HB
664

KETCHIKAN MEDICAL SOCIETY

3100 TONGASS AVENUE - KETCHIKAN, ALASKA 99901

March 14, 1978

TELETYPE TESTIMONY TO HEALTH EDUCATION & SOCIAL SERVICES COMMITTEE

Ketchikan Medical Society wishes to record its opposition to House Bill 664. Historically, and by Alaska statute, optometry has been a drugless profession. For the good of the people of the state of Alaska, we believe that optometry should remain drugless.

H.B. 664 requires only that optometrists pass a single examination before this significant expansion in their role is permitted. The examination will either be given by the optometry board itself with no legislated previous training requirements, or be given by a recognized school or college following an optometry board approved course of study. There is no mention of criteria for approval. There is no mention of by whom the institution is recognized. There is no mention of accreditation or university affiliation.

Further, the bill contains no definition of a diagnostic purpose, and no provision for any penalty for use of drugs in conditions other than those approved by the board. There is nothing in the bill to prohibit an optometrist virtually any use of this broad list of medications, if that use can be extended to be called diagnostic. Since optometrists by their licensing statute cannot legally have had any experience with these drugs, and since use of these drugs is part of the wider experience of medical doctors, it does not appear that the public is protected by the inexperienced licensing of the untrained to the exclusion of more experienced and qualified medical doctors.

Although optometrists are portraying the drugs they seek to use as harmless, it is precisely because of their effectiveness that they are being sought. Any drug brings with its desired effects certain other undesirable effects and occasional very serious complications. Optometrists are not trained or qualified to deal definitely with any of these complications; to whatever extent the complication involves more than the eye the optometrist is excluded by licensing statute from making anything other than a layman's assessment. We believe that the public deserves better protection than the optometrists offer in this bill.

In summary, although H.B. 664 is laudably brief and seductively simple, we do not believe that it serves the best interests of the people of Alaska.

HB664

March 31, 1978

Rep. Charlie Parr, Chairman
Pouch V
State Capital
Juneau, Alaska 99801

Dear Mr. Parr,

I am writing in regard to House Bill 664. I do not feel optometrists should be allowed to use certain medications for the eyes. I feel it would be dangerous as they are not physicians and are untrained in the use of drugs for treating eye problems. I feel only trained physicians should be able to use medications and I urge you to defeat House Bill 664.

Respectfully,

Michele A. Bone

Michele A. Bone
Speech and Language Pathologist
P.O. Box 8340
Ketchikan, AK 99901

cc: Rep. Terry Gardiner
Rep. Oral Freeman
Sen. Robert Ziegler

HB 664

March 24, 1978

Rep. Charlie Parr, Chairman
Pouch V
State Capital
Juneau, Alaska 99801

Dear Rep. Parr,

As a Registered nurse with thirty years experience I ask you to give serious consideration to House Bill #664. Placing drugs in the hands of and allowing them to be administered by untrained persons poses a serious threat to the health of the consumer. Do not be mislead into thinking these drugs mentioned in HB #664 are safe, as they all have potential side effects and it is our duty to protect the people from possible harm by allowing medications to be administered only by trained medical people. I would like to go on record as being opposed to HB#664 and urge you to vote against it.

Sincerely,

Ethelbelle Kondzela

Ethelbelle Kondzela, R.N.

CC: Sen. Robert Zeigler
Rep. Oral Freeman
Rep. Terry Gardiner

EYE CLINIC OF KETCHIKAN
RONALD L. TOKAR, M.D.
Eye Physician and Surgeon
Post Office Box 8636
Ketchikan, Alaska 99901
Telephone
(907) 225-2656

March 9, 1978

Representative Charlie Parr
Pouch V
State Capital
Juneau, Alaska 99801

Dear Representative Parr,

As one of two ophthalmologists in Southeastern Alaska, I would like to reveal and explain my opposition to HB 664.

I recently finished my training as an ophthalmologist last June and now practice in Ketchikan. Below is a review of my training.

4 years undergraduate school---------B.S. Degree
4 years medical school---------------M.D. Degree
1 year internship
2 years general practice in Alaska
3 years residency in ophthalmology
8 months private practice

I have completed and passed a written examination of the American Board of Ophthalmology and later this year will take a two and one half day oral examination. The above is typical of an ophthalmologists training. Please compare it to an optometrists.

I believe that the use of the drugs discussed in HB 664 by a non physician will be hazardous to the public for two principle reasons. First, all of the drugs may have side effects. The optometrists lack the experience and training to safely control these reactions when they do occur. Enclosed is a sample of the inserts required by the Food and Drug Administration to be distributed with each drug. Please read these.

During my ophthalmology training program, a patient experienced a serious reaction after receiving dilating eye drops. The patient, an apparently healthy male in his twenties, underwent a cardiac arrest in the eye clinic after receiving the eye drops. Fortunately, the examining ophthalmologist was capable of caring for the patient who did recover. This is unusual, but can happen. I myself was examining a patient last year when he underwent a seizure which we felt was triggered by the use of dilating drugs.

My second objection is that both the optometrist and the patient will be lured into a false sense of security with the use of drugs by non physicians. Optometrists were traditionally trained to treat the eye with glasses and have no medical training enabling them to recognize serious pathology.

Enclosed is a copy of a letter sent to me by a Ketchikan optometrist. There are numerous defects in the reasoning of this letter. I would like to use an important one to illustrate a point. The statement that if a pathological condition is observed, it would be referred to a proper health care practitioner. Since I have been in Ketchikan (8 months) the writer of this letter has never referred a patient to me for evaluation of pathology.

One can then make several assumptions and I will leave these to the committee to discuss. One could go much further elaborating other arguments against HB 664. I am sure my colleagues will testify to these.

The opposition to HB 664 as you know is opposed by most Alaska Physicians. I would like it to go on record that each and every physician in Ketchikan is opposed to HB 664. You will soon be receiving a letter from the Ketchikan Medical Society stating this fact.

I would appreciate this letter be offered as testimony to your committee. Thank you.

Respectfully yours,

Ronald L. Tokar, M.D.

ALASKA STATE MEDICAL ASSOCIATION
1135 W. Eighth Avenue • Suite 6 • Anchorage, Alaska 99501 • (907) 277-6891

February 14, 1978

Representative Charlie Parr
Chairman, House HESS Committee
Alaska State Legislature
Juneau, Alaska 99801

Dear Representative Parr:

The Alaska State Medical Association Council has reviewed HB 664, An Act Relating To The Practice Of Optometry. We see no purpose identified or expressed within the substance of the Bill. We further see no areas where the public interest will be served by its passage and several areas where compromised eye care, duplication and cost increases are possible if not likely.

At the outset, please understand that the ASMA properly has no interest or intent to interfere with the practice of optometry in Alaska. However, if an enlargement of the scope of optometry into the sphere of medical practice is comtemplated, it reasonably becomes our concern for the welfare of the public, not a simple jurisdictional dispute.

Optometry by derivation, definition, tradition, training and current practice means measurement of the eye for refractive error and a prescription of corrective lenses. Current practices also allows dispensing and sale of lenses and spectacles by the prescribing optometrist.

The current statute defining optometry is unfortunate in that it suggests diagnosis of visual impairment, apart from refractive error, lies within the responsibility of optometry.

Non-refractive visual impairment may be a most difficult and subtle medical diagnostic problem, at times challenging the combined expertise of ophthalmologist, neurologist, radiologist, and internists, and requiring sophisticated diagnostic equipment. Causes range from simple cataracts to subtle brain tumor, from transient vascular insufficiency to obscure metabolic disorders. The visual problem may be the first and only lead to a serious medical disease. Almost all non-refractive visual impairments will come to confirmatory diagnosis and treatment by a physician. It goes without saying that missed or delayed diagnosis can have serious potential consequences.

Before extending the scope of optometry, well beyond refraction and the sale of contact lenses and spectacles, into the intricate area of complex ophthalmological diagnosis, we ask that you assure yourself of the following:

(1) That there is a clearly demonstrated and defined unmet public health problem, that this legislation will solve it, and it is the most appropriate solution.

(2) That the general level of training of the practicing optometrist in Alaska at present is at a standard which will preclude frequent mis-diagnosis, delay, duplication of expense and inappropriate trials of corrective lenses for non-refractive disorders of the eye.

(3) That the use of ophthalmologic drugs in the practice of optometry is free of risk.

(4) That the expanded drug use is necessary and essential to increased accuracy in refractive error diagnosis.

We feel the answers to the above are not obvious, we see no urgency to enact the legislation without the most careful study of the implications and therefore urge that you allow ample time for its consideration.

Sincerely,

Winthrop Fish, M.D.
Chairman, Legislative Committee

WF:mlm
cc. ASMA Council
ASMA Legislative Committee

State Medical Board
Conference Call
February 2, 1978

A conference call was held by the Board of Medical Examiners on February 2, 1978, at 10:30 a.m., Juneau time.

Those present were:

Thomas Harrison, M.D.
Hilbert Henrickson, M.D.
Hugh Gellert

Also present was Loretta Prescott, License Examiner, from the Department of Commerce and Economic Development.

On February 6, 1978, Loretta Prescott, License Examiner, polled the remaining medical board members by phone:

Dr. William Compton - unavailable
Dr. Gary Walkup - unavailable
Louise Beighle - unavailable

Dr. Thomas Stengl voted yes to the following, constituting a quorum:

RESOLVED, that the Alaska State Board of Medical Examiners, requests that House Bill 664, "An Act relating to the practice of optometry." be defeated, as the State Medical Board feels that it allows the use of dangerous drugs by unsupervised, non-medical personnel.

LP/sa3/34

THE ALASKA HOSPITAL AND MEDICAL CENTER, Inc.

February 7, 1978

House Commerce Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

RE: House Bill No. 664
"An Act Relating to the Practice of Optometry"

Gentlemen:

The Medical Staff of The Alaska Hospital and Medical Center at their annual meeting, January 25, 1978, unanimously (75 members present) passed a motion to disapprove House Bill No. 664.

The Medical Staff feels that the use of medication requiring a prescription to purchase, to use and to dispense should be reserved for physicians. The drugs listed in the bill, namely: topical anesthetics, mydriatics, cycloplegics, and myotics, all have potentially serious side effects including anaphylactic shock, cardiac arrhythmias, significant elevation of blood pressure, stroke, psychosis, convulsions, precipitation of gluacoma, cataracts and retinal detachments. Any of these conditions, even if they would be recognized by an optometrist, could in no way be treated by an optometrist.

It is for this reason the Medical Staff feels very strongly that it is in the best interest of the citizens of Alaska to keep the use of potentially harmful and toxic drugs under physicians specifically trained in such areas and licensed in the state to use such preparations in the cure of the sick and in the diagnosis of disease states.

Sincerely,

C.J. Little, M.D.

, M.D.
C.J. Little, M.D.
President/Medical Staff

JP:CJL:lw

cc: House Judiciary Committee
Anchorage Ophthalmologic Society

2801 DeBarr Road • Pouch 8-AH • Anchorage, Alaska 99508 • Phone: (907) 276-1131

BARTLETT MEMORIAL HOSPITAL

P. O. BOX 3-3000 • JUNEAU, ALASKA 99801 • TELEPHONE (907) 586-2611
MILE 3 — GLACIER HIGHWAY

March 16, 1978

The Honorable Charles Parr, Chairman
Health, Education & Social Services Committee
House of Representatives
Pouch V
Juneau, AK 99811

Re: HB664 - Optometry

Dear Representative Parr:

The Juneau Medical Society is unanimously opposed to granting optometrists the right to practice medicine. We do not feel that it is in the best interest of our community health program.

We respectfully request that you take negative action on this piece of legislation.

Respectfully yours,

Estol Belflower MD

Estol Belflower, M. D., President
Juneau Medical Society

RUTHANN SAXTON SELDEN

March 10,1978

Dear Dr. Grendahl,
The PEER Group of Alaska (Practitioners Entering Expanded Roles) voted to oppose HB664 at our March 7, 1978 meeting. We are making our decision known via the Legislative Coalition of Health Care Professionals and this letter.

This is a serious issue. To be specific, we feel that the educational background of an optometrist does not include the essential indepth knowledge of how to correctly treat the untowarded side effects that may result when medication is used on the human body. As you know, some patients may be in life threatening situations as the result of the use of a medication that their body is sensitive to.

We as Nurse Practitioners do use medications that have possible untowarded side effects; obviously, we do not have the indepth knowledge of pharmacology and emergency medicine that the physician does. However, our role is in collaboration with a physician.

Therefore, in the interest of the people of the State of Alaska, we are making our decision known.

Sincerely,

Ruthann Selden, R.N., P.N.P.
Chairperson
PEER Group of Alaska
8816 Abbott Loop Rd.
Anchorage, Alaska 99507

HB664

DRS. WILSON AND WILSON, P.C.
ARTHUR N. WILSON, M.D.
JAMES A. WILSON, M.D., F.A.C.S.
ARTHUR N. WILSON, JR., M.D.
P.O. BOX 8478
KETCHIKAN, ALASKA 99901

March 6, 1978

Senator Robert Ziegler
U. S. Senate
Washington, D. C. 20510

Dear Senator Ziegler:

We have received a letter from Dr. Ed Craig under date of March 2, 1978. This letter is enlisting our support for HB664 which has been introduced into this legislative session by the Alaska Optometric Association. It states that the cover letter was sent to the various representatives to explain why optometrists need to use diagnostic drugs.

We have read this letter and also a letter under date of February 6, 1978 relative to the same questions and the copy of House Bill #664 introduced on January 19, 1978. Beside this, there was enclosed a special issue of the ACASCOP, volume 2, #9, June 16, 1975 which has the pharmacology curriculum guidelines for continuing education courses.

As stated in the letter of February 6, historically optometry has been a drugless profession. The optometrists have been treating refractive errors of patients and prescribing lens and various exercises for cases of defective vision.

The practice of ophthalmology as conducted by physicians goes much beyond this. There is so much to be learned in the history of various diseases. There is so much of importance in using drugs in the treatment of eye diseases. There are so many interactions between drugs that we simply cannot go along with the idea that optometrists should be using these different drugs.

We do not believe that all of these principles can be learned satisfactorily in a continuing education program such as contemplated in the guidelines behind this bill. We think there are too many chances of errors in treating patients where the practitioner has not had the equivalent of a medical education.

Very truly yours,

Arthur N. Wilson, M.D.
Arthur N. Wilson, M.D.
James A. Wilson, M.D.

Arthur N. Wilson, M. D.
Arthur N. Wilson, Jr., M. D.
James A. Wilson, M. D.

ANW/lj

cc: Honorable Oral Freeman
Pouch V
Juneau, Alaska 99811

cc: Honorable Terry Gardiner
Pouch V
Juneau, Alaska 99811

OPHTHALMOLOGIST
WILLIAM F. KINN, M.D.
BRUCE J. WOLF, M.D.
SAMUEL A. McCONKEY, M.D.

OTOLARYNGOLOGIST
RONALD E. TINSLEY, M.D.
RICHARD P. RAUGUST, M.D.
BRUCE G. WHIPPLE, M.D.

PLASTIC AND RECONSTRUCTIVE SURGEON
WILLIAM W. WENNEN, M.D.

EYE, EAR, NOSE & THROAT CLINIC

March 29, 1978

Representative Terry Gardiner
Chariman
Pouch V
Juneau, Alaska 99811

Dear Representative Gardiner:

It's my understanding that in the near future, you will be considering House Bill 664, an act relating to optometry. This Bill, if passed, would give optometrists (nonphysician) the power to use "diagnostic drops" in the eyes of their customers. There are several points that should be made, and they are as follows:

1) As concerns "diagnostic drops," the general nomenclature is certainly a misnomer. These drugs that they are asking to use are only called "diagnostic drops" by optometrists and not by physicians. It should not be forgotten that drops do not diagnose, people diagnose, and people with the proper training, experience, and background to make these determinations are physicians who have completed their academic and clinical training.[1]

2) Dilating the eye is not a prerequisite to making a diagnosis of eye disease. Dilating drops are not a prerequisite to supplying children with the proper glasses correction. Anesthetic drops are not needed for the diagnosis or the presumptive diagnosis of glaucoma.[2]

3) There is no maldistribution in Alaska between those that have the concern for providing eye care to our residents.

4) There is a high incidence of narrow angle glaucoma in residents in Alaska, particularly among the native population. Narrow angle glaucoma is a severe high pressure in the eye that's caused by dilating the eye, specifically caused by the drops that the optometrists want to be able to use.[3]

5) It is quite important that anyone involved with the use of medications, in any fashion, be capable of handling any systemic or local reactions to these medications, no matter how uncommon they may be. Optometrists have absolutely no training or preparation in the management of these potentially serious and, in some cases life threatening, untoward reactions that happen occasionally with the use of these medications.[4]

6) The trend in the United States toward this type of legislation, which has been going on now for some three years, is to defeat this sort of movement. In 1977, 17 states defeated similar legislation; the legislation was passed in five states, four of which are considered rural

1919 LATHROP STREET, P.O. 1248, FAIRBANKS, ALASKA 99707, PHONE 456-7767

states, the major argument being that optometry provided coverage in areas where no medical care was available. That is not the case in Alaska.

7) It should be mentioned that ophthalmology has no financial interest in this type of legislation and, as a matter of fact, this is not special interest legislation in any sense of the word. Ophthalmology is responding because we are the best qualified people to ask for an opinion.

8) Consumer protection should be quite prominent in your minds. It is evident from efforts in other parts of the United States that optometry is lobbying, both in the public sphere and in the legislative halls, to be the primary eye care provider across the United States. It is my contention that this further confuses the public as to who they are seeing for their eye care, rather than gives them any advantage.

9) It would seem that, of all the people available for comment, it would be those people who are both optometrists and ophthalmologists (physicians). I refer you to an article by Roger L. Hiatt, M.D., who is a former optometrist and now a physician, who is Chairman of the Department of Ophthalmology at the University of Tennessee College of Medicine in Memphis.

Thank you very much for your time in reading this brief summary. I would hope that you will have an opportunity to peruse the reference material that is included, that is, copies of letters that have been sent in the past to members of the Health, Education and Social Services Committee in the Alaska State House of Representatives.

Sincerely,

Sam A. McConkey, M.D.

SAM:ls

HB 664

March 21, 1979

To: Rep. Charlie Parr

Re: House Bill #664

Dear Rep. Parr,

I am very concerned about the pending legislation that would allow optometriststhe legal permission to use certain drugs. I want you and your colleages to defeat this proposal for the following reasons:

I have had direct experience with optometry in Arizona, Oregon and in Alaska that has shown me that as a group., optometrists are very resistant and hesitant to refer their patients to physicians when the optometrist observe a medical problem or the signs of a potential medical problem. I have seen this trend activity result in serious conditions for a member of my family and others. I have seen this happen in Ketchikan.

While I believe some optometrists are probably ethical, I fear that many engage in the above described activity. They do this because they don't want to lose patients and therefore business. It only takes a few to endanger many members of our society.

The drugs in question may be relatively harmless or potentially dangerous, I don't really know. I strongly feel that by allowing optometrists the use of some drugs, this will reinforce and promote their tendency to not refer medical problems to the appropriate professionals.

I sincerely hope that you recognise the dangers in what I've described. These are the reasons I'm against this bill and why I want you to vote against it.

Thank you for your consideration,

Stanley J. Bambauer

Stanley J. Bambauer
2141 Third Ave.
Ketchikan, AK 99901

copies to Rep. Terry Gardiner
Rep. Oral Freeman
Sen. Robert Ziegler

Pouch V
State Capitol
Juneau, Alaska 99801

HB 664

South Central District Dental Society

P.O. BOX 4-1800
ANCHORAGE, ALASKA 99503

March 28, 1978

Representative Charles Parr, Chairman
House HESS Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Representative Parr:

We, the South Central District Dental Society, wish to go on record as being opposed to HB 664, Practice of Optometry. Our position is based on information gleaned by the dental society that the current level of clinical and educational experience of the Alaskan optometrist is inadequate to take on responsibilities incurred with the administration of the drugs they requested in this bill.

Sincerely,

William P. Fell, D.D.S., President
South Central District Dental Society

cc: Jim Patterson, M.D.
Fred D. Bast, D.D.S.
Phillip L. Locker, D.D.S.
Mr. Henry Pratt

OPHTHALMOLOGIST
WILLIAM F. KINN, M.D.
BRUCE J. WOLF, M.D.
SAMUEL A. McCONKEY, M.D.

OTOLARYNGOLOGIST
RONALD E. TINSLEY, M.D.
RICHARD P. RAUGUST, M.D.
BRUCE G. WHIPPLE, M.D.

PLASTIC AND RECONSTRUCTIVE SURGEON
WILLIAM W. WENNEN, M.D.

EYE, EAR, NOSE & THROAT CLINIC

February 7, 1978

Mr. Charlie Parr
Chairman
Health, Education and Social
Services Committee
Alaska State House of Representatives
Alaska State Capitol
Room 112
Juneau, Alaska 99811

Dear Mr. Parr:

On behalf of the physicians in the State of Alaska who are concerned with eye care, I would like to again thank you for giving me some time out of your obviously quite heavy schedule in order that I might become better acquainted with House Bill 664, an act relating to optometry. I was able to see several members of your committee on my recent visit to Juneau and hopefully will have an opportunity to introduce myself to the remainder when I get to Juneau in the future. I plan this to be the first of several background papers that you and your committee might wish to consider in your deliberations on House Bill 664.

I think it is appropriate that I give you some background into my education and status within the ophthalmologic community in Alaska. I received an undergraduate degree in premedicine at West Virginia University in Morgantown, West Virginia in 1962. I had my medical school training at the Medical College of Virginia, graduating with a degree of Doctor of Medicine in 1966. I served a year of surgical internship and a year or surgical residency at the same institution, completing that course of study in 1968. In October of 1968, I was inducted into the armed forces as a surgeon with the United States Air Force, stationed at Eielson Air Force Base near Fairbanks, Alaska. Following a 30 month tour of duty, I was in the private practice of general medicine in Fairbanks, Alaska for one year. In 1972, I became associated with the Medical University of South Carolina in an ophthalmology residency program, completing that course of study in June of 1975. From January until March of 1975, I was also a teaching fellow in ophthalmology, concerned with the education of medical students at the Medical University of South Carolina. In July of 1975, I returned to Fairbanks, Alaska and have been in the private practice of ophtoalmology with the Eye, Ear, Nose and Throat Clinic since that time. I am a Diplomat of the American Board of Ophthalmology. This accrediting board was the first medical specialty board established in America at a time when optometry was in its infancy and long before licensing boards for optometry existed. The privilege to practice my specialty is the culmination of 13 years of post high school education. This is in contrast to the average six to eight years spent by optometrists in post high school education today and is in greater contrast to the four years or less post high school education of approximately 50% of all optometrists presently practicing in the United States.

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WHAT OTHER STATES HAVE DONE

House Bill 664 is a continuation of a nationwide move on the part or organized optometry to be legislated into the practice of medicine. Since 1971 until 1977, nine states had passed similar laws. In 1977, as of August the 25th, 14 states had denied the use of drugs to 8,275 optometrists. There were five states that passed drug related optometric bills. Four of these states, namely Montana, Wyoming, New Mexico, and Kansas, are certainly in the category of rural states and indicates that the major direction of optometry toward pressing this legislation today is most certainly in rural areas. The defense against that argument that optometrists can provide their care where no ophthalmologists are available, is as follows: In those communities where no ophthalmologists practice, there are physicians with medical "know-how" to deal with eye problems on an urgent basis and refer them for ophthalmologic care to nearby cities. A colleague of mine, Dr. Charles Bobo, Greenwood, South Carolina, studied the population that presented to a small rural community hospital emergency room over the course of one year from July 1, 1975, to June 30, 1976, and in his independent study, showed that 80% of the patients seen in this emergency room sitting were capably treated by the general practice family type physician and only 20% of those needed to be seen by an eye specialist. This certainly refutes the attempt by ambitious optometrists to make a case for being allowed medical functions in rural areas by claiming that there are too few ophthalmologists. The Eye, Ear, Nose and Throat Clinic in Fairbanks, Alaska, of which I am a partner, has, for years, been carrying out not only ophthalmologic but ear, nose and throat clinics in remote areas and in bush communities for the care and welfare of patients that prefer to live in a rural setting. It might be mentioned that our prices for these clinics are exactly the same as they are in our offices in Fairbanks, Alaska.

Find enclosed a copy of some random court rulings as to what other states have had to say in defining optometry and optometric responsibilities.

I will follow this report with others over the next several days, outlining various other points of interest concerning consumer protection and other pertinent data as may be important in your committee's consideration of this bill.

Sincerely yours, I remain,

Sam A. McConkey, M.D.

SAM:ls
cc: Representatives: M.F. Beirne
Don Bennett
Thelma Buchholdt
C.V. Chatterton
Samuel A. Cotten
Alfred C. Nakak
Al Ose
Randy Phillips

OPHTHALMOLOGIST
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BRUCE G. WHIPPLE, M.D.

PLASTIC AND RECONSTRUCTIVE SURGEON
WILLIAM W. WENNER, M.D.

EYE, EAR, NOSE & THROAT CLINIC

February 8, 1978

Representative Charlie Parr
Chairman
Health, Education and Social
Services Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Mr. Parr:

This is the second in a series of background reports that I hope will be valuable to you and your committee in your deliberations of House Bill 664.

CONSUMER EFFECTS AND CONSUMER PROTECTION

As regulations evolve to guide the delivery of health care under a federalized system, the role of paraprofessionals in medicine is being defined. A short time ago, most optometrists were "eye examining - glasses fitting" employees of chain and jewelry stores. Now they are a national political effort attempting to legislate themselves into the position of primary eye care practitioners; House Bill 664 is such an attempt, and as presented, this bill is vague, illogical, and unacceptable and is not in the public interest.

Optometry organized for its present effort many years ago and began to implement programs for presenting generally persuasive nonmedical evidence to legislators in many states recently. Before medicine could rally its forces to articulate the logic which is clearly on the side of medicine and the public, several legislatures were persuaded to transform optometrists into quasi-physicians.

Ophthalmologists have been forced to assume responsibility for protecting the public health against optometry. This situation is unfortunate because optometry was once respected for many decades by medicine and the public for having provided vision improvement (not health care) for millions of Americans. The result of their present legislative attempts to intrude upon the practice of medicine could be continuous disharmony and perhaps even the destruction of optometry as a respectable science. Nurses, ambulance attendants, and others who have been trained under the supervision of medicine are appreciated, enjoy a good reputation, and are classified as paramedical personnel, but optometrists insist upon being nonmedical and refuse to accept medical supervision. It is possible for optometry to join the American health care delivery system under qualified medical supervision if vision care is to be included, as is currently done in the U.S. military services and in other countries; but until then, optometry is risking its reputation as a fine profession and the state legislators are being encouraged to transform optometrists into quasi-physicians by legislative fiat which is not in the public's best health interest.

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A recent poll nationally showed that the public fears blindness second only to cancer. Americans deserve to expect better primary care for possible eye or related bodily disease and not what optometrists are remotely prepared to offer. Despite the claim of their nonphysician educators, optometrists, by background, training, and experience, do not have the capability to diagnose medically related eye problems or eye diseases, drops or no drops. The diagnosis of disease is the practice of medicine. Optometrists are not trained to practice medicine. Many individuals can recognize departures from normal and even make diagnostic guesses, but definite diagnosis and the ability to recognize fine differences between one disease and another rests solely with the physician. It requires understanding, not only of disease but also knowledge of its response to medical and surgical methods of treatment. Ophthalmic diagnosis further requires an understanding of diseases as they effect not only the eye but the body as a whole. Only an ophthalmologist, schooled first in medicine, has this ability. We can not divorce the eye from the human body.

Ophthalmologists and organized medicine have no vendetta against optometry. Optometrists practicing in their traditional role are needed. They are a value testing for glasses and performing those functio for which they have education and experience. The concerted political effort by optometry to become the primary eye care group, however, is not acceptable, logical, or reasonable. Physicians look upon this with alarm. It is a serious threat to quality eye care and patients will suffer. Optometrists are not able to make medical determinations because it is not within the scope of their training. By contrast, legally limiting the profession of optometry to the area of activity in which they are trained to function will not reduce their effectiveness. It will help safeguard their whole profession from the potentially irresponsible action of a few and will promote the health of the public.

If all that I have said is true, then one might reasonably ask why an expansion of the traditional role of optometry is being considered. The answer lies in two areas primarily. First, the desire of legislators to contain the cost of medical care, and second, the need for optometry to improve its collective status.

The legislators have been lead to believe that if optometrists provide basic eye care, the cost might be less than care provided by ophthalmologists. The hypothesis seems attractive on the surface, but in truth, optometrists tend to over prescribe glasses for minimal refractive errors; whereas, ophthalmologists do not. Thus, the total cost of examination and glasses by an optometrist often exceeds that given by an ophthalmologist. If lessened expense is the object, refractive care delivered by trained ophthalmic assistants working under the direct supervision of ophthalmologists costs less and gives the patient better care. Such care now exists in certain prepaid health plans and university eye departments. Duplication of effort and poor referral routes also raise the cost of eye care given by optometrists. Frequently, a patient with a serious eye problem first consults an optometrist for examination, is referred on to the patient's physician for a reexamination, and finally sees the ophthalmologist, who should have been consulted in the first place. Too often, optometrists are reluctant to refer directly to an ophthalmologist, and this custom is expensive.

Optometrists, as well as other paraprofessionals, desire to improve their status. This need is no small factor motivating optometrists to spend large amounts of money and personal effort as they move to "expand the scope of optometry." The way to gain this expansion, as organized optometry sees it, is not through education but by legislation. The public relations experts for optometry have coined phrases for optometrists like "GP's of the eye," "dentists of the eye," and "optometric physicians." Such labeling is fraudulent and misleading. In the Optometric Weekly of July 7, 1977, there was a statement that an expanded definition of optometric services in the Army had been approved. This was not true, has been refuted, and has resulted in the issuance of a mandate from the United States Department of Defense that there shall be medical supervision of optometrists in all branches of the military. Yet optometry has loudly and falsely proclaimed in the state legislatures of this country that civilian optometrists should be allowed the unfettered use of eye drops like their brothers in the military.

Of late, we have seen advertisements in leading newspapers in the country and heard radio ads inserted by state optometric societies using material supplied by the American Optometric Association which are deliberately false and misleading, particularly in those densely populated states whose legislatures have not seen fit to grant optometrists the right to use drops and diagnose or treat eye disease. These ads are now being prohibited by the state attorney's general and departments of consumer protection.

In the summer of 1977, the Washington Society for the Prevention of Blindness successfully stopped an optometric advertisement aired in the guise of a public service announcement: "The Washington Optometric Association reminds you that an eye examination will detect early symptoms of diabetes, arteriosclerosis, and hypertension." Excerpts of a protest to the Consumer Protection Division of the Washington Attorney General's office prompted removal of this fraudulent advertising after the Washington State Attorney General said in part, "This health service message, couched in such broad terms, might have the capacity to mislead a layperson to expect and rely on a wider range of medical services than are actually obtainable from optometrists."

Many optometrists are not enthusiastic about organized optometry's effort to encroach upon the practice of medicine. Recently, Richard Ball, writing in the Optometric Weekly, posed a question to his fellow optometrists when he wrote, "Should we be first class O.D.'s or second class M.D.'s."[1] This stand is supported by the deans and some professors of several colleges of optometry.[2] Also, many optometrists are becoming gun shy because of the mounting resistence to their legislative attempts to encroach upon medical practices. Organizations such as Leagues of Women Voters, labor unions, federations of state, county, and municipal employees, and leading newspaper editorials throughout the land oppose the ruling of pseudophysicians of optometrists.[3] They recognize that these back door attempts at redefining optometry only serve to further confuse the public as to the capabilities of the two practitioners in the eye care field. A number of ophthalmologists who were formally optometrists and then went to medical school and by way of the ophthalmology residency route became qualified ophthalmologists,

vigorously oppose this legislation because they know better than all others that the medical eye care rendered by eye physicians is the only medical eye care that should be available to the public."

Optometrists and ophthalmologists should compliment and support each other. Disregard for excellence, such as would result from enactment of the proposals put forth in Bill 664, will adversely effect the superior level of eye care currently offered to patients in Alaska.

In closing, I might quote from a thesis entitled, "The Expansion of Optometry into Medical Practice": "The regulation of the practice of optometry is not for the benefit of the licensees but for the benefit of the state and its people...no where does case law state that public protection will be qualified, i.e., that...the risk (may be increased) 'a little bit' but not 'a lot.' The intent is protection...the language is explicit."

Please find enclosed some pertinent editorial comments, as well as some consumer articles that have appeared in other parts of the country as concerns this legislation. Thank you very much for your time in reading through this material.

Sincerely,

Sam A. McConkey, M.D.

SAM:ls
cc: Representatives: M.F. Beirne
Don Bennett
Thelma Buchholdt
C.V. Chatterton
Samuel R. Cotten
Alfred C. Nakak
Al Ose
Randy Phillips

REFERENCES

1. Ball, R., "Should we be first class O.D.'s or second class M.D.'s," Optometric Weekly, volume 67, page 874 through 895, 1976.

Optometric Weekly, April 3rd, 1976, James C. Miller, O.D., Mappanee, Indiana, "(I) think optometry has too many quasi-physicians now! If these optometrists want to be physicians, they should have gone to medical school...if we believe the end result will be to our benefit or to the benefit of the public, we are inane."

In Optometric Weekly, April 3rd, 1976, under a column headed "Vox Oculi," over half the optometrists writing in agreed that they could never appreciate the difficulty and intensiveness involved in treating eye disease until he or she is educated to a point of being able to handle it on a daily basis. "There is no present need for the move and the necessary education is not available for optometry to attempt to secure drug utilization." Richard Ball, American Optometric Association, Interprofessional Relationships Committee.

September 15, 1976, American Optometric Association News, James A. Rakes, optometric resident, V.A. Hospital, Lexington, Kentucky. "The day will come when optometrists can treat disease with the approval of ophthalmology, but they will have to earn it through the same hard work that ophthalmology residents must go through. There is no shortcut to therapeutics."

Optometrist, Philip C. Lafrance, Laconia Eye Clinic, Laconia, New Hampshire, "Optometrists, in their many years of training, are not adequately trained to correctly define an eye disease."

2. Dean Henry B. Peters of the University of Alabama School of Optometry writing in the Journal of the Americal Optometric Association, June, 1977, said, "not one of our schools is prepared by either faculty resources or available clinical experiences to accept this challenge (of preparing optometrists to treat eye disease) at the present time." "Optometric educational institutions have serious responsibilities within the present practice of optometry and precious few resources to carry them out...the resources necessary to adequately prepare students and practitioners to treat eye disease are simply not available." "It is going to be difficult or impossible...to provide the educational requirements for the expansion of optometry into the area of treatment of ocular disease."

Meredith W. Morgan, O.D., Dean emeritus of the School of Optometry of the University of California at Berkley, "As far as I know, there is not a school with the curriculum adequately designed to educate students in pharmaceutical therapy and there is not a school with adequate resources to establish such a curriculum."

3. New York Federation of Women's Clubs, Inc., April 30, 1976, a drug bill in New York State. They took a public stand against the passage of this bill. The New York State AFL/CIO, a nonmedical union, advised its constituency that "optometry is not a medical profession and optometrists are not engaged in medical practice. Optometry is confined to a limited area of the measurement for and fitting of eye glasses that traditionally is outside medicine." Please find included copies of several editorials from leading newspapers throughout the country.

4. Five optometrists who furthered their education by going to medical school and became M.D.'s (ophthalmologists) have testified as follows: "Although we had courses in anatomy, physiology, histology, and many other scientific disciplines, including some courses about drugs, our training was superficial compared to medical school training. Furthermore, it was directed with an entirely different perspective in mind, that of examining the eye for vision defects and correction thereof." The five M.D.'s who thus spoke out in unison are Charles Denton, O.D., M.D.; Roger DeShaies, O.D., M.D.; Roger L. Hiatt, O.D., M.D.; Marshall Johnson, O.D., M.D.; and William Roberts, O.D., M.D.

American Optometric Association News, September 15, 1976, James A. Rakes, O.D., an optometric resident at the V.A. Hospital in Lexington, Kentucky, "An optometrist will never appreciate the difficulty and intensiveness of educating the ophthalmology resident until he sees it on a daily basis." He also noted that the experience that he was having had "opened his eyes to the inadequacy of the average optometry student's background in pharmacology and pathology."

THE ATLANTA CONSTITUTION

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PAGE 4-A, WEDNESDAY, JANUARY 11, 1978

Pulse of the Public

Optometrists and Ophthalmologists

MARIETTA—The controversy over Senate ill 20, which would allow optometrists to use angerous drugs, is an issue very few people an address based on first-hand knowledge and xperience.

I am one of only three people in Georgia a position to do so. Currently, I am an oph-almologist (M.D.) practicing in Marietta. An phthalmologist is an eye specialist. Prior to ecoming an ophthalmologist, however, I was a optometrist (non-physician).

After completing medical school to be-ome an ophthalmologist and having attended otometry school earlier, I can say without servation the difference in an optometrist's aining and an M.D.'s is overwhelming. The phthalmologist's training is essential to per-orm medical services and to safely use drugs.

I became an ophthalmologist because I anted to be allowed legally to diagnose and eat medical and surgical eye disease. To do requires the use of drugs. As an optometrist was neither trained to use drugs nor did I ed them to perform the services for which I d been licensed.

The training an optometrist receives does ot compare to the training of a medical doc-r. Although optometric training has been mewhat improved since I was a student, it ill remains inferior to that of an M.D. Anyone ggesting that an optometrist is professionally uipped to use serious drugs is playing a dan-rous game with human lives and precious e sight.

The drugs involved in S.B. 20 are power-l. They have no place in the optometry ofession. The public should not be subjected use of the drugs by optometrists who are not ained to practice medicine.

There are no short cuts to medical exper-tise. The same option I exercised is available to every optometrist in Georgia. If an optome-trist wants to practice medicine, that optome-trist should be required to become a medical doctor as I have.

IRVING T. STALEY, M.D.

Opticians Oppose Bill

DUNWOODY—The Georgia Society of Dis-pensing Opticians, which has over 600 state-wide licensed members, strongly opposes Sen-ate Bill 20 which would allow optometrists, who are not medical doctors, to use diagnostic drugs in eye examinations.

Opticians, who are skilled technicians licensed to fit, adjust, and dispense eye glasses from the prescription of an ophthalmologist or optometrist, serve an important and unique role in the delivery of eye care to the public. Because of our position in the area of public eye care, we are compelled to express an opin-ion regarding S.B. 20. Ophthalmologists are medical doctors (M.D.s) who specialize in the treatment and diagnosis of medical and surgi-cal eye disease. Optometrists are not medical doctors. Optometrists are licensed to evaluate the eyes for visual behavior and prescribe glasses accordingly.

The clincial and patient training of an optometrist is unequivocally inferior to that of the ophthalmologist. To allow these non-physi-cians to use drugs which are unnecessary in eye screening examinations poses an unwar-ranted, serious hazard to public health.

Optometrists are not trained sufficiently to treat reactions which can arise in the process of administering drugs; moreover, the public should not be subjected to serious drugs un-necessarily.

The greatest danger to the public should S.B. 20 become law, is mis-diagnosis and delayed recognition of disease. The proper legal role of optometry is not to make specific diagnosis and determine whether a patient is to be treated or not, but to screen for the pres-ence of eye disease in the course of an exami-nation. To do otherwise constitutes the practice of medicine which is not the role of the op-tometrist.

As president of the Georgia Society of Dispensing Opticians, I, along with our state-wide membership, vigorously oppose S.B. 20 in the best interest of public health.

DAVID F. MELDRUM

Letters will be subject to standard editing and must bear the writer's signature and address. Short letters are best. On request the writer's name will be withheld.

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Doctoring the eyes

Public confusion about the distinction between ophthalmologists and optometrists is understandable. Both are called "doctors," although only ophthalmologists actually have medical degrees, and both diagnose and treat eye conditions. But the distinction between the two professions has always been blurred and ophthalmologists fear that a bill allowing Massachusetts optometrists to administer drugs during eye examinations would further confuse the public, lead to missed diagnoses of serious eye diseases and endanger public health.

Optometrists are seeking the legislated right to use drugs, in the form of eye drops, for three kinds of examinations: local anesthetics to aid in measuring pressure on the eye, mydriatics to make the pupil larger and give a better view of the eye's back wall, and cycloplegics to eliminate muscular movements that hamper thorough examinations.

But some of these drugs can be dangerous. In some cases, severe nervous disorders have resulted from examinations in which the drugs have been used. Convulsions are rare but known to occur. Death has also resulted from application of even these mild, surface-applied drugs, although also rarely.

Optometrists argue that they are fully trained today to treat the occasional negative reaction to eye drugs which they wish to use. In Massachusetts, for instance, optometrists undergo four years of schooling after receiving their undergraduate degree, which often is in the sciences. They say that they are taking more drug application training, both in class and in clinics, than is needed for the limited authority they are seeking. They point out that 22 states, including Rhode Island and Maine, have already passed legislation enabling optometrists to apply diagnostic drugs and that serious complications have been negligible.

Nevertheless, serious complications are a possibility and patients have a right to be secure in the knowledge that a medical technique used by a doctor, a paraprofessional, a nurse or anyone else in the health delivery field is safe. They also have the right to know that should a complication arise they will be quickly and properly treated.

The Massachusetts legislation, H6670, has passed the House but received an unfavorable report from the Senate Ways and Means Committee. It is scheduled for a floor vote, possibly today. Senators should be cautious in voting on this legislation because many medical doctors, who are the best-trained authorities in society concerning the application of diagnostic and other drugs, believe the bill contains inadequate safeguards for the public. And where the public's health is in question, the prudent course would be to follow the doctors' advice.

THE POST'S OPINION

Keep Eye Care Standards High

If it does anything in the field of eye care, the Colorado General Assembly should strengthen further the standards of protection against misuse of dangerous drugs in eye diagnosis, not relax those standards to suit the demands of optometrists.

Colorado optometrists are supporting House Bill 1094 in the current legislative session. If passed, the bill would give optometrists the right to use drugs in diagnostic procedures.

Optometrists are non-medical specialists. They test your eyes for refractive errors and measure their focusing powers. They may provide or prescribe glasses and/or exercise to improve sight.

Now, it would be most convenient for them to use a whole host of drugs to dilate, constrict or anaesthetize the pupil. The procedure would be simplified; the patient might get by a bit cheaper.

The word "might" in that sentence is important, however, because the patient also might have his eyesight impaired by use of those drugs. In some cases, death could result.

At present, the use of drugs is restricted to opthalmologists. Opthalmologists are medical doctors who specialize in defects and diseases of the eye.

While opthalmologists may prescribe glasses or contact lenses, there is considerable interplay in their relationship with optometrists. When serious eye problems are suspected, such as glaucoma, the optometrist sends his patient to the opthalmologist.

There are insufficient numbers of the latter to prescribe glasses for everyone who needs them. Both bodies of expertise thus find work; the optometrist offers a somewhat less expensive option for the person simply in need of glasses.

But under H.B. 1094 the optometrists could extend their service by moving into the use of drugs in diagnosis.

There are several things to keep in mind. One is that drugs don't just wash out of the eye. They go into the tear ducts and are absorbed by the body.

Here are some of the drugs available for eye diagnosis:

• Neosynephrine in 10 per cent solution. This concentration is 80 times stronger than the neosynephrine solution used in nasal drops. It can cause a stroke if improperly used.

• Atropine. One drop of atropine in one per cent solution can keep a patient's pupil dilated for 10 days.

• Phospholine iodide. This is a pupil-constricting agent, used in combination with the dilating drugs. Absorbed in the body, this drug can affect the enzyme system and could—in rare circumstances—cause death if used in combination with anaesthetics.

The anaesthetic drugs are valuable in detecting glaucoma because they help in measuring eyeball pressure. Again, they are potentially dangerous and must be handled by experts.

The bill proposed by the optometrists would require pharmacology training. This is not good enough. The optometrist needs only five years of training, three of which are in professional studies. The opthalmologist spends a minimum of 11 to 12 years in pre-med, med school, internship and residency. Obviously, a medical school offers qualitative advantages as well.

The subject is not one for easy answers. One could not object to a move toward parity if training were parallel and equal. But the public needs total protection where the use of dangerous drugs is involved. The standards should remain high; the only question the assembly should ask in the interests of citizen health is this: are those standards high enough?

Albuquerque, New Mexico
February 7, 1977

Editorials • Comment

ALBUQUERQUE JOURNAL

Optometrists Win; People Lose

The top-heavy 7-2 vote by which the New Mexico Senate Public Affairs Committee gave its do-pass to the optometrists' diagnostic medicine bill is cause for alarm; it is to be hoped it is not indicative of things to come.

It was simply a case of lawmakers without medical training passing on the medical qualifications of others without medical training.

If a summer short course can qualify two thirds of the state's optometrists to administer and understand all the possible ramifications of diagnostic drugs, then it must follow that the American people are supporting a grossly overtrained and overly qualified medical profession. The latter, of course, is a conclusion that no one with health problems is willing to, or can afford to, accept.

Sentinel Star
Orlando, Florida
December 10, 1976

Sentinel Star

"Not for its sake alone — but for the sake of society and good government — the press should be free" — James A. Garfield

Orlando, Florida, Friday, December 10, 1976

Eye To Eye On Eye Drops

WE DON'T always agree with physicians. In fact, in our years of reporting local medical society news there have been notable occasions when we differed sharply with what has been called that group's "closed shop" policies.

Physicians can be secretive when it suits them, occasionally indifferent to the point of callousness, and frequently too immersed in their own small world to make an appreciable contribution to communities that support them in styles ranging from comfortable to luxurious.

But we see eye to eye with the Florida Society of Ophthalmologists which seeks to amend a questionable statute the State Board of Optometry claims permits optometrists to prescribe drugs and eye drops.

Ophthalmologists are doctors of medicine or doctors of osteopathy whose training in pharmacology has given them an intimate knowledge of the risks and benefits of drugs administered to living tissue. They have completed medical training, served a supervised internship and residency, specialized and passed their state boards.

Optometrists have had classroom training only in correcting faulty vision through mechanical procedures. They are qualified to prescribe lenses for certain eye deficiencies, but they lack the pharmacology and training to treat diseased tissue.

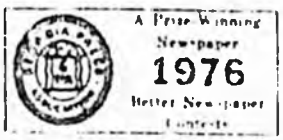
Eye drugs can cure or cripple. They can produce high blood pressure, skin rash, fever and convulsions. They can bring on glaucoma, delirium, mental confusion and blindness. They should be prescribed by qualified physicians exclusively.

Florida ophthalmologists are justified in proposing legislation to restrict their use and the fact that Atty. Gen. Robert Shevin has described the present law as "vague" should alert legislators to its danger.

Augusta, Georgia
January [illegible], 1977

Sunday Chronicle-Herald

"The history of liberty is a history of limitations of governmental power, not the increase of it. When we resist, therefore, the concentration of power, we are resisting the processes of death, because concentration of power is what always precedes the destruction of human liberties." — Woodrow Wilson



Kill Senate Bill 20

The Georgia Society of Ophthalmology and the Medical Association of Georgia are acting in the best interest of the people in their opposition to a measure that could, as they claim, "create physicians by legislation rather than education."

The measure is Senate Bill 20. It deserves defeat. It concerns ophthalmologists — who are physicians, specializing in vision problems, with a minimum of 12 years of specialized training — and optometrists, who examine eyes for glasses and receive only six years of training, none of which is in a hospital setting.

Senate Bill 20 would allow the optometrists to use medications without supervision of a physician, such as an ophthalmologist. It is true that in large institutions such as Veterans Hospitals and the Nation's armed forces, optometrists are permitted to use and dispense drugs. Nevertheless, there is always an ophthalmologist nearby who could handle any emergency arising out of the utilization of the drugs.

Experts say that many of the drugs used in the treating of eye disorders affect the autonomic nervous system, and convulsions, lung and heart irregularies as well as accute glaucoma attacks could arise. A basic weakness in the bill, say foes, is the fact that optometrists are not trained in how to counteract adverse effects of drugs.

We think, in light of this, that if an optometrist wants to legally dispense medications a course of action available to him is one an ophthalmologist already has taken: Enroll in medical school and undergo years of specialized training.

The State

Columbia, S. C.
February 12, 1977

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The Eye Of The Storm

A SEEMINGLY innocuous bill pending before the House Medical Affairs Committee has South Carolina's medical profession in a state of apprehension — and optometrists in a state of anticipation.

At issue is a proposal to amend the existing statute relating to optometrists so as to permit their use of "topical ocular diagnostic pharmaceutical agents" in their examination of eyes. They contend, rather plausibly, that their diagnoses of optical conditions can be helped through the use of certain chemical agents in specific cases.

This contention is meeting vigorous opposition from *physicians* who specialize in the diagnosis, care, and treatment of diseases and other abnormal conditions of the eye. These ophthalmologists, to give them their official medical identification, fear that the general public will suffer if optometrists (who are not trained and licensed as doctors of medicine) are authorized to employ potentially harmful drugs in the examining of eyes.

Both the ophthalmologists and the optometrists readily admit that the two groups play essential, although separate, roles in eye care. Under ordinary circumstances, optometrists who come across indications of eye disease will refer their patients to an ophthalmologist. Conversely, ophthalmologists may refer patients to optometrists when visual needs involve only the prescribing and fitting of lenses, whether conventional or contact.

But they part company with respect to the use of drugs by optometrists. Furthermore, the concern over possible ill effects extends not just to the ophthalmologists but to the entire medical profession, as evidenced by the S.C. Medical Association's recent adoption of a resolution urging the legislature, "for the protection of the people of South Carolina," *not* to allow optometrists to assume the medical functions inherent in the use of drugs.

The State agrees with the physicians of South Carolina in this matter. Without in the least derogating the very useful services rendered by optometrists, we nonetheless feel that medical treatment should be limited to those practitioners who have been medically trained. Eyesight is too precious — and too perishable — to be subjected to ministrations which, however well intentioned, might result in permanent loss or impairment of vision.

Both the ophthalmologists and the optometrists have their hands full in meeting the current demand for eye care. Let us hope they can continue working within their respective fields of preparation and competency as currently defined by law and custom.

Tallahassee Democrat
Tallahassee, Florida
February 7, 1976

Tallahassee Democrat

Malcolm B. Johnson, Editor
William M. Phillips, Managing Editor
W. H. Harwell Jr., General Manager

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4—Sat., Feb. 7, 1976

As our editors see it

Safeguards are needed in eye care business

There is some professional dissent pervading the eye care business.

Dictionary definitions list an optometrist as a practitioner who measures vision and corrects visual defects without the use of drugs or surgery. Florida law, however, puts no prohibition on the profession of optometry. The law defines optometric services "to be the diagnosis of the human eye and its appendages and...determining the refractive powers of the human eyes, or any visual, muscular, neurological or anatomic anomalies ... and the employment of lenses, prisms... and any other means or methods for the correction, remedy or relief of any insufficiencies or abnormal conditions of the human eyes."

This is pretty powerful stuff. Optometry which is a measuring science now sounds like a medical science.

Ophthamologists as medical doctors specializing in the treatment of disease or defects in the eye are understandably concerned over the license given the optometrists by Florida law. They maintain that to "diagnose" the human eye and employ "any means" to correct abnormal conditions is not within the realm of optometry.

They're right. Optometrists serve a need in the community for the measuring of visual inaccuracies and the prescription of corrective glasses. Their training does not include enough pharmacology to safely prescribe drugs, nor enough anatomy to accurately diagnose disease.

Most optometrists are practicing within the logical limits of their profession. They do not attempt to treat diseases of the eye nor prescribe drugs for improvement of eye conditions.

But the potential for jeopardizing health standards is there. The law should be made more specific.

Thus far the legislators have declared that the "professions" should fight it out by themselves. Legislators have also claimed that this isn't their battle, that legislating a more precise definition does not fall within their jurisdiction.

What they neglect to mention is that the state has police powers that may be invoked to provide for the health and safety of its inhabitants. Defining the limits to the profession of optometry will not reduce the effectiveness of optometrists. It will safeguard the profession from the potentially irresponsible actions of a few and promote accurate and effective health care of the many.

Tallahassee, Florida
August 5, 1976

Define professional limits

By COLLINS CONNER
Democrat Staff Writer

When you're sick, do you go to a doctor? More to the point, when you go to a doctor, do you go to a doctor?

The health care field is growing by leaps and bounds. Most of us are confused and disoriented enough trying to weave our way through the physician specialties. What adds to the confusion are other categories of health providers that seem to straddle the fence between medical doctors and other health professions.

Like podiatrists, who aren't MDs but do provide physician services for problems with the feet. Or naturopaths, or osteopaths or chiropractors. None of these are medical doctors, but all provide health care.

They are all allowed to use drugs in their courses of treatment. And under the list of which professionals are allowed to dispense and prescribe their drugs through the services of a pharmacist, they are all included as "practitioners."

* * *

WHETHER OR not the public understands the intricate limits to the practices of these health providers, the providers themselves do. And so too do other professionals whose duties intermingle with these providers.

That isn't the case with optometrists. Not only is the public sometimes confused about the limits to optometry, but other professionals, such as the pharmacists, and even the optometrists themselves interpret those limits in varying ways.

According to the state statute defining an "optometrist," he is able to use any means to examine, diagnose and treat impairments to or disease of the eye.

The optometrists asked the Florida Attorney General's office if that statute gave them the right to use drugs in their diagnosis and treatment.

CONNER
. . . Seeking drug use

And the Attorney General's office replied, "well, the statute doesn't exclude that possibility."

Enter confusion.

* * *

A SOUTH Florida druggist had a prescription telephoned to his store by an optometrist. The druggist informed the optometrist that under the statute governing pharmacists he was not allowed to fill that prescription.

The optometrist said all that had changed. After all, the Attorney General said it wasn't forbidden for the optometrists to prescribe drugs.

So the pharmacist filled the prescription. And in doing so, according to the Florida Board of Pharmacy, the druggist put himself in a precarious position.

Stuck in the middle, the pharmacist's board must make a compromise between a statute that says optometrists can prescribe drugs and a statute that says pharmacists can't fill their prescriptions.

* * *

THE PHARMACISTS are advised to supply the optometrist with medicines he wishes to use for diagnostic purposes, but not to fill prescriptions for medicines needed for treatment of eye problems.

It's as though the druggists must say, "I can give him medicine in general which he may use as he pleases, but if I fill his patient's prescriptions, it will indicate that I am cooperating in the treatment of a patient which will reflect on my liability."

The debate, for the most part, is way past the comprehension and interest of the average citizen. That's the whole point in having the Legislature define professional limits — to safeguard the interests of an unknowing population.

In this case, the Legislature hasn't considered the safety of the public. It hasn't even considered the risks to the professionals involved.

From stupid statutes mighty snafus grow.

Ruidoso News
Ruidoso, N. M.
December 9, 1976

Stuph & Junk

. . . by

Cale Dickey

YOUR EYES AT STAKE

New Mexico's opthalmologists are rankled at optometrists . . . 'cause optometrists are pushing for rights to administer drugs in the treatment of eye disorders . . . which is roughly akin to taking a horse suffering from colic to a farrier for treatment.

Simply stated an optometrist is trained to examine your eyes for defects, to prescribe corrective lenses and to suggest exercise therapy.

An opthalmologist is a medical doctor . . . that's M.D. . . . who took additional schooling to specialize in eye disorders and their treatment . . . and there are the delicate eye operations performed by opthalmologists . . . and while a farrier might correct a limp in a horse, an optometrist isn't licensed to practice medicine, because optometrists don't receive a degree as a medical doctor with their degree in optometry that lets them refer to themselves as "doctor".

A good optometrist is a credit to himself his community and his clientele . . . he does his thing by fitting you with glasses so that you can see well . . . for this service he receives an adequate stipend . . . he's happy . . . and you have good fitting glasses . . . but because a good automobile mechanic can keep your car running smoothly doesn't mean he can fix your clock. And even the best glass eye doesn't do a thing for your peripheral vision.

One Man's Opinion

by

William C. Crane.

Eyes Are Important

An amendment to Code Section 84-1101 is being proposed in the General Assembly. This amendment pertains to you and your eyes, and should be of paramount importance to you the public.

Basically it would allow an optometrist to use pharmaceutical agents for diagnostic purposes if the optometrist has received pharmacological training and accreditation from an accredited institution of higher learning and certification by the Georgia State Board of Examiners in Optometry.

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IT WOULD seem that as written the bill is too vague as to requirements and drugs allowed.

Remember your eyes are your most valuable asset other than your life.

How wonderful to see a blue bird, a sunny spring morning, Jonquils blooming in the twilight, a beautiful girl running down the street, a group of boys playing soccer. The rainbow after the rain, the mountains, valleys and lakes, the ocean at sunrise or sunset. Nothing can surpass the sheer beauty that the eyes convey to your brain.

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THIS WRITER believes in seeing an optometrist for prescription glasses and an ophthalmologist for eye trouble involving the use of drugs or surgery. For your information the following description and training of each profession is printed for your guidance and if after reading this you believe that further thought should be given to passage of this bill, then call your senators and representatives and voice your thoughts.

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"AN OPHTHALMOLOGIST is a primary care physician qualified to provide comprehensive diagnostic eye examinations for both systemic and ocular diseases and the initiation of medical treatment including the prescribing of indicated medication and lenses. He is educated, trained and licensed as a Doctor of Medicine (or Osteopathy) and is the portal of entry for the public into medical care systems. His education usually includes four years of college, plus four years of medical school, one year of internship and 3-4 years of ophthalmology residency, for a total of 12-13 years of basic training."

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"AN OPTOMETRIST is a limited practitioner whose formal education (two years pre-optometry college classroom required study, plus a four year college curriculum in optometry) limits him to testing for vision problems unrelated to disease. Optometrists test depth and color perception and the ability to focus and coordinate the eyes. When necessary, they prescribe and fit lenses. Some are taking additional classroom training in an effort to expand their services into the practice of medicine. Ocular pharmacologists who are M.D.'s testify that classroom training is inadequate and that the trend is a public health hazard."

(Views expressed by our columnists do not necessarily reflect the editorial opinion of the DeKalb New Era.)

NEW MEXICAN Opinion

Santa Fe, N.M., Wed., Feb. 2, 1977

Defeat eye bill

The Senate Public Affairs Committee is scheduled to hear a controversial bill proposed by the state's optometrists which would establish a dangerous precedent in praviding eye care.

The measure, Senate Bill 123 introduced by State Sen. Ray Leger, a Las Vegas Democrat, would permit the state's optometrists to prescribe eye treatment drugs.

The bill is being advanced as a consumer oriented proposal which would reduce the cost of care and make more care available throughout the state. National optometrists organizations have launched a nation-wide push for such measures which have been successful in some states.

The state's opthalmologists - licensed medical doctors - bitterly oppose the bill. They argue that an optometrist, who is not a medical school graduate and who does not have medical training, shouldn't not be permitted to prescribe drugs - in some cases dangerous drugs which can have harmful side effects.

Optometrists counter by saying that they have already received or will receive more than 70 hours of training from optometry schools in the use of these drugs.

In our opinion, it is impossible to compare 70 hours of training from an optomery school to the four years of medical school, one year of intership, and three to four years of opthalmology residency which each opthalmologist must undergo before he can be licensed.

Permitting optometrists to prescribe drugs would build in a false sense of security for many patients which may cause them to ignore or overlook serious problems.

In literature it has been said that the eyes are the windows to the soul. In medicine the eyes are an important window and indicator to how the rest of the body is functioning.

If there is something wrong with a patient's eyes that requires the use prescription medicines, it should be a doctor looking into those eyes, not an optometrist.

The legislature has the responsibility to protect the public's health and safety by defeating this measure.

Santa Fe, New Mexico
February 7, 1977

NEW MEXICAN Opinion

Santa Fe, N.M., Mon., Feb. 7, 1977

Limit eye drugs

Should the New Mexico Legislature enact a vague law which permits optometrists to use certain drugs for diagnostic purposes even though some of those drugs can cause harmful side reactions?

That is the baaasic problem facing the House of Representatives now that the Senate has passed a controversial bill backed by the state's optometrists.

Last week a New Mexican editorial opposed this bill on the grounds that optometrists should not be allowed to treat eye patients with prescription drugs.

This brought out a flock of optometrists protesting that they were not seeking the use of prescription drugs to treat eyes, but were merely asking for the right to use a limited number of drugs for diagnoses.

The version of the bill which passed the Senate last week, was amended to limit optometrists to using these drugs for diagnostic work. Even now there is still debate between optometrists and opthalmologists and their lawyers over what the bill does nor does not permit or the original bill did or did not permit.

Optometrists say they need to use these drugs, for which they have received special training, to dialate eyes and perform more accurate, complete eye examinatmions. There are 17 states which permit optometrists to use these diagnostic drugs. New Mexico's optometrists contend the state's prohibition imposes a financial hardship on state residents seeking adequate eye care.

Opthalmologists counter that the optometrists refuse to be specific on exactly what type of drugs they want to use. Even optometrists admit that some of the diagnostic drugs involved can cause harmful side reactions in some people, although both groups say reactions are rare.

Opthalmologists, who are trained medical doctors, contend that optometrists, who do not have medical training, are not fully prepared to handle these reactions including possible heart and respiratory problems and convulsions.

There is no specific limitations on the drugs which can be used, although optometrists say they do not intend to use all drugs which fall under the category "ocular diagnostic pharmaceutical agents." The final Senate version of this bill is too vague. It should be as specific as possible about what drugs and under what conditions optometrists should be permitted to use.

We repeat our original concern, that some of these drugs can be dangerous, if used on the wrong patient, in the wrong concentrations and under the wrong circumstances. To protect the public's health the legislature has a responsibility to be as specific as possible.

Evening Independent
St. Petersburg, Florida
June 15, 1976

independent thinking

Efficient?

The crack management team that recently gave the City of St. Petersburg such a fine rating for administra-

EVENING INDEPENDENT

Opinion

16-A Tuesday, June 15, 1976

We hope [illegible] nd that of every other [illegible] ing privileges - - got the [illegible] message.

Clear Case

Their position may not be visionary, but Florida ophthalmologists have made it clear: "Diagnosis" of medical eye problems and use of "any means" of treatment are properly the duties of well-trained medical men — not just optometrists.

And most optometrists don't dispute that.

But a few apparently are prescribing drugs for patient eye problems, when chiefly optometrists are to measure vision and correct defects without drugs or surgery.

The Florida law, it turns out, allows optometrists to use "any means" in "diagnosis." Obviously, a further clarification of that statute is in order.

At least, that's how we see it.

Orlando Sentinel Star
Orlando, Florida
June 19, 1976

Sentinel Star
Orlando, Florida

Florida

14A
Sat. June 19
1976

EDITORIAL

Limit Prescription Drug Use

THE FLORIDA Society of Ophthalmology is petitioning the legislature to prohibit optometrists from prescribing drugs in its treatment of eye ailments. Favorable legislative action would nullify a recent decision by the Florida State Board of Optometry allowing use of drugs for diagnosis and treatment of disease by optometrists.

The opthalmologists' petition should receive legislative priority.

We have nothing against the optometric practice of prescribing glasses to correct vision if the affliction is not caused by eye disease. Indeed, one editor doesn't mind admitting she chooses her own reading glasses at McCrory's spectacle counter.

But permanently impaired vision and even blindness can result from drugs prescribed by an unqualified practitioner, and optometrists, whose training is limited to fitting corrective lenses by mechanical means, do not qualify as physicians.

Ophthalmologists, on the other hand, are medical school graduates who have served internships and residencies and have specialized in the treatment of eye disease.

In the interest of public health, prescription drugs should be dispensed at the discretion of physicians only.

ALBUQUERQUE JOURNAL

Robert A. Brown, Senior Editor Gerald J. Crawford, Editor

Wednesday, November 24, 1976

Fences Work Two Ways

The pending legislative confrontation between the medical doctors in the New Mexico Medical Society and the optometrist-members of the New Mexico Optometrical Ass[illegible] the earmarks of a showdown between [illegible]essional closed-shop monopolies.

B[illegible]e we're inclined to side with the [illegible]ety and its members, primarily because health-and-safety risk involved in placing [illegible]nostic drugs in the hands of those not trained in the care of the entire human body and all its parts.

But poetic justice suggests that the optometrists, in their efforts to trespass on the precincts of another privileged sanctuary, should be governed by the same rules with which they have protected their own. No long memory is required to bring back the days when the optometrists enjoyed free rein in New Mexico's legislative halls, even to the point of infiltrating the legislature and, for brief spans, virtually controlling it.

In those days the optometrists were able to impose rules making it a crime for a pharmacist, a jeweler or any other non-optometrist to even look at a pair of eyeglasses. Worse still, they succeeded in imposing and enforcing a muzzle on the free press, prohibiting newspapers and broadcasters in the state's border cities from publishing price-oriented advertisements from optometrists in adjoining states.

The optometrists have worked hard at perfecting the pattern of the professional sanctuary. It would seem only equitable now that they should live within that pattern.

Albuquerque Journal
Albuquerque, New Mexico
November 24, 1976

Jim Bishop

Our Eyes: Only Two For Each Customer

Glaucoma, whether chronic or acute, is treatable. It cannot be cured. The world of medicine has reached a stage where it can stop the threat of blindness in its tracks. It cannot restore sight; merely stop it at whatever level it has attained when treatment begins.

MOST OF US are fairly faithful in having an annual examination. Our brains are imprisoned in fragile structures called the body. Our doctors examine the parts and give us counsel about weight, blood pressure, heart, lungs, kidney function, many things.

He merely peeks into each eye to see if the blood vessels are engorged. He gives it as much attention as his peek into your ears.

An optometrist can prescribe proper glasses. An optician will grind them and fit them. Only the ophthalmologist is qualified to look inside your eyes, study the optic nerves and tell you that your windows on the world are in reasonably good health.

Eyes are rationed. Only two to a customer.

JIM BISHOP, NATIONALLY SYNDICATED COLUMNIST, APPEARING IN OVER 200 NEWSPAPERS, TOTAL CIRCULATION EXCEEDS 20 MILLION

OPHTHALMOLOGIST
WILLIAM F. KINN, M.D.
BRUCE J. WOLF, M.D.
SAMUEL A. McCONKEY, M.D.

OTOLARYNGOLOGIST
RONALD E. TINSLEY, M.D.
RICHARD P. RAUGUST, M.D.
BRUCE G. WHIPPLE, M.D.

PLASTIC AND RECONSTRUCTIVE SURGEON
WILLIAM W. WENNEN, M.D.

EYE, EAR, NOSE & THROAT CLINIC

February 9, 1978

Representative Charlie Parr
Chairman
Health, Education and Social
Services Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Mr. Parr:

This third installment will be devoted to optometric education in the United States and also on the quality of care that the citizen of Alaska might expect from optometrists practicing in Alaska.

OPTOMETRIC EDUCATION

A study entitled, "New Englanders, Their Eyes, And Those Who Profess To Care For Them", by Samuel E. Wallace, PhD (sociology), University of Tennessee, was sponsored by New England Council of Optometrists and funded by the National Institutes of Health (NIH). This study was completed in 1974 and was intended to provide justification for a new optometric college in New England. The report deals with a single school, the "MCO" (Massachusetts College of Optometry), now called New England College of Optometry, which evolved from a private school begun in 1896. The degree O.D. was first conferred in 1951. Today (1970) there are 209 students in four classes. Entrance requirements are a minimum of two years undergraduate college work with at least a "C" average, then four years are required to earn the O.D. degree.

Dr. Wallace evaluated the quality of the students and noted the following (Quotes are direct quotations from the text): 1) All students had two years of undergraduate training with most earning a B.A. or B.S. degree. 2) Only nine of the 209 students had an entrance grade average of B or better; therefore, 200 students were C students (only 4% of the students at this college, then, had a B or better average. 3) Most of the students took premedical or predental undergraduate courses but "had to give up their original aspirations because of their poor grades." 4) The professors "complained that the students refused to do any assigned homework and are immature in their study habits, that they have to be spoon fed." The students "refused to take any initiative in the learning process" and "will learn only what is specifically presented to them in class."

Wallace, too, reviewed the faculty and noted the following: 1) Thirty full-time and 14 part-time faculty members hold degrees varying from O.D. to PhD and M.D. Most, 19, holding an optometric degree alone is their highest academic degree. 2) Several teachers proudly said that some of their courses

1919 LATHROP STREET P.O. 1248, FAIRBANKS, ALASKA 99707, PHONE 456-7767

are "almost as good as the courses given in medical schools." 3) "Faculty members must share and unconsciously reinforce the anti-intellectualism and the inferiority feelings" of the students.

Regarding the quality of courses, Wallace noted: 1) Several of the required courses "repeat knowledge that the students should already have when he arrives. 2) "Many of the courses are conducted basically on the level of a high school or freshman college introductory biology course." 3) The classes are "almost all lectures where the professors simply repeat what's in the text." 4) In a typical pathology course, the practical advice given by the professor to the student, if he recognizes the disease, is to "refer it out." 5) "The classes are characterized by a lot of whispering, sleeping, and general inattention on the part of the students." 6) The optometry students "tend, as a group, to be unimaginative and show a remarkable lack of initiative."

Wallace concludes that the optometric student's education "seems almost as if it is make-work to take up the four years that the Optometric Society has decided should be devoted to the study of optometry for the sole purpose of achieving a social status comparable to that of medicine."

THE CLINICAL TRAINING OF AN OPTOMETRIST

Wallace investigated the optometry students exposure to patients and their problems. This is the nonlecture portion of their training and takes place in the optometric clinic. It is during this period of time that the student gains practical experience in both "visual examination" and, hopefully, some experience in the detection of pathology.

The following points of interest were made by Dr. Wallace: 1) One of the primary problems of the clinics is "a lack of patients." Students are "fortunate to fit a dozen pairs of contact lenses, shared between two students." Students "carry out maybe 25 or 30 complete visual examinations in the course of an entire academic year." 2) The limited time an ophthalmologist spends on call in these clinics indicates "the very few cases of pathology which the optometric clinic sees." 3) "In general, 90% of the patients are between the ages of 15 and 30 years." (It should be noted that this age group has a very low incidence of eye diseases.) 4) The optometry students provide "routine eye examinations rather than investigating pathology." 5) At another optometric clinic, "cases of pathology are so few and far between at the clinic that he (the ophthalmologist) has very little to do." 6)When pathology was suspected, the work-up was improper and the follow-up not documented. 7) Regarding the use of tonometry (measuring the eye pressure for purposes of detecting glaucoma) optometry students have "very little confidence in the tonometry readings." The findings, with respect to readings obtained by the optometry students, "seem to be quite unstable" and interpreted by Wallace as being "worthless."

Even if we ignore the supposed exposure and training the optometry students obtain in detecting pathology, Wallace notes that in the area of visual examinations, "The clinic staff did prescribe spectacles more often than was absolutely necessary." (It would seem that this certainly would increase the cost of health care to the consumer.)

THE PRACTICING OPTOMETRIST

Because of the lower educational requirements, optometrists begin practice generally at a lower age than most other professionals. The average optometrist has been in practice 18 years and, therefore, has the educational standards of 1951. Wallace notes that 80% of practicing optometrists do not have a bachelors degree and 33% do not even have an O.D. degree. Within that 33% group, some have had no formal training. (The average age of the practicing optometrist in Alaska today is 40. On the average, they have been in practice 15 years. The average graduate finished optometry school in 1962.)

Wallace observed the efficiency and competency of an ophthalmic assistant who had only two years of training and contrasted him with a recent graduate of MCO. He noted that only "a few minutes of observation was needed to conclude that the ophthalmic assistant was far superior in all respects."

Wallace continues, recognizing the "incompetent optometrists found among recent graduates, as well as among older ones" in observing the "low and inadequate academic standards at the MCO" coupled with the "poor quality of optometric performance and pathology detection," he suggests "the average level of patient care in the future will deteriorate."

Wallace notes that organized optometry is attempting to establish 10 to 20 new colleges of optometry and that "at a time when we need more ophthalmologists, we are getting more and more optometrists." The current oversupply of optometrists increases "commercial competition", gives "them so little to do that they do even less," contributes to lowering "the income of all practitioners and gives them no choice but to sell spectacles in order to survive."

"Quality is optometry's most pressing need, not quantity." Recognizing the quality of optometry students, Wallace reports that half of the current students "probably should be dismissed before they have a chance to go in to practice."

Wallace suggests that increased communication between ophthalmologists and optometrists would indicate to many optometrists "just how inadequate their examinations now are."

Alluding to the optometric-ophthalmologic conflict, Wallace notes that "optometrists have numbers on their side while ophthalmologists have everything else." "Ophthalmologists should begin now to assert the changes which they too know should be made in optometry."

In summary, Wallace states that with the present underutilization of optometrists, "at least 10,000 vacancies now exist every week in optometrists' appointment schedules" and that no new optometrists are needed in New England for at least three years. In contrast, there is a serious shortage of ophthalmologists and projected growth of ophthalmologic manpower falls far below that required just to maintain the present level of "overutilization."

ON OPTOMETRIC "FACT SHEETS"

You will be seeing so called "optometric fact sheets" and will be hearing optometric testimony as to their capabilities in pharmacology, diagnosis, and pathol-

ogy after approximately 3,500 hours of lectures in clinics and optometry school. According to the Random House dictionary of the English language, pharmacology is the science dealing with the preparation, uses, and effects of drugs; diagnosis is the process of determining by medical examination, the nature and circumstances of a diseased condition; and pathology is the science or study of the origin, nature, and course of diseases. These are all scientific studies associated with general medical studies, and no optometry school is equipped to prepare medical students.

Optometrists will incorrectly imply that their courses in pharmacology compare favorably with those of medical and dental students, but they won't tell you that medical students go far beyond the textbook courses in pharmacology and spend many more hours in courses in therapeutics. This is the application of pharmacologic knowledge to patients with disease and the recognition and management of local and bodily drug reactions. Even pharmacists have never considered themselves adequately trained to evaluate drug dosage or administer drugs. They won't tell you that the average ophthalmologist, in addition to medical school and an internship, has, in a three year residency, spent more than twice the number of hours required in the entire optometric curriculum, devoted solely to ophthalmology lectures and constant clinical exposure to the diagnosis and treatment of disease and surgical problems of the eye.

The fact sheets won't tell you that optometric clinical exposure is almost totally in the realm of examining eyes for glasses and so called "visual training" and that this exposure is very scant in numbers of patient contacts. In optometry school, there is no hospital training whatsoever, nor are optometry students exposed to sick eyes or sick patients.

The Optometric Manpower Resources Projects, published by the United States Department of Health, Education and Welfare in 1976, shows that the median age for active optometrists in this country is 49.4 years; that only 25% of active optometrists in 1973 were under 40 years of age and that 48% were over 50 years of age. This means that about 75% of optometrists practicing today have had little or no exposure, even at the textbook level, to pharmacology and clinical disease diagnosis. Are these the people we wish to entrust with the use of potentially dangerous drugs. Bill 664 would allow this if it were enacted.

Today there are no M.D.'s teaching at two of the nations 13 optometry schools and no full time M.D. professors in any optometry school, according to a catalog study by the Physicians Education Network in December of 1977. In truth, a new accredited optometric school called Ferris State College of Optometry, has no M.D. on their staff in either a full or part-time capacity and only one O.D. If this is an accredited school with the lack of qualified instruction, even at the optometric level, this certainly qualifies as a "diploma mill" in all senses of the connotation. If then this is a diploma mill and is an accredited school of optometry, one must question the validity of the accreditation methods for all of the schools of optometry throughout the United States.

Optometrists also won't tell you that many of them in practice today have only the degree of bachelor of science in physical optics. The O.D. degree originated in independent optometric institutes and is a relatively recent degree in many optometry schools. They won't tell you that under the statutes, optometry is not considered to be one of the "healing arts." They almost certainly won't

tell you that a recent study conducted by the American Board of Ophthalmology and instigated by the federal General Accounting Office, shows not only that we have too few ophthalmologists in this country, but that the number of optometrists presently being graduated is "clearly excessive when compared to the amount of work available to them," and therein lies a key factor in the rapidly developing political efforts of optometry to expand thier capabilities by legislative acts; they need to make work for themselves.

ON OPTOMETRISTS PRACTICING IN THE STATE OF ALASKA

According to figures obtained in February of 1978 from the Department of Commerce, Division of Licensing, there are 38 licensed optometrists in Alaska. Their educational background is as follows:

24 attended Pacific University College of Optometry (1951 to 1976)
5 attended Illinois College of Optometry (ICO)
4 from 1948 to 1960 and 1 graduated in 1977
3 attended Southern College of Optometry
2 attended the University of Houston College of Optometry
1 attended Southern California College of Optometry
1 attended Los Angeles College of Optometry (No longer listed as an optometric school)
1 attended Northern Illinois College of Optometry (No longer listed as an optometric school)
In one case, it is unknown to the Department of Commerce where he went to school.

The following is a summary of pharmacology training at these various institutions.

Pacific College of Optometry has NO M.D., PhD, or anyone with a masters or bachelors degree in pharmacology teaching at that institution.

Illinois College of Optometry, prior to 1960, had NO M.D., PhD, or anyone with a masters or bachelors degree in pharmacology teaching. The one graduate of 1977 may have been taught by one professor in the category of PhD or masters or bachelors degree.

Southern College of Optometry has NO M.D., PhD, or anyone with a masters or bachelors degree in pharmacology teaching at that institution.

University of Houston College of Optometry has NO M.D., PhD, or anyone with a masters or bachelors degree in pharmacology teaching at that institution.

Southern California College of Optometry has NO M.D. teaching in pharmacology; has two instructors listed as either a PhD or masters or bachelors degree.

It follows that at least from all the available evidence, the maximum number of optometrists in the state that had any pharmacology training from any qualified instructor at all, is two; one from the Illinois College of Optometry who graduated in 1977 and the one graduate of Southern California College of Optometry. It appears that the maximum number of optometrists in the state that had any pharmacology training from any M.D. or M.D./PhD in pharmacology is zero.

The maximum number of optometrists in the state that had any instruction at all from any full-time M.D.on the staff of the school is zero.

The maximum number of M.D.'s in even a part-time capacity on the staff of any school attended by 37 of the 38 optometrists in Alaska, is two. From a survey of the Blue Book of Optometry which was last issued in 1976, it appears that the maximum number of members of the State Board of Optometry that even have a bachelors degree from any school is two of the six board members that are listed. It would seem reasonable that there would be an ophthalmologist either in the teaching or in the clinical aspect of optometric education, but it appears from the available evidence, that the maximum number of optometrists currently practicing in Alaska that had any full or part-time instruction, either by lecture or in the clinical setting by an ophthalmologist, is zero.

Please find enclosed a study compiled by the Educational Catalog Study Committee of the South Carolina Ophthalmologic Society in December of 1977, entitled, "Who Teaches Optometrists Medicine." The data that I've previously described can be substantiated from this chart, as well as other quite interesting points including faculty/student ratio as compares with three southern medical schools. The Comments section is particularly important when it shows what the position of the M.D.'s on the staff of any of these schools participated in. It should be noted that I completed by ophthalmology residency in 1975 at the Medical University of South Carolina College of Medicine.

Sincerely,

Sam A. McConkey, M.D.

SAM:ls

cc: Representatives: M.F. Beirne
Don Bennett
Fred E. Brown
Thelma Buchholdt
C.V. Chatterton
Samuel R. Cotten
Steve Cowper
Alfred C. Nakak
Al Ose
Randy Phillips
Sarah J. Smith
Leslie E. Swanson

WHO TEACHES OPTOMETRISTS MEDICINE?

CURRENT SCHOOL CATALOG STUDY COMPARES FACULTIES AT SEVERAL TYPICAL MEDICAL AND DENTAL SCHOOLS WITH FACULTIES AT *ALL* OPTOMETRY SCHOOLS IN THE U.S.

MEDICAL COLLEGES	Total # of Students	Total # of Faculty	Faculty/ Student Ratio	Total # of M.D. Professors (Full or Part Time)	Full Time Clinical* Teaching M.D. Specialists	OPHTHALMOLOGISTS (M.D. Eye Specialists)			PHARMACOLOGY DEPARTMENT		O.D.s	O.D./Ph.D.	Other Ph.D., M.S. or B.S.	COMMENTS
						Full Time	Part Time	M.D. Residents	M.D.s - M.D./Ph.D.	Ph.D., M.S. or B.S.				
Medical University of South Carolina College of Medicine	660	1,281	1.9	651	201	3	23	9**	6	25	0	0	630	* *CLINICAL* — Refers to working with patients in hospitals or out-patient clinics. ** Ophthalmology Residents spend 3 months during their 3-year residency in an intense basic science course taught by nationally prominent Ophthalmologists at Colby College, Waterville, Maine.
Duke University College of Medicine	489	1,102	2.3	632	483	8	10	16	2	7	0	0	470	
Medical College of Georgia	720	944	1.3	495	246	3	10	8**	2	10	0	0	449	
DENTAL COLLEGES														
Medical University of South Carolina College of Dentistry	160	312	2.0	74	0	0	0	0	6	25	0	0	123	84 D.D.S. teaching mostly Clinical 9 are D.D.S., Ph.D.
Medical College of Virginia College of Dentistry	439	353	.80	33	0	0	0	0	8	20	0	0	127	126 D.D.S. teaching mostly Clinical 20 are D.D.S., Ph.D.
COLLEGES OF OPTOMETRY														
Southern College of Optometry	604	49	.08	2 PART TIME	0	0	0	0	0	0	37	2	7	The 2 part time M.D.s are classroom lecturers in Pathology.
Illinois College of Optometry	600	56	.09	1 PART TIME	0	0	0	0	0	1	47	1	6	The only M.D. is a part time Lecturer in Pathology.
Pennsylvania College of Optometry	552	89	.16	5 PART TIME	0	0	2	0	0	1	55	4	17	
Southern California College of Optometry	384	83	.22	5 PART TIME	0	0	2	0	0	2	65	5	8	
Pacific University College of Optometry	340	23	.07	1 PART TIME	0	0	0	0	0	0	12	1	8	The only M.D. is a Professor of Physics and Optics, part time.
New England College of Optometry	332	66	.20	4 PART TIME	0	0	2	0	0	1	52	5	4	
University of Houston College of Optometry	284	64	.23	2 PART TIME	0	0	0	0	0	0	47	4	7	The 2 part time M.D.s are Classroom Lecturers in Pathology.
Indiana University College of Optometry	276	38	.14	0	0	0	0	0	0	0	21	4	11	No M.D.s on Staff.
Ohio State College of Optometry	228	63	.28	1 PART TIME	0	0	1	0	0	0	46	4	12	The only M.D. is part time. He lives 100 miles away in Cincinnati.
University of Alabama College of Optometry	160	48	.30	3 PART TIME	0	0	0	0	1	0	22	9	12	All M.D.s are part time classroom lecturers. One M.D./Ph.D. lectures in Pharmacology.
State University of New York College of Optometry	160	122	.76	9 PART TIME	0	0	6	0	0	0	87	3	22	
University of California Berkeley College of Optometry	256	77	.30	9 PART TIME	0	0	6	0	0	0	43	11	12	One part time M.D. teaches in Public Health, one in Engineering and one in Physiological Optics
Ferris State College of Optometry	100	31	.31	0 PART TIME	0	0	0	0	0	3	1	0	29	All but 2 of these 29 also teach in the Biology and Chemistry departments of the Undergraduate College.

STUDY THE CHART : CAN MEDICAL EYE CARE BE ENTRUSTED TO OPTOMETRISTS WHEN THIS STUDY PROVES THAT THERE ARE *NO* FULL-TIME M.D. INSTRUCTORS IN ANY OPTOMETRY SCHOOL ANYWHERE?

Study Compiled for PEN Inc. by the EDUCATIONAL CATALOG STUDY COMMITTEE OF THE SOUTH CAROLINA OPHTHALMOLOGICAL SOCIETY

OPHTHALMOLOGIST
WILLIAM F. KINN, M.D.
BRUCE J. WOLF, M.D.
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OTOLARYNGOLOGIST
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PLASTIC AND RECONSTRUCTIVE SURGEON
WILLIAM W. WENNEN, M.D.

EYE, EAR, NOSE & THROAT CLINIC

1919 LATHROP STREET, P.O. 1248, FAIRBANKS, ALASKA 99707, PHONE 456-7767

February 10, 1978

Representative Charlie Parr
Chairman
Health, Education and Social
Services Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Mr. Parr:

It is appropriate that in this installment, the medical community's views on the use of medications and the potential hazards of same be discussed.

DRUGS AND DRUG CARE

Optometrists claim that the drops they propose to use are necessary and innocuous and the health care system will thereby be expanded. This is a spurious claim. The health care system will not be expanded and the rural areas will not be served by allowing nonmedical people to dilate pupils to look for disease which they are not trained to diagnose. Death or serious disability can be caused by an untrained person overlooking a tumor, early glaucoma, or a detached retina in a nonmedical attempt at "diagnosis." Diagnosis is (by definition) the determination of the presence or absence of disease and, if present, a determination of its nature. Optometrists are not able to make this medical determination because it is not within the scope of their training. By contrast, legally limiting the profession of optometry to the area of activity in which they are trained to function, will not reduce their effectiveness. It will help safeguard their whole profession from the potentially irresponsible action of a few and will promote the health of the public.

The use of cycloplegics, mydriatics, topical anesthetics, and miotics by optometrists nonmedically trained, as called for in Bill 664, could be extremely dangerous. These drugs cover an extremely broad range of action. Some can produce serious systemic side effects or surgical emergencies which require immediate recognition and treatment. Also, since these drugs are often used for treatment, rather than as diagnostic aids, in the hands of the nonphysician, they could be subject to abuse. Cycloplegics paralyze the muscle within the eye which controls focusing of the lens; mydriatics dilate or enlarge the pupil of the eye; topical anesthetics are drops which numb the lining membrane of the lids and outer eyeball; miotics make the pupil smaller and are used in the treatment of glaucoma. In passing, it should be stated that at no place in the drug formulary does the Food and Drug Administration suggest that miotics are to be used for any diagnostic purposes. This is a quite obvious additional reason why Bill 664 is a sham for therapeutic use of drugs.

ON THE DANGER OF DILATING DROPS

In some instances, dilating drops can cause acute glaucoma which may then be a surgical emergency or at least require intensive medical treatment. An optometric "fact sheet" just being circulated, widely claims that this does not occur. This is just not true. Any ophthalmologist in active practice has seen drop induced acute glaucoma. In susceptible individuals, cycloplegics and mydriatics can produce a wide variety of complications, can aggravate existing heart problems, or may even produce toxic mental disorders or coma. Children are particularly susceptible to these eye-drops and often become cranky, sleepy, or even delirious while waiting in the office. Action to remedy this must be immediately available and can't wait on referral to medical help elsewhere. I always have on hand emergency medical equipment, such as oxygen, airways, and oral and injectable drugs to handle unforeseen emergencies. No optometrist is capable of this medical response. There is no justification for optometrists to want to use mydriatics or cycloplegics. Until very recently, they opposed ophthalmologists use of cycloplegics in refraction of the eyes and labeled it in one of their little bulletins "a cruel test" that produces "an abnormal state for examining the eye for glasses." If they want these drugs to better look into the interior of the eyes, it is truly a sham because most optometrists have not been trained in peripheral retinal examinations. Symptoms calling for this type of evaluation, such as floaters and flashes of light, are fairly specific and deserve prompt referral to an ophthalmologist. New, small pupil ophthalmoscopes will enable the optometrist to see more clearly into the inside of the eye, and they do not require the use of dilating drugs. The more common eye diseases, such as diabetes, evidence of high blood pressure, glaucoma, optic nerve injuries, edema, or swelling of the optic nerve due to brain tumors, and infections commonly presenting in the back part of the eye can all be diagnosed quite adequately without the use of any dilating drops.

ON THE SIDE EFFECTS OF MIOTICS

Miotics are a large group of drugs of varying properties and actions which are used chiefly in the treatment of glaucoma. They are not diagnostic aids and while certain miotics may be used in one kind of glaucoma, their use in another kind of glaucoma may be wrong. In glaucoma caused by inflammation, all miotics may be contraindicated. Side effects of many miotics are common, often serious, and require an absolute appreciation of high blood pressure, coronary heart disease, circulatory and respiratory collapse (shock), and the way one drug may react with other drugs that the patient may be taking. Only an ophthalmologist can appreciate the consequences of these side effects.

ON TOPICAL ANESTHETICS

Ophthalmologists use topical anesthetics in certain tests to measure the pressure within the eye. This is called tonometry; one test used in determining if a patient has glaucoma. We also use topical anesthetics for minor surgical procedures. New air puff tonometers and others which do not require

anesthesia are more than adequate to satisfy the optometrists' desire to screen a patient for glaucoma. These non-drug methods, coupled with examination of side vision and looking at the optic nerve through normal size pupils, provide adequate data to the optometrist with regard to the possible presence of glaucoma. The final diagnosis and treatment of the glaucoma must rest with the ophthalmologist.

In downgrading the risks of adverse reactions to anesthetic drops, optometric "fact sheets" often refer to medical reports out of context or use authorities with the title "doctor" who are not M.D.'s and who do not personally participate in the day to day eye care of real live people. This is especially significant when the so called authorities are PhD's teaching in optometry schools' or are faculty members of schools of public health whose doctorates are often in vital statistics or health systems planning.

Dr. William Havener, Professor of Ophthalmology at Ohio State, is frequently quoted as an authority who denies existance of toxic effects to topical anesthetics. Yet the item to which optometric fact sheets refer, namely Dr. Havener's repert of the relative lack of a toxicity to a single dose of benoxinate in 1,000 patients, fails to explain that this is only one of many available types of anesthetic drops.

Dr. Havener, a strong opponent of optometric drug legislation, in his recent book, "Synopsis Of Ophthalmology" on page 430, states that "the surface active anesthetics are often relatively toxic and severe systemic reaction may result from applications of excessive amounts of topical anesthetics. Healing the corneal epithelium (outer cell layer) is markedly slowed by topical anesthetics which inhibit cell metabolism and growth...also, local allergies may develop (which may be) recognized by red and swollen eyelids accompanied by itching."

Dr. Robert P. Burns at the University of Oregon Medical School, echoed Dr. Havener's concern in "A Synopsis On Occular Pharmacology And Therapeutics," published by C.V. Moseby Company. He warns that "severe hypersensitivity reactions with corneal clouding have been described after the use of topical proparacaine."

There have been documented examples of patients requiring corneal transplants because an optometrist had illegally provided them with a bottle of proparacaine for pain relief after the optometrist had illegally performed a minor surgical procedure on the cornea. He didn't have the foggiest notion that these drops were potentially dangerous, so when the patient complained of increased pain, he just told the patient to use the drops more often. This, of course, further damaged the cornea.

Even an article in the American Journal of Optometry and Physiologic Optics in November of 1977, stated that "adverse drug reactions are potentially serious and becoming increasingly common."

At a meeting of the New England Ophthalmologic Society in Boston, a symposium devoted to toxic reactions to eyedrops, such as those which optometrists seek legislative approval to use through Bill 664, revealed that mild to severe reactions to these drops in office practice are seen by all ophthalmologists and

often require immediate medical care.

I'm offering to the committee a copy of the 1977 Physicians' Desk Reference for Ophthalmology. This lists, among other drugs, all the approved topical anesthetics, cycloplegics, mydriatics, and miotics, along with the literature required by the FDA that must accompany each bottle of drops or tube of ointment. This includes the possible side effects of each medication. The book also lists systemic medications which can have adverse effects upon the eye, something only the physician can appreciate.

Bill 664 is the more illogical for assuming that a hurry up lecture course in pharmacology, whether in optometry college or in an optometric meeting, could render the optometrist capable of using drugs, especially when the bill places in the hands of the Board of Examiners in Optometry the right to determine the educational and professional competence of its own practitioners. How can members of a board, who themselves have never had training in the use of drugs and the diagnosis of disease, be given the power to pass on the qualifications of their own people in these medical areas.

Ophthalmologists in Alaska have long been well aware of the fact that Alaskan natives have a particular predisposition to a condition known as narrow angle glaucoma. This condition or predisposition in the native population is more than just occasional, and I can assure members of this committee that if optometrists are allowed the unrestricted use of drops that dilate the eye, that they will increase the morbidity among this group of patients to an alarming degree. The ultimate health costs are going to be astronomically increased because of the surgery fees that are going to be required to solve the problems created by the narrow angle glaucoma cases that we will have necessity to operate on. This is a most important consideration, and if anything, the problem in the preceding paragraph has been understated.

Optometrists have recently claimed that the use of drops would provide increased benefits to the patient and aid in earlier detection of eye disease. The fact is, that since the origin of their profession, optometrists have taken pride in and proclaimed their ability to measure the eye, fit glasses or contacts, and refer the patients whose vision deviates from normal for medical evaluation and care, all without the need to use eyedrops. All aspects of eye examinations and vision care, for which optometrists are trained, have been and can continue to be performed without the use of drugs. The noncontact air puff tonometers permits screening of intraocular pressure to detect the possibility of glaucoma without the need to use anesthetic drops. Topical anesthetics, mydriatic, or miotic drops are not required for the fitting of eyeglasses or contact lenses. External defects of the eye can certainly be recognized without the use of eyedrops. Defective vision not correctable by refraction and visual field defects indicative of internal eye or nervous system disorders, can easily be detected without the use of drops. Optometrists are adequately trained to recognize the many symptoms which indicate a need for medical referral. They are not trained in medical diagnosis and, therefore, have no real need to use so-called "diagnostic drops." It is misleading to the legislature and to the

public to imply that any drug is purely diagnostic. The classes of drops optometrists are seeking to use for "diagnostic purposes" are, in fact, used for therapeutic purposes in the evaluation and treatment of eye diseases.

Thank you again for your time in reading this material.

Sincerely,

Sam A. McConkey, M.D.

SAM:ls

cc: Representatives: M.F. Beirne
Don Bennett
Fred E. Brown
Thelma Buchholdt
C.V. Chatterton
Samuel R. Cotten
Steve Cowper
Alfred C. Nakak
Al Ose
Randy Phillips
Sarah J. Smith
Leslie E. Swanson

OPHTHALMOLOGIST — OTOLARYNGOLOGIST — PLASTIC AND RECONSTRUCTIVE SURGEON

WILLIAM F. KINN, M.D.
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WILLIAM W. WENNEN, M.D.

March 20, 1978

Representative Al Ose
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Re: House Bill 664

Dear Represertative Ose:

I have taken the liberty of writing to Representatives Cotten, Nakak, and Phillips on some points I felt needed clarification following the hearing that you chaired on House Bill 664 during mid March. I hope you can have these letters made available to you.

I would ask you to consider now the fact that dilating drops are not needed to diagnose 99% of the pathologic disease processes associated with the eye. They probably are not necessary for the remaining 1%, if an adequate history is taken from the patient. With the exception of ophthalmology, medical practitioners across the United States evaluate millions of patients a year in the course of yearly physical examinations which include examination of the eyes without the use of drops. They first check your vision (in which no drops are needed) and then look into your eyes with an instrument called an ophthalmoscope. If they can't see in well, it means that there is a reason (e.g., cataract, blood, or corneal scar) that needs referring to an eye physician (ophthalmologist). However, barring this, they can see quite well into the back of the eye and competently diagnose, or at least suspect conditions, such as diabetes, high blood pressure, blood vessel disease, leukemia, optic nerve disease, and a multitude of other various and sundry disease processes that effect not only the eye but the entire body, all without drops. They simply don't need to use them, so they don't use them.

Neurologic disorders, including brain tumors, blood vessel disease in the brain, and multiple sclerosis, are regularly diagnosed by a good history from the patient (no drops are needed) and by a visual field examination in which drops are contraindicated.

Drops don't diagnose, people diagnose! You can't educate a drop, but you can educate people.

A major point was made that drops made it simpler to diagnose refractive errors (the need for glasses) in children. I wonder how optometry has performed this function for all these many years in the past? The truth is that historically, optometry has been denied the use of medications because they were not trained to use them and they have developed excellent ways to

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determine these needs in children without drops. Ask them what "fogging technique" means. This is the mechanism by which they refract young children and do a quite excellent job at it without using any medications at all.

Please don't consider a compromise position on this legislation. Vote against House Bill 664.

Thank you for your time in reading this letter.

I remain, sincerely,

Sam A. McConkey, M.D.

SAM:ls

OPHTHALMOLOGIST
WILLIAM F. KINN, M.D.
BRUCE J. WOLF, M.D.
SAMUEL A. McCONKEY, M.D.

OTOLARYNGOLOGIST
RONALD E. TINSLEY, M.D.
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BRUCE G. WHIPPLE, M.D.

PLASTIC AND RECONSTRUCTIVE SURGEON
WILLIAM W. WENNEN, M.D.

March 20, 1978

Representative Alfred Nakak
Alaska State House of Representative
Pouch V
Juneau, Alaska 99811

Re: House Bill 664

Dear Representative Nakak:

Although you could not attend the testimony on House Bill 664, allow me to correct some misinterpretations that you may have heard. Roy Box, optometrist from Juneau, said he had dilated thousands, probably 10,000 native patients and never seen a case of narrow angle glaucoma. As you are aware, there are approximately 35,000 native Alaskans residing in Alaska, and probably no one in the state, save Dr. Milo Fritz, M.D., with his 30 years experience, could have had this type of exposure to our native residents. Nevertheless, it has been documented by the Alaska Native Health Service, as well as by independent U.S. and foreign researchers, that there is an extremely high incidence of this problem in Alaska. Optometry says the incidence is 1 in 18,400 - the truth is, in Alaska native adults, the incidence is 1 in 1,900. At the Alaska Native Health Service Hospital in Anchorage, there are not three operations a year or per month, but three operations for narrow angle glaucoma per week. It is further documented by the Alaska Native Health Service that the incidence of this problem in Alaska natives is 18 times that of caucasians. Dilating drops cause narrow angle glaucoma attacks - even optometry agrees with this.

Please don't compromise the eye care available to all Alaskans. Vote to defeat House Bill 664.

I remain, sincerely,

Sam A. McConkey, M.D.

SAM:ls

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OPHTHALMOLOGIST | OTOLARYNGOLOGIST | PLASTIC AND RECONSTRUCTIVE SURGEON

WILLIAM F. KINN, M.D.
BRUCE J. WOLF, M.D.
SAMUEL A. McCONKEY, M.D.

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RICHARD P. RAUGUST, M.D.
BRUCE G. WHIPPLE, M.D.

WILLIAM W. WENNEN, M.D.

EYE, EAR, NOSE & THROAT CLINIC

March 20, 1978

Representative Sam Cotten
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Re: House Bill 664

Dear Representative Cotten:

It was, needless to say, a real education for me to have had the opportunity to see and participate in the legislative process before the House HESS Committee last week. It would appear that you and your colleagues are daily presented with well prepared arguments for and against issues that you, as representatives, must decide upon. This task, obviously, is much more difficult if the legislation concerns technical or professional issues with which you may be unfamiliar. It's unfortunate that House Bill 664 is before you as a legislative action. Issues such as this should be handled medically and obtain appropriate certification rather than by legislative fiat. We are not in the political arena because we want to be, we are in it because medicine is clearly being maligned at the expense of the public health. We did not bring this proposal to you, optometry did. On behalf of the ophthalmologists (medical doctors), let me make quite clear that this is in no way "special interest legislation," in the usual sense. The medical community, and in this case ophthalmology in particular, is the most informed segment of the community at large to present to our elected officials the facts. One wouldn't ask a fuel oil dealer for information on how to build an oil pipeline and expect that this would be the best advice one could obtain.

As you are well aware, this is the fourth year of such effort on the part of organized optometry to pass such a bill in legislatures across the country. Until 1974, there were only eight states where optometrists were using drops for "diagnostic purposes." Six of these eight states had statutes that were inadequate, i.e., did not address the question of drug use (Florida, Indiana, New Jersey, Idaho, Minnesota, and Nevada). Optometry took this to mean that drugs were not prohibited, and so they have been using drops in these states. In 1974, a nationwide effort was undertaken, the effects of which have now reached us.

Ophthalmology was not ready for it and before it could get its "act together," a well funded and aggressive optometric effort got this legislation through several states, among them were California where an early multimillion dollar effort in this "always the first" state succeeded. Oregon passed this legislation by one vote in a legislature whose senate was presided over by an optometrist. It, however, failed in Washington before ever being admitted as formal legislation.

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In 1977, "diagnostic drug bills" passed in five states (Montana, Wyoming, New Mexico, North Carolina, and Kansas), while it was defeated in seventeen states. Four of these states were "rural states," the main thrust of optometry being an unequal distribution of ophthalmologists and optometries; thus, our addressing this problem before your committee. No states thus far this year have had such bills made law. It has been defeated in four states this year (Georgia, Missouri, Mississippi, and South Dakota).

The trend should be quite evident - defeat at the rate of four to one in states where there has been an informed legislature and public. I hope this may answer the question of what other states are doing. I must admit to philosophical differences in this approach, but I understand the reasons for doing it.

Please don't consider a compromise position on this legislation. Vote to defeat House Bill 664.

I would appreciate your passing this on to the other HESS Committee members. I plan to write a letter on the topic of Alaska natives to Representative Nakak soon, and I would hope that he will have copies made for you.

Sincerely,

Sam A. McConkey, M.D.

SAM:ls

OPHTHALMOLOGIST
WILLIAM F. KINN, M.D.
BRUCE J. WOLF, M.D.
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PLASTIC AND RECONSTRUCTIVE SURGEON
WILLIAM W. WENNEN, M.D.

March 20, 1978

Representative Randy Phillips
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Re: House Bill 664
Optometric Drug Bill

Dear Representative Phillips:

I have taken the liberty of writing letters on topics brought up by various members of your HESS Committee during the March 13 - 14 hearings, to those committee members involved. I hope you can have these letters that were sent to Representatives Cotten, Ose, and Nakak made available to you.

Allow me, please, a few minutes of your time to set the record straight on PEN. This movement was organized in 1977 to counteract the overwhelming position that medicine was faced with, that is, optometry's well funded invasion into the practice of medicine. The map that was referred to was only for the year 1977, that is so stated on the page. I consider this a poor ill-advised move on the part of optometry for them to consider you could not see through this. I do not apologize for PEN. I would like to quote the PEN statement of purpose: PEN exists solely to utilize its resources and combined influence to present, promote, and promulgate through communication outward and communication inward these simple truths: The American people must be protected by placing and keeping health care in the hands of experts whose abilities are established by having reached a standard level of medical education.

The logical minimum level of education necessary for leadership to protect the public in shaping the optimum health care delivery quality standards in the United States is the degree of doctor of medicine or osteopathy, earned at a school of medicine or osteopathy at an accredited institution of higher learning.

The government at every level should cooperate with medicine in establishing these health safety standards.

Membership in PEN is available to any law-abiding citizen who subscribes to these truths and desires to be informed, as well as to participate, in informing the public at large.

Please find enclosed several issues of PEN for your perusal. They will fit well with the copy given to you by the optometric leader.

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One appropriate question is, what would ophthalmology do if it had a choice? The answer is, we would do what the final witness for optometry did - he is an employee of Dr. Ken Richardson, M.D., an ophthalomogist from Anchorage, Alaska. This young man from Israel is exceptionally well trained and has been on the periphery of medicine for some time. He does very specialized studies under the guidance of Dr. Richardson and performs an excellent service to the patient. He has a cousin who is a nationally known physician educator in the field of ophthalmology, Dr. Arnold Patz, Baltimore, Maryland. Yet, he knows full well his limitations and capabilities - he testified that "if something is wrong, I don't care what it is." By his choice and his alone, he prefers to work with an ophthalmologist rather than be on his own in a separate optometric practice. The perfect solution, as he is well aware and in which he concurs - witness his current position.

My medical group, the Eye, Ear, Nose, and Throat Clinic of Fairbanks, Alaska, has hired an optometrist who will be working with us beginning this fall. This is not public knowledge due to his fear that if it were known what he planned to do, i.e., work with an eye physician, he would not pass the optometric state board test for licensure in Alaska. We respect his position.

Please don't consider a compromise position on this legislation. Vote against House Bill 664.

Sincerely,

Sam A. McConkey, M.D.

SAM:ls

Hold for Bill HB 633 HB 664

JOHN J. EUFEMIO, M.D., F.A.C.S.
BOX 907
KODIAK, ALASKA 99615
TELEPHONE 486-4191

February 22, 1978

Mr. Terry Gardiner
Chairman House Judiciary
Mail Stop 3100 Pouch H
Juneau, Alaska 99811

Dear Mr. Gardiner:

Please record my support for Bill #633. I have been a physician in Alaska for fourteen years and feel that optometrists should have the capability to use diagnostic pharmaceutical agents. I have been practicing with an optometrist in my office for several years and feel that they can diagnose eye conditions at least as well, if not better, than the average family physician and make appropriate referral. I[illegible]al areas, often optometrists are the only consultative [illegible]e available, and I personally find the optometrist shar[illegible] my office extremely useful.

Sincerely,

Dr. John J. Eufemio, M.D.

cc: Mr. Charles H. Parr

HB 664

Kodiak Professional Building

BOX 1727 KODIAK, ALASKA 99615

March 4, 1978

RE: H.B. 664
Parr Hess
Gardiner H J Com.

Gentlemen:

I am writing in favor of modifying the Statutes under which Optometrists practice in this state. As I understand the situation this bill permits optometrists to utilize certain medications in the eye for diagnostic purposes. This to me, seems a very reasonable proposition.

I realize that there are counter arguments to this position, primarily from physicians specializing in ophthamology. However, in the State of Alaska, especially in rurual areas where apparently any irregular practitioner wishing to practice medicine does so, it seems ridiculous to place restrictions on a group of reasonably trained optometrists.

Sincerely,

Michael Emmick, M.D.

ME/ns

cc: Chairman of House Health Education & Social Services
Chairman House Judiciary Committee

Member file
HB 664

The
ALASKA OPTOMETRIC ASSOCIATION

AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

April 21, 1978

Representative Terry Gardiner
Chairman
House Judiciary Committee
Pouch V
Juneau, Alaska 99811

Re: House Bill 664

Dear Representative Gardiner:

I know you have already received some information concerning House Bill 664 and I am writing, of course, to urge your committee's approval of this legislation with one amendment. I would urge your committee to delete the amendment included by the Health, Education & Social Services Committee, page 2, lines 13 & 14. This amendment was put in the bill by Representative Mike Beirne and represents the desire of organized medicine to gain control of all health care professionals not under their wing. The reason for this is, of course, economic. No other legislature that has passed this kind of legislation has seen fit to have an ophthalmologist as a member of the optometric board, but attempts have been made to place these amendments on bills such as this in other states in order to get their foot in the door and hopefully eventually take over and reduce my profession to the status of a physician assistant. I am sure you are aware that this is not a new argument and has been going on since optometry began emerging as an independent profession in the early 1900's. The American Medical Association has gone so far as to pass a resolution in a convention that they held in Seattle some time in the 1950's condemning optometrists as cultists and making it unethetical for any physician to teach or offer knowledge to any practitioner or school of optometry. This resolution has been rescinded as a result of a threat of a law suit, but it has been the attitude of medicine that no other than physicians, who are not controlled by the economics of medicine, shall have so-called medical knowledge. The result has been of course that independent health care providers have gained their own expertise in their particular area of health care and are now well established and optometry and dentistry are two of the primary examples of this kind of educational evolution. My profession is also rapidly growing and is in the process of developing five new schools to add to the somewhere around thirteen or fourteen that now exist in the United States as compared to the medical profession which has a much

larger number of schools than optometry but who also have only five new schools developing. Every new optometry school that has been developed is a result of a tooth and nail battle with the state ophthalmological and medical societies, again as a result of their worry of competition.

It's sort of like climbing a mountain that is tipped backwards and I'm sure that you can well imagine that my profession has earned its status as the third largest health care providing profession in the United States and must have something to offer when you consider the old struggle that has and will continue to go on as we continue our legitimate attempt to keep pace with modern techniques and knowledge.

There has been no argument to the concept that 95% of the care provided by ophthalmologists is also equivalent to the care provided by optometrists with only 5% left in the absolutely medical realm.

Considering this fact, a physician can provide vision care services with only a medical license and I am reasonably sure that there are no areas in a test for a medical licensure that covers the provision of vision care. I am also reasonably sure that very little of the certification examination for ophthalmology, which is a national board, covers much on vision care provision. The placement of an ophthalmologist on the optometry board is an attempt to establish a precedent which has no real value when you consider the stated function of licensing boards is to protect the public and has nothing to do with one profession attempting to subvert the other. Again, amongst the 15 to 18 other states that have passed this type of legislation recently, none have seen fit to put a physician of any scope on the board of examiners in optometry and conversely optometry has not asked to have one of their members serve on the medical examiner's board, even though physicians can provide whatever care they see fit with no test for qualifications in the vision care area.

Reams of testimony have been presented by the medical associations and its various members purporting to show optometrists are not qualified to handle and utilize these agents in their practice. Claims have been made that optometrists are going to prescribe these agents for treatment of disease and are vastly enlarging the scope of the services they already provide. None of these even approaches the truth. It is not the intent of the Alaska Optometric Association to seek to treat eye disease through this legislation and it clearly states so in the bill. It is also not the intent of the Alaska

Optometric Association to enlarge its scope of practice. These agents will be used in procedures that are already in use by optometrists throughout the nation and most of the free world and merely provide the optometrists to choose more and in some cases more accurate instrument to screen patients for eye pathology and to upgrade his provision of vision care services to certain selected patients. It is our belief that with the use of drugs that dilate the pupil we will be able to earlier detect eye disease and, therefore, make better and more treatable referrals to eye physicians. The drugs that are used to numb the front of the eye will enable the optometrist to use a wider range of instruments to screen the patients for glaucoma, again for referral to the proper medical practitioner. The instrument that is widely used and readily available now is absolutely not portable and, therefore, limits the optometrist's ability when he is holding clinics outside of his own offices, which approximately 70% of the practicing optometrists in Alaska now do.

The drops that make the pupil smaller are intended for emergency treatment of glaucoma that could be induced with the pupil enlarging drug. This drug was added to the classes of drugs enacted in Oregon for use by optometrists at the request of Oregon physicians; so it is also included here. There is a conservative 15 year's worth of optometric experience using these agents in the P.H.S. and military doctors in Alaska and not one case of glaucoma has been induced, so you can see that the chances are extremely remote.

Optometrists are just as liable for detection of disease as are physicians and HB 664 will also help protect the doctor and patient from this possibility. I am enclosing a 1971 definition by Elliot Richardson of optometry that recognizes optometric training and sets out the responsibilities of optometrists in caring for their patients.

If you do not feel you or a member of your committee cannot amend HB 664 removing the eye physician from the optometry board, I would like to suggest a couple other approaches. The legislature would mandate a committee of 3 persons, an optometrist, a pharmocologist and ophthalmologist to be recruited by the optometry board to act as an advisory group to determine qualifications of optometrists and recommend specific drug lists; or a physician recommended by the Alaska Optometric Association be appointed to the board instead of an ophthalmologist.

Dr. Craig has asked me to comment on your letter concerning a mutual agreement between optometry and medicine. I was President of the Alaska Optometric Association in 1971 and invited every ophthalmologist in the state to attend our annual meeting as my guests so there would be no registration or other costs to them. Most did not give me the courtesy of a reply, some replies were too unprofessional to pass on, and only one man attended and was told not to return or he may have problems. I see no change in this isolationist attitude. I hope you can realize that the first move in this direction was made by my group in 1971 with a slap in the face response. Hopefully this attitude will change some day, but I hope the poor relations of our two organizations will not interfere with a definite improvement in services optometrists could provide with the passage of HB 664.

Sincerely,

Roy A. Box, O.D.
Chairman, Legislative Committee
Alaska Optometric Association

RAB:rs
Enclosure

ELLIOT RICHARDSON, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION AN WELFARE, FILLED A 1971 REPORT WITH THE PRESIDENT AND CONGRESS ON ADMINISTRATION OF THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT.

The report contained the following language concerning optometry:

> "Optometrists are trained to detect any departure from the optimally healthy eye. The scope of optometric services has expanded beyond basic clinical refractions, fabricating and dispensing eyeware; now included are visual screening examinations, clinical intrumentation, contact lens fitting, visual training, orthoptics, low-vision aids for the partially sighted, artificial eyes, industrial vision consultation and public and community health. The most rapidly expanding area of service is in school consultation and remedial services for low achievers. The optometrist is trained and bound by professional ethics to refer patients in whom indications of disease have been found to a physician or other health practitioner for definitive diagnosis and appropriate medical surgical or other treatment."

Oregon V

Rep. Gardner.

This is the moderate reply I received and I did not ask him to speak, merely attend. He did the same thing all physicians do; jumped to the conclusion that optometrists treat eye disease which is in error.

THOMAS J. HARRISON, M.D.
Diseases and Surgery of the Eye
825 L STREET, SUITE 501
ANCHORAGE, ALASKA 99501
Telephone 277-4151

May 26, 1971

Roy A. Box, O.D., President
Alaska Optometric Association
Juneau, Alaska

Dear Dr. Box:

I appreciate your request to speak at the annual Alaska Optometric Association Convention in Fairbanks, June 9th to the 11th. Other commitments make it impossible for me to participate in the meeting however; I am interested and concur with your suggestion that optometrists and ophthalmologists develope a more cooperative relationship. I am also anxious to correct a misunderstanding as to the type of information I would be able to offer if attendance at your a meeting were possible. The recognition, diagnosis and treatment of specific eye pathology is the responsibility of the physician. To speak of specific eye pathology would therefore, not be particularly pertinent. However, the appropriate conditions and timing of referrals from optometrists to ophthalmologists is pertinent and of extreme importance. It is this subject to which I would have addressed my comments.

All sub-normal visual acuities that do not have a physician confirmed diagnosis must be referred promptly. Once an

established diagnosis is made and all possible routes of treatment have been explored and the condition has been proven stable, then the continued care of the patient falls within the realm of optometry. All suspected asymptomatic pathology found should also be referred. It is of importance that disease entities, even those entities which have a rather predictable course such as cataracts, should be promptly referred to a physician. For example, referring of a cataract for surgical treatment several years after its initial discovery by the optometrist is not acceptable. Many cataracts are secondary to serious retinal pathology. Examination at an early stage, when the early cataract still allows for adequate retinal examination, will prevent missing serious pathology. Another example, in point, is squints. Strabismus cases need to be evaluated by an atropine refraction some time along the line of their treatment. It is also important to definitely establish that the squint is not caused by a sixth nerve palsey or other serious disease entity. HB 884 would permit this procedure by optometrists we already routinely check for this now paralysis etc.

Once a referral is made to an ophthalmologist from an optometrist and a diagnosis made and treatment instigated it is the duty of the ophthalmologist is to acknowledge the referral by letter and if the patient so desires return him to the optometrist for refraction.

Thank you again for the offer to participate in your annual convention. I believe that the above paragrpahs adequately summarize the remarks that I would make.

Sincerely yours,

Thomas J. Harrison MD

Thomas J. Harrison, M.D.

file HB 664

DR. JOHN T. SHANK
OPTOMETRIST
P. O. BOX 827
KODIAK, ALASKA 99615

TELEPHONE 486-5504

April 19, 1978

Mr. Terry Gardiner
Chairman House Judiciary
Mail Stop 3100 Pouch H
Juneau, Alaska 99811

Dear Mr. Gardiner:

As a member of the Optometry Board of Examiners, I would like to voice my concern about an amendment made by the HESS Committee to House Bill #664.

The amendment to put an ophthomologist on the Optometry Board is not justifiable. Ophthomologists are well trained in surgery and pathology of the eye, but they have no optometric training. It would make as much sense to put an optometrist on the Medical Board to determine their competency. If this amendment is allowed to stand, I would recommend that the above be done.

The bill as written before this amendment was added was a worthwhile piece of legislation.

I hope that you and your committee will see fit to do justice to this bill.

Thank you for your time and patience.

Sincerely,

John T. Shank O.D.

Members file HB664

April 20, 1978

Representative Randy Phillips
Pouch V
Juneau, AK 99811

Dear Rep. Phillips:

Thank you for your letter concerning HB 664 in which you asked my opinion relative to the commitee substitution. The placing of an ophthalmologist on the optometry board raises serious objection from me.

While ophthalmology deals with diseases of the eye and performs surgery upon the eye, optometry is the only profession specifically licensed in the United States to deal with human vision and related visual problems. Optometry does not need to be policed by a related but distinctly different profession.

The optometrist has spent four years training for his profession. All thirteen optometry colleges now include a comprehensive study of pharmocology. The pharmacological curriculum (enclosed) is accepted by The Association of Schools and Colleges and is similar to that taught to medical students.

Modern technology has made sophisticated diagnostic equipment available, but their value to the patient diminishes when the law disallows them to be used in conjunction with diagnostic pharmaceutical agents. The optometrist's ability to view a larger portion of the eye with the use of these drugs, will result in the earlier detection of eye diseases. Of course, early detection will result in the early referral to an ophthalmologist.

Recent graduates from optometry colleges are now specifically tested in the use of diagnostic drugs by the state boards. Having passed this exam, they should not require policing from another profession. I find that none of the other states which have passed this drug legislation have an ophthalmologist sitting on their boards.

I hope I have answered the question for you. Please let me know if I can furnish any further input.

Respectfully,

Ed Craig, O.D.

cc: Box, Gardiner
encl.

ASSOCIATION of SCHOOLS and COLLEGES of OPTOMETRY

SPECIAL ISSUE OF ASCOPE

Vol. 2 Number 9 June 6, 1975

Pharmacology Curriculum Guidelines for Continuing Education Courses

Prepared by the Council on Academic Affairs of the Association of Schools and Colleges of Optometry, Richard Hazlett, O.D., Chairman

These guidelines have been prepared for distribution throughout the optometric profession and education system.

Before final adoption of these guidelines, consideration was given to comments received from a wide professional audience.

Adopted
March 13, 1975

Guidelines for Pharmacology Continuing Education

I. Purpose: To establish guidelines for continuing education courses in pharmacology for practicing optometrists.

II. Course objectives: to increase the optometrist's knowledge of:
- A. the systemic effects of systemic medications from a mechanistic, diagnostic and therapeutic standpoint,
- B. the ocular effects of systemic medications from a mechanistic, diagnostic and therapeutic standpoint,
- C. the ocular effects of ocular drugs from a mechanistic, diagnostic and therapeutic standpoint,
- D. the systemic effects of ocular drugs from a mechanistic, diagnostic and therapeutic standpoint, and
- E. diagnostic ocular pharmaceutical agents (DPA) --- theory and practice.

III. Guidelines for the course content.

- A. General Pharmacology
  - 1. Principles of Drug Actions
    - a. Dosage forms
    - b. Routes of administration
    - c. Pharmacodynamics
      - (1) absorption
      - (2) distribution
      - (3) fate (metabolism)
    - d. Mechanisms of action
      - (1) agonists and antagonists
      - (2) receptors and acceptors
      - (3) synergism, additivity and competitive antagonism
  - 2. Host Factors and Placebos
  - 3. Drug Categories (to include adverse ocular and systemic effects)
    - a. Neuropharmacologic agents
      - (1) anesthetics
      - (2) CNS depressants (general)
      - (3) effects of drugs on synaptic transmission
      - (4) major and minor tranquilizers
      - (5) antidepressants
      - (6) CNS stimulants (general)
      - (7) analgesics (selective CNS drugs)
    - b. Cardiovascular agents
      - (1) hemopoietics
      - (2) antihypertensives
      - (3) anticoagulants
      - (4) cardiac glycosides
      - (5) antiarrhythmics
      - (6) vasolidators

c. Renal agents
d. Gastro-intestinal agents (especially anticholinergics)
e. Endocrine drugs (including steroids and the birth control pills)
f. Antiallergic agents
g. Antibiotic-chemotherapeutic agents.
h. Antifungal agents
i. Disinfectants
j. Vitamins
k. Antiviral agents
l. Cancer chemotherapeutics
m. over-the-counter (OTC) agents

4. Drug abuse
5. Drug contraindications during pregnancy

B. Ocular Pharmacology
1. Principles of Drug Actions
a. Dosage forms
b. Routes of administration
c. Pharmacodynamics
(1) absorbtion
(2) distribution
(3) fate (metabolism)

2. Drug Cateogries, to include adverse ocular and systemic effects, and
a. Neuropharmacoligic agents (autonomics)
(1) review of nervous systems
(2) autonomic drugs
((a)) sympathomimetics
((b)) parasympathomimetics
((c)) sympatholytics
((d)) parasympatholytics
(3) ocular anesthetics
b. Agents affecting trans-membrane fluid transport
c. Antibacterial agents
d. Antinflammatory agents
(1) antihistamines
(2) steroids
(3) sympathomimetics
(4) parasympatholytics
e. Antiviral agents
f. Antifungal agents

3. Differential Diagnosis of Ocular Neuromuscular Disorders
4. Review of Ocular Side Effects of Systemic Drugs
5. Review of Systemic Side Effects of Ocular Drugs
6. Review of Ocular Side Effects of Ocular Drugs
7. Ocular Urgencies and Emergencies, including glaucoma management
Contraindications During Pregnancy
Urgencies and Emergencies
tice and Jurisprudance

IV. ctivities

1. patient history
   a. Medical history
   b. Patient's current drug regimen, and the effects of these drugs on ocular structure and function
2. Sterile technique--proper instillation of "drops"
3. Refractive examination and fundus examination
   a. pre-medication procedures
      (1) advice to patients (effects of DPAs)
      (2) tonometry
      (3) angle evaluation
   b. Application of mydriatic/cycloplegic and related examination procedures
   c. Post-medication procedures
      (1) corneal examination
      (2) tonometry
      (3) advice to patient (i.e., return of pupil to normal, etc.)
   d. Diagnostic techniques and instrumention
      (1) tonometry, including Goldmann applanation
      (2) angle evaluation with the biomicroscope, including gonioscopy
      (3) stain analysis
      (4) monocular and binocular fundus examination, including indirect ophthalmoscopic and biomicroscopic procedures
4. Clinical competency

A. comprehensive examination procedure will be established to evaluate each student as to his skill and competency in the use of DPAs and relevant instrumentation, and

B. the effect of systemic medication on ocular structure

C. the effect of ocular instillations on systemic sturcute and function.

JUN 9 1975

Editor's view

FUNDUS PHOTOGRAPHY

Twenty-two states now permit optometrists to use pharmaceutical agents in diagnosis. This authorization has opened up many new vistas of examination heretofore unavailable to O.D.'s. One of these, retinal photography, is explored in this issue.

Previously, office photography in optometry was limited to contact lens fitting, strabismus records, and the like. With mydriatrics and with advanced equipment technology, optometrists can avail themselves of fundus photography and compile patient records of internal normalities and abnormalities.

Complete and comprehensive records are the best defense against malpractice suits. What better way to prove that you viewed a patient's fundus than by taking a photograph of it! And what better practice management is there than to show a patient what the retina of his eye looks like.

Fundus cameras are rapidly becoming important tools of the modern optometrist. They will soon take their place with biomicroscopes as basic equipment in the practice of optometry.

This month we carry an important article on the management aspects of fundus photography written by a relatively new O.D. who has made the technique an important part of his practice. You may find after reading it that this is an area that you too should embrace.

Irving Bennett, O.D.

18 other states (1.) unmet public need - inadequate care
(2.) use drugs is not risk free
(3.)

Original sponsor: Commerce Committee

Offered: 4/14/78
Referred: Judiciary

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR HOUSE BILL NO. 664

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the practice of optometry."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.72.300(2) and (3) are amended to read:

(2) "optometry" is the employment of means or methods [, OTHER THAN THE USE OF DRUGS,] for the diagnosis of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription or application of lenses, prisms or ocular exercises for the correction or relief of the human eye;

(3) "practicing optometry" means the diagnosis [, BY MEANS OR METHODS OTHER THAN THE USE OF DRUGS,] of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription of lenses, prisms or ocular exercises for the correction or relief of the human eye, or the holding of oneself out as being able to do so;

* Sec. 2. AS 08.72 is amended by adding a new section to read:

Sec. 08.72.305. USE OF DRUGS FOR DIAGNOSIS. (a) No person practicing optometry may use drugs for diagnostic purposes unless he has

(1) passed the board's examination on the subject of pharmacology as it relates to optometry and the use of topically applied drugs; and

(2) completed courses and clinical experience approved by the board and offered by a recognized and accredited school or college of optometry and passed an examination, given by that school or college, which relates to topical application of drugs to the eye,

(b) No person practicing optometry may administer drugs except for

including proper responses to reactions which may result to topical applications to the eyes.

recognition of pathology and diagnosis of a vision anomaly.

(c) Topical anesthetics, mydriatics, and cycloplegics may be used by a person practicing optometry under conditions approved by the board; the board may authorize the use of myotics for emergency purposes only.

* Sec. 3. AS 08.72.020 is amended to read:

Sec. 08.72.020. MEMBERSHIP OF BOARD AND TERMS OF OFFICE. The board consists of five persons, appointed by the governor. Members serve staggered terms of three years. [THE TERMS OF THE PUBLIC MEMBERS OF THE BOARD SHALL BE SET SO THAT THEY DO NOT EXPIRE AT THE SAME TIME.]

* Sec. 4. AS 08.72.040 is amended to read:

Sec. 08.72.040. QUALIFICATIONS. Three board members shall be licensed, practicing optometrists who have been residents for at least three years. <u>One shall be a licensed physician, board certified in ophthalmology.</u> <u>One shall be a person who has</u> [TWO SHALL BE PERSONS WHO HAVE] no direct financial interest in the health care industry.

Introduced: 1/19/78
Referred: Health,Education &
Social Services and Judiciary

IN THE HOUSE BY THE COMMERCE COMMITTEE

HOUSE BILL NO. 664

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(b) No person practicing optometry may administer drugs except for

a diagnostic purpose.

(c) Topical anesthetics, mydriatics, cycloplegics and myotics, may be used for diagnostic purposes by a person practicing optometry under conditions approved by the board.