313; JAOA 1978; 49(11):1320; JAOA 1980;51(9): 818). In that year she also began working as a referee and on the editorial board of the JAOA. During the 1980s, she often presented to AOA members about acquiring hospital privileges and served on panels discussing hospital-based care at AOA meetings (JAOA 1985;56(4): 327). See: Wong SG. Historical perspective of optometrists’ and other health professionals’ involvement in hospitals Volume 59, Number 8,8/88 594-597).


17. Dr. Tony Chan is a 2020 inductee to the National Optometry Hall of Fame.