SOUTHERN CALIFORNIA COLLEGE OF OPTOMETRY

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President

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Members of the Alaska State Medical Board

Dear Members of the Board:

First of all, thank you for the opportunity to appear before you and deliver this written letter of support for the expansion of the optometry practice act in Alaska. It is a pleasure to offer you my personal opinion on this most important subject.

As a licensed practitioner of both optometry and medicine, I write in support of changes in the Alaska Optometry Law, which will update the optometry practice act to the proper level for the education and training of the fine optometrists in your state. I know this topic is an emotional issue; however, I believe that careful review will substantiate the fact that modern optometrists have the appropriate education and training.

Alaska is truly a rural state where, in a number of communities, the optometrist is the best trained and best equipped practitioner to treat common eye problems and eye diseases. This fact makes passage of modern optometry practice acts extremely important and would certainly improve the quality of health care delivery to the people of your beautiful state.

I personally practiced family medicine in Hartville, Ohio, after having completed a Family Practice Residency in Akron, Ohio. The only professional eye care in our community at that time was provided by an optometrist. He and I exchanged patients freely and comfortably for primary care.

Let me offer some specific observations of my own regarding optometric and medical education:

Medical school traditionally prepares the student in general medical and surgical background for post-graduate training programs. Detailed anatomy and physiology of organs such as the eye is <u>not</u> emphasized during medical school. As well, during surgical rotation in medical school, it is uncommon to be exposed to ocular surgery. Because heart disease, cancer, and stroke are the biggest killers of the U.S. population, medical school clinical training is heavily devoted to general internal medicine, general surgery, obstetrics-gynecology, and pediatrics. There are usually fourth-year electives in 4 to 12 week blocks where a student may increase his/her exposure to subspecialty medical and surgical areas such as: ophthalmology, ear/nose and throat, urology, pulmonary medicine, cardiology, etc. In my experience, a small minority of students choose ophthalmology as a clinical rotation.

By a small personal survey in the area of California in which I now reside, most primary care physicians (general practitioners, family practice, internists, and pediatricians) admit that they had from one to three weeks of medical school devoted to ophthalmological care. This includes both didactic course work and clinical experience. I do not need to remind you that these physicians treat eye diseases on an unrestricted basis.

On the other hand, optometry school is mostly devoted to ocular training. There are courses in general pathology and ocular signs of systemic disease because the optometrist is responsible to detect systemic diseases with ocular manifestations and to make appropriate referrals. Included with the systemic disease education is the specific education and training in the use of systemic medications and medication interactions, especially in regard to medications utilized in the management of ocular conditions. The detailed ocular anatomy, ocular physiology, ocular pathology, and ocular pharmacology training in optometry school is far superior to the same ocular topics in any general medical school course in the country. This is not to slight medical education; there simply is not enough medical school curriculum time to devote to the eye because of training in vital organ systems such as the heart, lung, vascular system, etc. Additionally, the prerequisites for optometry school meet or exceed the requirements for medical school admission and the Optometry Admission Test parallels that of the Medical College Admission Test. With all the prerequisites and the primary care doctoral program in optometry school, the graduate is trained to make professional judgments and is quick to consult with other health care providers when a patient requires needed services outside the scope of practice. Alaska optometrists now routinely work with medical specialists and subspecialists in the interest of the highest quality patient care.

The clinical education of an optometrist does not have to parallel the education and training of an ophthalmologist any more that the education and training of a family physician needs to parallel that of a surgeon.

In summary, I would like to point out that ophthalmologists are vitally needed. Patients would be in sad shape without their advanced expertise in the areas of severe ocular trauma, cataract surgery, retinal surgery, complicated ocular infections, etc. These are all vital secondary and tertiary care conditions which optometrists do not propose to treat. I do regret that the opposition resorts to “scare tactics” in this legislative turf battle. In my opinion, the risk to the public is not an issue.

I also feel strongly that optometrists are vitally needed. There is no question that the Board of Examiners in Optometry for the State of Alaska will protect the people by insuring adequate education, continuing education and training for any optometrist.
It seems unfair to patients and a waste of resources to prevent optometrists from providing care at the highest level of their education and training. At best, constraints on the profession contribute to an increase in health care costs, especially with the many rural areas of Alaska served only by optometrists. When primary care is provided by specialists it is well known that the delivery of health care adds expenses to the system.

Sincerely,

Lesley L. Walls, O.D., M.D.