HB

79

RESEARCH AND BACK-UP ON HB79

STATEMENT ON SB 75/HB 79 FOR THE

ALASKA OPTOMETRIC ASSOCIATION

by

Boyd L. Walker, O. D.

My name is Dr. Boyd L. Walker. I am a licensed optometrist in Alaska and have been in full-time practice in the state since 1973. I am a member of the Alaska Optometric Association and the American Optometric Association.

I appreciate the opportunity to speak with you today regarding HB 79, SB 75, which pertains to the use of diagnostic pharmaceutical agents (DPAs) by qualified and licensed Doctors of Optometry.

As in any argument, there are two sides to the situation, and given the abilities of statisticians and researchers today one can find supportive evidence for any point of view on practically any subject one might wish to consider. That being the case, and since I feel that this issue is of utmost importance to the consumer of vision care in this state, I am going to state my case using only one reference. By doing so I hope to avoid the confusion and suspicion which may be created by using a myriad of references of possibly questionable integrity. This reference, which I shall place at your disposal should you wish to peruse it, is an independent report to the Congress of the United States, compiled by the U. S. Department of Health, Education and Welfare in July of 1976. This report was not in any way sanctioned by the optometric community, quite the contrary it was an investigative effort on the part of H.E.W. to determine what part an optometrist should play in the delivery of eye health care today. I believe that as elected representatives of the public, you each have a commitment to your constituents to make a decision based upon substantiated fact rather than upon emotion, heresay, or unfulfilled wishes of any special interest group. It is with that in mind that I present to you the following information.

I would like to begin by giving you a definition of the scope of optometry which is excerpted directly from page 21 of the H.E.W. Report to the Congress.

> "The institute of Medicine of the National Academy of Sciences, in describing primary health professions who are direct providers of patient care, defined optometry as follows: "The Doctor of Optometry (O.D.) is a health professional who performs eye examinations to determine the presence of visual, muscular, or neurological abnormalities, and prescribes lenses, other optical aids, or therapy, such as eye exercises to enable maximum vision. Optometrists are trained to recognize disease conditions of the eye and ocular manifestations of other diseases, and to refer patients with these conditions to the appropriate health professional."
>
> This definition, as well as available documentation on the utilization of optometric services, points to the optometrist's role as a provider of primary health care services. In this role, the optometrist functions as a principal point of contact within the health care system for persons having visual complaints, including certain numbers who have symptoms or conditions that require referral to other health practitioners."

As this points out, optometrists have an ability and a responsibility to recognize and refer pathological conditions of the eye. The diagnostic pharmaceutical agents which we are asking to use in this bill are nothing more than tools which will enhance our ability to discover possible pathology and refer the patient to the proper medical authority.

At this point I must stat that it is not the intent of optometrists to use these drugs indiscriminately on all patients, but rather only upon those patients in which it cannot clearly be determined that a pathological condition does not exist. The exception to this being the use of corneal anesthetics in the measurement of intraocular pressure. Our law as it now exists prevents the optometrist from using these agents which ophthalmologists use for the exact same reasons. This clearly limits the optometrists from doing that which he is ethically and legally bound, i.e. assuring that those

patients he sees have been screened for eye disease using the highest level of technology available today.

It has been argued that Optometrists do not have the professional training to allow them to administer diagnostic agents to their patients. Some would even argue the obvious and say that optometrists are not trained to detect pathological conditions of the eye. On page 95 of the H.E.W. Report to the Congress is found the following description of optometric education:

> "All optometry schools share certain basic curricular elements which follow at least two years (and for the majority of students four years) of undergraduate studies, predominately in the biological sciences.
>
> The basic elements include:
>
> - A biological science component.
> This includes gross and microscopic human anatomy, general human physiology, biochemistry, and pharmacological principles, all presented with emphasis on the visual system and related structures.
>
> - Physiological optics.
> Vision processes, visual stimuli, accommodation mechanisms, neurophysiological mechanism, ocular motility, binocular perception.
>
> - Pathology.
> Essentials of bacteriology and virology, principles of health and disease, tissue changes in pathology, ocular diseases and abnormalities, ocular manifestations of systemic disease.
>
> - Optics.
> Light, Lenses, optical systems, ophthalmic materials.
>
> - Professional orientation (health practice).
> Epidemiological procedures, the epidemiology of specific disorders, health care organization, public health, interpersonal relations, management of practice.
>
> - Clinical skills.
> Patient history, refraction, visual performance measurement, detection and diagnosis of visual anomalies and visually-related learning and perceptual disturbances, low vision rehabilitation, care of the aging patient, contact lens fitting.

A more complete listing of this common subject matter is found in attachment B to this Section. The catalogues of the schools provide stil' more detail."

Following is a copy of Attachment B, Section 1; I would like to call your attention to subsections (h) and (i).

ATTACHMENT B

BASIC ELEMENTS OF THE CURRICULUM OF SCHOOLS OF OPTOMETRY

1. Biological science knowledge base.

   a. Gross human anatomy and microscopic anatomy, with emphasis on head, neck, and thorax.

   b. Embryology, gross and microscopic anatomy of the human nervous system - concentrating on the central nervous system.

   c. General human physiology, including the study of the fundamental organ systems and the mechanisms which regulate body function. Emphasis is on the sensory, motor and cardiovascular systems.

   d. Basic concepts of general and cellular biochemistry, with study of nomenclature, structure, and reactions of organic molecules. Emphasis is on the visual system - tears, intraocular fluids, lens, retinal photochemistry, and actions of drugs upon these.

   e. Concepts of human genetics and genetic disorders, including the frequency and distribution of genetic disease, inheritance patterns, polygenic inheritance, chromosomal abberration syndromes, multifactorial genetics, and principles of genetic counseling.

   f. Gross and microscopic anatomy of the lids, orbit, orbital content, globe, muscles, nerves, and vessels, and embryology of the eye.

   g. Vegetative physiology of the eye, extraocular and intraocular fluids, corneal and lens metabolism, ocular circulation, retina and optic nerve metabolism.

   h. General pharmacological principles, methods of administration, various systemic drugs and their pharmacological action and side effects with emphasis on those that affect the visual system, such as cataractogenic and glaucoma-producing drugs.

   i. Pharmacology; uses, doses, contraindications, and adverse effect of drugs producing miosis, mydriasis, cycloplegia, accommodation, and ocular anesthesia. The pharmacology, use contraindications, and adverse effect of drugs commonly used in treating visual and ocular problems.

As you can see there is no shortage of educational opportunity for the optometrist to become well acquainted with human ocular conditions as well as the uses, contraindications, and side effects of the use of pharmaceutical agents.

To further demonstrate this very important point regarding the quality of the education which optometrists receive on the subject of pharmacology. I would like to read the testimony given before the Oregon State Legislature by Dr. Ronald H. Winters, Assistant Dean, and Associate Professor of Pharmacology and Toxicology at Oregon State University. Before reading this, I would like to clarify Dr. Winters' title. He is a pharmacologist, any by definition is one who studies drugs in all their aspects. From pharmacologists all health care professionals, including ophthalmologists, derive information regarding all aspects of drugs. See the following pages for his testimony.

School of Pharmacy
Oregon State University
Corvallis, Oregon 97331 (503) 754-3725

29 January 1975

In studying and evaluating the proposed legislation authorizing the use of diagnostic pharmaceutical agents (DPA's) by optometrists, three principal questions have emerged relative to my areas of expertise as an educator specializing in curricular design and as a pharmacologist: 1) is the overall curricular design utilized by the College of Optometry at Pacific University appropriate for the education and training of optometrists to use DPA's in their practice; 2) is the specific curricular component concerned with pharmacology appropriately constructed; 3) from the perspective of a pharmacologist, is the use of DPA's by optometrists a safe procedure likely to result in an overall improvement in patient care?

In the course of my efforts over the past three years to coordinate the redesign of the professional curriculum of the School of Pharmacy at Oregon State University, I have had considerable occasion to review the curricula of a large number of health profession schools, both in Oregon and elsewhere. Further, as my own graduate training in pharmacology was conducted largely at the University of Oregon Medical School in Portland, I am especially familiar with the curriculum of that institution, with emphasis on the pharmacology component. Finally, I have participated in a number of national and international meetings of professionals concerned with curricular design and implementation in many of the health-related fields. In comparing the curriculum of the College of Optometry at Pacific with the curricula of other health profession

schools utilizing a pharmacological component, I am convinced the approach developed by Pacific is both efficient and effective, and is clearly educationally sound. Moreover, that structure includes what I consider to be the sine qua non of proper instructional design--the competency of the graduate is evaluated in a series of prescribed and standardized formats (i.e., institutional, Oregon State Board of Optometry, and national board examinations) prior to the awarding of a license to practice. Thus, individuals who may have succeeded in passing individual courses but who have not adequately integrated the body of knowledge as a whole are not permitted access to the public as professionals. This safeguard, in my view, is instrumental in protecting the public, the institution, and the profession, and should stimulate your confidence in the proposal at hand.

Examination of the pharmacology component of the curriculum has also led me to a favorable conclusion. It is clear that the student is well-prepared for his first exposure to courses dealing with DPA's and other drugs, and is carried through this portion of his coursework in an effective manner. It is my judgment that a program designed to prepare practitioners to utilize DPA's must rest on a sound didactic base, capped by supervised clinical experience in the use of the agents in question. I feel strongly that a quality didactic base is offered at Pacific, and that passage of the proposed legislation will quickly result in the implementation of an appropriate clinical component as already outlined by the school.

The question of the relative safety and productivity of the proposed procedures must be addressed, and in my view, these two issues cannot be rationally separated; that is, neither safety nor efficacy are unidimensional characteristics, but instead are interrelated as a cost/benefit ratio or in medicine, a therapeutic index. Three important considerations relate to the expected safety in the use of DPA's by optometrists: 1) what agents are to be used; 2) what doses of these agents are to be employed; 3) how will these agents be administered? The four principal

categories of DPA to be used are miotics (agents that constrict the pupil), mydriatics (agents that dilate the pupil), local anesthetics (substances that reduce feeling in the cornea), and cycloplegics (agents that alter the ability of the eye to focus on near objects). The most salient pharmacological feature of these compounds is their relatively short duration of action, generally measured in minutes. If nothing else, this characteristic itself tends to minimize the likelihood of an adverse reaction simply because the drug is effectively inactivated by the body in relatively short order. Secondly, the doses to be utilized in diagnostic procedures are indeed very small. Using one to two drops of solutions of one-half to two and one-half percent strength in each eye provides the patient with a total dose far less than is obtained in many over-the-counter cold remedies readily available to the patient on only his/her discretion. Thirdly, by limiting the administration of these compounds to the topical route (dropped in the eye), it is not likely that more than twenty percent of the total dose will be absorbed into the blood for general circulation in the body. At that concentration level, these agents are essentially devoid of pharmacological activity. When coupled with the virtual absence of reported adverse reactions in states where this practice is common, one cannot help but conclude that the use of DPA's in the format proposed is extremely safe.

How much benefit is to be derived from this practice is, as I've said, the other side of the coin. In my judgment, the judicious use of DPA's will permit a substantial increase in the ability of the optometrist to detect potentially harmful diseases of the eye. By allowing this health-care professional to examine the patient more completely, the optometrist will be in a better position to refer to physicians (ophthamologists, internists, pediatricians, and family practitioners) those patients requiring further diagnosis and possible treatment. In view of the established fact that optometrists serve as the primary eye-care professionals for a majority of the population, it is apparent that the anticipated gain for the patient is large.

It would appear, therefore, that a near optimal situation prevails here: the proposed use of DPA's by optometrists is clearly both very safe and likely to be most effective in patient eye care. Further, it is evident that considerable planning has been conducted by the College of Optometry at Pacific, and that the school is ready, capable, and indeed has already begun providing educationally sound classroom instruction in the use of diagnostic pharmaceutical agents, with implementation of actual clinical instruction awaiting legislative approval. Thus, with the cost/benefit or therapeutic ratio a very favorable one to all parties concerned, I respectfully encourage the swift passage of the proposed legislation.

Ronald H. Winters, Ph.D.
Assistant Dean
Associate Professor of
Pharmacology and Toxicology

I would like to explain that Dr. Winters refers to Pacific University in his statement because it is the only optometry school in the Northwest, and therefore the one with which he has had direct experience. As the information I presented earlier indicates, all optometry schools provide similar training. It is apparent from his testimony that Dr. Winters realizes a potential risk involved with the use of any type of drug, but that with proper training this risk is far outweighed by the potential benefit to the eye care patient.

Finally and most importantly, as Dr. Winters mentioned, this bill limits the use of these DPAs to those individuals who can demonstrate by passage of a licensing examination that they are indeed capable of judicious use of the drugs. One such test of an individual's knowledge in this area is the National Board of Examiners in Optometry examination. This is a national examination which consists of eight separate subjects, one of which is Ocular Pharmacology. A discussion of this examination begins on page 91 of the H.E.W. Report to the Congress. This test will soon be a prerequisite to the taking of the Alaska State Board examination for licensure.

I am sure that much more can be said regarding the use of diagnostic pharmaceutical agents by optometrists. I have tried to avoid all but the crucial questions which are: (1) Does an optometrist have a responsibility to detect pathology of the human eye in the course of an examination? (2) Does an optometrist have an educational background that will allow him to safely administer these drugs to his patients? I feel that the answer is undeniably YES.

Apparently the consultants who collaborated to make the H.E.W. report possible, as a result of their extensive investigation of optometry reached the same conclusion. The following is excerpted from the RECOMMENDATIONS AND ADDITIONAL CONSIDERATIONS OFFERED BY STUDY CONSULTANTS of the H.E.W. Report to the Congress, page vii, second paragraph:

> "During the course of the study effort, a number of additional issues and concerns were identified by the expert consultants which, although important considerations, represent matters not directly responsive to the specific legislative charge as interpreted by the Department. These recommendations and comments, made unanimously by the consultants, are presented here to provide an opportunity to bring these matters to the attention of Department Agencies and the Congress. Because the following items go beyond the requirement of this report, the Department has not fully examined them and makes no recommendation at this time.
>
> 6. ...
>
> e. Joint development of appropriate revision to State licensure laws to permit use of diagnostic drugs (mydriatics and local anesthetics) by optometrists.
>
> While such joint endeavors are evident in various areas of the country, they need to be broadened and routinized."

At the present time 24 states have identified the need for the use of DPAs by optometrists, and to date there have been no reported incidences of malpractice arising from the use of these agents. Furthermore, no state which now permits the use of diagnostic pharmaceutical agents by optometrists has yet seen evidence that would convince them that this is not in the best interest of the public.

I therefore urge you to support Senate Bill 75 and House Bill 79 for the good of the people of Alaska.

Thank you for gi ing your consideration to this very important piece of legislation.

USE OF DIAGNOSTIC AGENTS

By

OPTOMETRISTS

in the

UNITED STATES ARMED FORCES

All three branches of the military, either in regulations or at local hospital options, require or allow optometrists to utilize diagnostic agents to aid them in their examinations.

1. UNITED STATES AIR FORCE

   Optometrist AFM 36-1 (C13)
   2. Duties and responsibilities
      a. "Conducts examinations of eye with or without the use of diagnostic drugs,". (enclosed)

2. UNITED STATES NAVY

   Change # 57 of U.S. Navy Medical department manual gives optometrists the right to use drugs for taking intraocular tension.

3. UNITED STATES ARMY

   (local Army post option)
   Ex. Modification of regulations providing for the optometric use of diagnostic drugs at the U.S. Army General Hospital, Fort Gordon, Geogia. "to include use of diagnostic drugs such as mydriatics, cycloplegics, and topical anesthetics". (enclosed)

OFFICER AIR FORCE SPECIALTY

OPTOMETRIST

★1. SPECIALTY SUMMARY

Conducts examinations of eye to determine visual efficiency and performance by means of instrumentation and observation; prescribes corrective procedures; and applies knowledge of optics and physiology to research and teaching activities.

2. DUTIES AND RESPONSIBILITIES

★ a. *Conducts examinations of eye:* With or without the use of diagnostic drugs, examines eye to ascertain presence or absence of defects or visual anomalies which can be corrected, remedied, or relieved by use of lenses, prisms, orthoptics, contact lenses, or other ophthalmic devices. Performs external and internal examination of the eyes and refers suspected and detected pathology to the appropriate medical specialties. Determines refractive errors such as myopia, hyperopia, or astigmatism and prescribes appropriate treatment for these and other visual problems. Ascertains through clinical tests, range of vision and ability and ease with which eyes maintain clear, comfortable, binocular vision at any distance of fixation.

b. *Prescribes treatment to conserve or improve vision:* Prescribes appropriate lenses to correct various errors of refraction. Prescribes and administers orthoptic or visual training in those instances where such procedures are indicated, as in ocular muscle imbalances, fusional problems, and as an adjunct in treatment of strabismus. Refers for medical treatment or surgery, those cases characterized by disease or injury. Examines and tests lenses for proper workmanship and conformance to prescription.

c. *Conducts research:* Plans and conducts research in broad areas of clinical optometry and physiological optics; such investigative studies to include, among others, physical standards, protective and corrective eye wear, examining methods and techniques, and perceptual problems associated with aeronautics and space flight.

d. *Directs optometry personnel:* Plans work assignments for optometry personnel including preparation and maintenance of optometric records. Observes and checks work of technicians to determine compliance with procedures governing optometric activities. Instructs optometry technicians in local operational procedures, and in the use and maintenance of ophthalmic instruments.

e. *Plans and directs occupational vision programs:* Plans, supervises, and participates in eye protection programs in accordance with AFR 160-112 and AFR 167-3. Identifies eye hazardous areas and occupations, and supervises visual screening of personnel in such areas. Arranges for professional services, and procurement and dispensing of safety eye wear for military personnel and civilian employees of the Department of the Air Force.

3. SPECIALTY QUALIFICATIONS

a. *Knowledge*: Knowledge of procedures and methods used in eye examinations, and examining and testing lenses is *mandatory*.

b. *Education*:

(1) Graduate of a college of optometry approved by the Surgeon General, USAF, is *mandatory*.

(2) Master's degree or Doctor of Philosophy degree in physiological optics is desirable for research and teaching assignments.

c. *Experience*: A minimum of 12 months' experience in optometry assignments is *mandatory*. It is *mandatory* that experience include conducting examinations of the eye to determine presence of visual defects; prescribing lenses and orthoptic therapy to correct, conserve, or improve vision; and examining and testing compliance to acceptable standards and conformance to prescription.

d. *Training*: None.

e. *Other*: State license to practice optometry is *mandatory*.

4. SPECIALTY DATA

a. *Grade Spread*: Second lieutenant through colonel.

b. *Related D.O.T. Job*:
Optometrist ——————— 079.108

c. *Related DOD Occupational Group*: 6H

DEPARTMENT OF THE AIR FORCE
USAF SCHOOL OF AEROSPACE MEDICINE (AFSC)
BROOKS AIR FORCE BASE, TEXAS 78235

August 1975

OPTOMETRY PROGRESS REPORT

Optometry Seminar

Brooks AFB, Texas will host the 4th USAF Optometry Seminar from 30 September through 2 October 1975. The quotas have been allotted to the Major Air Commands, and contacts should be in process for selection of the attendees. If you have not received word about whether or not you can participate in this continuing education program, see your Administrative or Executive Officer. The TDY funding for attending is not from your organization's budget, so this should not be a deterent for approval.

Special Pay

Special pay legislation was not completed prior to the June 30, 1975 expiration date for the $100/mo. award to optometrists and veterinarians. The military members in these specialties on duty prior to 1 July 1975, continue to receive the special pay without interruption; however, the professionals that enter(ed) on active duty after that date will not unless legislation authorizes it. The DOD favors the special pay legislation, and the House Committee has favorably responded with a rider to the Appropriations Bill which will make the effective date retroactive to 1 July 1975. It is expected that this authority will run to 1 October 1977.

Drug Applications

Two years ago AFR 160-12, Professional Policies and Procedures, was revised to include the following, in paragraph 3g " ... Optometrists have the knowledge and skill necessary to perform the following functions:

(1) Performs complete visual examinations with or without the use of diagnostic drugs ... " USAF pharmacies will honor prescriptions from optometrists for ophthaine, mydriacyl, etc., in compliance with their needs for ophthalmic drugs for diagnostic purposes.

It is not unusual for optometrists at some of the smaller USAF Clinics where no ophthalmologist is assigned to work in close coordination with Flight Surgeons on Sick Call and physicians in Emergency Rooms in handling ocular disease and trauma dispositions. In these circumstances therapeutic ophthalmic drugs may be recommended by the optometrist and ordered by the

medical doctor from the pharmacy. If optometrists are enjoined to order therapeutics directly, it is highly recommended that approval for this action be in writing. Capt Steiner, at Webb AFB, TX, has been accorded this courtesy by the Pharmacy and Therapeutics Committee and may order: Neosporin ophthalmic; Blephamide ophthalmic; Garamycin ophthalmic; Sodium Sylamyd; Vasocon ointment; and Darvon, plain. Note that no steroid combination drugs were authorized. Dr Steiner is a former enlisted Air Force pharmacist, had a course in Pharmacology at the University of Houston Optometry College, and is well versed in drug effects, which was a major consideration in his award of direct drug therapeutic use at Webb AFB.

Contact Lenses and Occupational Vision

Air Force Regulation 161-31, Occupational Vision Program, prohibits the use of contact lenses in eye hazardous jobs except: "Special cases where persons must wear contact lenses for medical reasons will be considered on an individual basis." A request for reappraisal of this policy was made two years ago to permit the judgment of the local optometrist to weigh whether the usual eye protective device was inadequate, and the environment constituted a greater hazard to the contact lens wearer over others in the same situation, before restricting the wear of contact lens. No change in regulation resulted from this request.

A waiver of the prohibition was recently made at Kirtland AFB following advice by Lt Col Coker, Chief of Occupational Vision in the USAF Surgeon General's Office. This was a local waiver granted by the Occupational Vision Team when Maj O'Brien, Optometrist, indicated that in his professional judgment the patient's visual performance would be compromised with spectacles in climbing poles and stringing wire. The letter of waiver, forwarded through channels, concluded: "Additionally request that you take action through AFSC to request from HQ USAF/SGPA (the OPR of AFR 161-31) that AFR 161-31, para 3c(1) be amended to permit the Base Occupational Vision Team to locally authorize persons to wear contact lenses in eye hazard area when justified by particular medical reasons." The mechanism for issuing a waiver is now apparent, but the basic issue still seems unduly restrictive.

Federal Services Optometry Seminar

The AOA sponsored a Federal Services Optometry Seminar held in early April in Washington, DC. The attendees would form a "Who's Who" in AOA, AFOS, Military, Public Health and Civil Service Optometry. The issues addressed by the workshops were: Pay and Promotion; Optometry Corps; Vision Care Delivery; Clinic Evaluation; Education; Rationale for Federal Vision Care; Interprofessional Relations and Attitudes; and the Reserves.

MEDFG-HPS-S-Opt | Modification of USAGH Regulation 40-102

CO, USAGH
ATTN: AJGMD-HPS

Ch, Optometry Section
USAGH

4 October 72
MAJ Nichols/wl/2381

1. Recommend that consideration be given to the following modification of paragraph 10 (Optometrist Privileges) USAGH Regulation 40-102, dated 28 September 1971.

2. Optometrist Privileges:

Permission to conduct examinations of the eyes to ascertain the presence of absence of defects or visual anomalies, and prescribe the appropriate optometric therapy to correct, remedy or relieve such visual anomalies by the use of lenses, prisms, orthoptics, contact lenses, as outlined by AR 40-3, C-25 dated September 1971, AR 40-121, and SOP of Elective Contact Lens Program, Optometry Clinic, USAGH, Fort Gordon, Georgia, or other optometric procedures (to include use of diagnostic drugs such as mydriatics, cycloplegics and topical anesthetics) commensurate with training and experience. Refer patients for medical consultation, treatment or surgery when ocular manifestation of disease is detected.

3. The above modifications are suggested in accordance with AR 611-101, ch 23, 13 April 1970, AR 40-1, ch25, September 1971, and AR 40-121, paragraph 4-6.

ALEX C. NICHOLS
Major, MSC
Chief, Optometry Section

1 Incl
SOP

DISPOSITION FORM

For use of this form, see AR 340-15, the proponent agency is TAGCEN.

REFERENCE OR OFFICE SYMBOL	SUBJECT
DASG-HCC	Optometry Policy Statement Update

20 THRU: ~~DASG-HC~~ 0 6 APR 1977 FROM DASG-HCC DATE 4 Apr 77 CMT 1
~~DASG-ZB~~ Rwg
COL Biehusen/ms/71917

TO: DASG-ZA

1. In view of recent civilian interest in the role of the optometrist and the recent editorial addressed to The Army Surgeon General in the Journal of the AOA of which you are aware (Inclosure 1) a firm policy statement is in order setting forth the role of the Army optometrist.

2. Existing policy is stated as portions of correspondence of General Heaton (1968, Inclosure 2) and General Jennings (1971, Inclosure 3). No policy statement as such exists.

3. Your Consultants in Ophthalmology and Optometry agree that the proposed policy statement below is fair and represents the Army policy concerning the role of the optometrist.

POLICY STATEMENT

Army optometrists provide optometric patient services in accordance with accepted medical guidelines. They examine the eyes and adnexa, to include refraction and other procedures, prescribe lenses to correct refractive error and improve vision. They refer patients to physicians for diagnosis and treatment of suspected disease. They use topical anesthetics and cycloplegic drugs to perform tonometry and cycloplegic refractions. When using these drugs immediate medical care is available in the event of adverse reaction.

3 Incls
as

Frederick C. Biehusen
FREDERICK C. BIEHUSEN, M.D.
Colonel, MC
Chief, Consultants and Ambulatory Care Division

APPROVED ~~DISAPPROVED~~ 20 Apr 77

Richard R. Taylor
RICHARD R. TAYLOR, M.D.
Lieutenant General
The Surgeon General

DA FORM 2496 REPLACES DD FORM 96, WHICH IS OBSOLETE. ☆GPO-1975-655-422/1003

EDUCATIONAL QUALIFICATION OF ALASKAN OPTOMETRISTS

1. Statement on Pharmacology Training in Optometry in Oregon, 1975
   By: L. Levine, Ph.D.

2. Curriculum Comparison on Pharmacology between:

   Oregon Medical School
   Oregon Dental School
   Oregon College of Optometry

3. Association of Schools and Colleges of Optometry (ASCO)

   This study suggests pharmacology curriculum guidelines for continuing education courses for practicing optometrists. Should legislation pass, this guide would serve as a framework for setting up such a program.

4. 1973 National Board of Examiners in Optometry

   All applicants for Board certification to practice optometry in Oregon must pass all of the written sections of the National Boards with a minimum score of 70%.

   Enclosed copies of sections related to diagnostic agents:

	Hours of Testing
Ocular Pharmacology	1.0 hr.
Ocular Pathology	2.0 hrs.

   Other sections of the Boards not included but available upon request:

	Hours of Testing
Ocular Anatomy	2.0 hrs.
Visual Science I	2.5 hrs.
Visual Science II	2.5 hrs.
Theory and Practice of Optometry	2.5 hrs.
Theoretical Optics	3.0 hrs.
Ophthalmic Optics	2.5 hrs.
Social, legal, ethical, economic and professional aspects of optometry	1.0 hr.
	19.0 hrs. testing

5. List of the United States Optometric Colleges and Schools

Statement on Pharmacology Training in Optometry in Oregon

L. Levine, Ph. D.

The most revered and the most widely used textbook in the field of pharmacology in American medical and dental colleges is Goodmand and Gilman's "The Pharmacological Basis of Therapeutics". For example, during the current academic year (1974-1975), as in previous years, this "blue bible" of pharmacology is the required textbook for the pharmacology courses offered in both the University of Oregon Medical School and Dental School. (It may be noted that during the two occasions when a formal 2-hour course in Optometric Pharmacology was taught at the College of Optometry in Forest Grove, Goodman and Gilman was the required text. It may be of further interest that the senior author is a member of a long time Portland, Oregon family, and that his original professional training was in the field of Optometry.) The current (4th) edition of Goodmand and Gilman identifies the scope of the field of pharmacology as embracing "...the history, source, physical and chemical properties, compounding, biochemical and physiological effects, mechanisms of action, absorbtion, distribution, biotransformation and excretion, and therapeutic and other uses of drugs" (p.1). It is at once apparent that the totality of the discipline of pharmacology is very large, and that students and practitioners of health-related professions must generally limit their attention to drugs that are "useful in the prevention, diag-

nosis, and treatment of human disease, or in the prevention of pregnancy..." and to "chemical agents ... commonly responsible for household poisoning as well as enviornmental poisoning." (p.1).

Even to achieve these admittedly limited objectives, the student must give attention to a number of the classical subdivisions of pharmacology. These are listed in Goodman and Gilman (pp. 1,2) as (a) the physical and chemical properties of drugs, (b) pharmacodynamics, (c) pharmacotherapeutics, and (d) toxicology. Of these, pharmacodynamics has reference to "the study of the biochemical and physiological effects of drugs and their mechanisms of action." It is largely based on "...the subject matter and the experimental technics of physiology, biochemistry, microbiology, and pathology." Further, in pharmacodynamics "...Many basic principles of biochemistry and enzymology and the physical and chemical principles that govern the active and passive transfer and distribution of substances across biological membranes are readily applied..." On the other hand the term "pharmacotherapeutics" deals with "...Many drugs (which) stimulate or depress biochemical or physiological function in man in a sufficiently reproducible manner to provide relief of symptoms..." or are useful "...because they have only minimal effects on man but can destroy or eliminate parasites." (All quotes from Goodman and Gilman, Ch. 1).

From the foregoing it is obvious that mastery of the subject matter of pharmacology requires appreciable prior training in a number of important areas of human biology: anatomy, physiology, biochemistry, microbiology, and pathology. Further, for a study of drugs of consequence to the field of Optometry, specialized additional preparation in ocular anatomy, neurology, and ocular pathology are essential prerequisites. Thus on the one hand, the study of pharmacology cannot properly be undertaken early in a professional program since it presupposes a command of, and builds on the background provided by, several of the basic biological sciences. On the other hand, neglect of the study of pharmacology once the lengthy prerequisite preparation has been negotiated, fails to complete a logical sequence, and is irresponsible since it prevents delivery of the highest level of professional vision care to the public.

Inspection of the current catalogs of the University of Oregon Medical School and Dental School (1974-1975) reveals that the programs of study leading to the M.D. and the D.M.D. follow a rational progression of courses in the basic preclinical disciplines, which are necessary prerequisites to beginning the study of pharmacology. In both institutions, classroom and laboratory introduction to pharmacology is deferred until the second year and awaits prior or parallel training in gross and microscopic human anatomy,

bicchemistry, physiology, neuroanatomy, microbiology, and pathology. Since the medical and the dental practitioner will require clinical application of his pharmacological knowledge, it is sensible and appropriate that all of the preceding courses have practical components in the form of required laboratory work, and that the initial classroom and laboratory exposure to pharmacology is followed in succeeding terms with practical training in the use of drugs under immediate supervision of qualified faculty members.

The course of study presently required of all students in the College of Optometry in Forest Grove directly parallels and is equivalent to that of the Medical and Dental Schools as regards the number and level of the basic biological science courses relevant to the study of pharmacology. Currently, the program does not provide training in human anatomy, relegating that subject to the pre-optometry status, but provides more specialized morphological instruction in ocular anatomy and neuroanatomy. The curriculum includes core courses in physiological chemistry, physiology, neurology, microbiology, general and ocular pathology. All of these courses carry required laboratory work except physiological chemistry and microbiology, and all of these courses are completed before pursuing a required 2-semester hour lecture and demonstration class in Optometric Pharmacology.

Awaiting implementation, to complete the pharmacological

training of an optometrist, is a three-year old proposal for the development and suitable staffing of a Special Clinic in Pharmacology, which a student would enter after completion of the required two-hour lecture course. This Pharmacology Clinic would provide student clinicians with medically supervised practical experience in the use of topically-applied "eye drops", belonging to the group called Diagnostic Pharmaceutical Agents (DPA's), on themselves and on clinic patients.

Attached are (a) a synopsis of the biological science coursework offered in the Colleges of Optometry in the U.S., (b) a topical outline of the course in Optometric Pharmacology offered at the College of Optometry in Forest Grove, and (c) current curricula of Colleges of medicine, dentistry, and optometry in the State of Oregon.

The total learning experience leading to competence in optometric pharmacology is thus spread over all four years of the professional program. The faculty responsible for the teaching of the relevant basic biological science coursework all possess earned doctorates (Ph.D.'s) in the disciplines in which they provide instruction, hold memberships in the appropriate professional societies, and the majority are actively engaged in research programs in their specialized areas. The course in Optometric Pharmacology is staffed by a Ph.D. in Physiology, with extensive research experience

involving the experimental use of all classes of DPA's, with membership in the American Physiological Society and nomination for membership in the American Society for Pharmacology and Experimental Therapeutics (pending); a practicing O.D. with military experience in Viet Nam, during which he acquired extensive training in the use of all classes of DPA's from ophthalmological colleagues; and a practicing physician in Forest Grove with special interst and experience in ocular drugs. Thus the graduating O.D. is provided with all of the background and training necessary to equip him to deliver optimal vision care to his patients through the appropriate utilization of Diagnostic Pharmaceutical Agents.

CURRICULUM

COLLEGE OF OPTOMETRY 1974-1975

Courses in the Professional Curriculum

The duration of the regular professional curriculum in Optometry is four academic years and requires completion of 135 approved semester hours. This is preceded by a minimum of two years of pre-optometry.

First Professional Year

Optometry 333 Geometrical Optics	3
Optometry 334 Laboratory Geometrical Optics	1
Optometry 335 Ocular Anatomy and Physiology	3
Optometry 336 Laboratory-Ocular Anatomy	1
Optometry 337 Optometric Orientation	1
Optometry 338 Physical Optics	3
Optometry 339 Laboratory-Physical Optics	1
Optometry 340 Physiological Chemistry	3
Optometry 341 Laboratory-Physiological Chemistry	1
Optometry 342 Ophthalmic Optics	3
Optometry 343 Laboratory-Ophthalmic Optics	1
Optometry 344 Advanced Human Physiology	3
Optometry 345 Laboratory-Advanced Human Physiology	1
Optometry 346 Physiological Optics I	3
Optometry 347 Laboratory-Physiological Optics I	1
Optometry 348 Experimental Psychology	3
Optometry 349 Laboratory-Experimental Psychology	1
Optometry 399 Optometric Procedures I	3

Second Professional Year

Optometry 400 Optometric Procedures II/ Receiving Clinic	2
Optometry 401 Optometric Procedures III/ Receiving Clinic	3
Optometry 433 Bases of Pathology	3
Optometry 434 Laboratory-Bases of Pathology	1
Optometry 435 Physiological Optics II	3
Optometry 436 Laboratory-Physiological II	1
Optometry 437 Structure and Function of the Nervous System	3
Optometry 439 General and Ocular Pathology	2
Optometry 440 Ocular Pathology Detection and Visual Fields	3
Optometry 441 Optometry I/Theory and Methods of Clinical Refraction	3
Optometry 442 Optometry II/Basic Case Analysis	4
Optometry 444 Contact Lenses	3
Optometry 445 Laboratory-Contact Lenses	1

Third Professional Year

Optometry 518 Psychophysiology of Vision	3
Optometry 519 Psychology of Vision Laboratory	1
Optometry 520 Human Visual Perception	3
Optometry 521 Laboratory-Psychology II	1
Optometry 533 Optometry III/Advanced Case Analysis of Motor Dysfunctions	3
Optometry 534 Laboratory-Optometry III	1
Optometry 537 Visual Training I	3
Optometry 538 Laboratory-Visual Training	1
Optometry 539 Basic General Clinic I	1
Optometry 540 General Clinic II	2
Optometry 541 Optometry IV/Low Vision and Geriatrics	2
Optometry 542 Laboratory-Optometry IV	1
Optometry 545 Environmental Vision	3
Optometry 551 Optometry V/Strabismus and Amblyopia	3
Optometry 552 Laboratory-Optometry V	1

Fourth Professional Year

Optometry 633 National Problems of Health Care	3
Optometry 635 General Clinic III**	2-5
Optometry 639 Optometry VI/Advanced and Contemporary Clinical Procedures	2
Optometry 640 General Clinic IV	2-5
Optometry 641 General Clinic V.	2-6
Optometry 642 Optometric Pharmacology	2
Optometry 646 Specialty Clinics	1-4
Optometry 690 Research	2-6

*During the last three years and a half a minimum of 12 hours of general clinic is required. Only 6 hours of general clinic are shown. The remaining 6 hours may be scheduled whenever is convenient.

**Scheduled Summer between third and fourth years.

CURRICULUM DENTAL SCHOOL 1974-1975

First Year

	Credit Hours
Fall Interval	
*An 417, 418, 419, 421 Human Morphology	—
BCh 411-2 Biochemistry	—
BeS 411 Omnibus	2.0
BeS 411 Principles of Behavior Management	1.0
BeS 411 Personal Adjustment	1.0
CB 411 Crown and Bridge Technic	1.2
CJT 411 Cell Biology	0
*DA 411-2 Dental Anatomy	—
*DM 411 Dental Materials	—
MB 411 Microbiology	2.0
OD 411 Oral Examination Technic	1.5
*PD 411-2 Preventive Dentistry Technic	—
PD 411 Public Health Dentistry	2.0
Winter Interval	
An 417, 418, 419, 421 Human Morphology	—
BCh 411-2 Biochemistry	7.9
CB 412 Crown and Bridge Technic	2.1
CJT 412 Biology of Inflammation	2.0
*CJT 412-3 Infectious Diseases	—
CJT 412 Mineralization	1.5
DM 412 Dental Materials	—
DA 411-2 Dental Anatomy	3.0
MB 412 Immunology	3.5
PD 411-2 Preventive Dentistry Technic	2.0
PD 412 Nutrition	1.0
Per 412 Periodontics Technic	1.5
*Phy 412 Physiology	—
Spring Interval	
An 417, 418, 419, 421 Human Morphology	13.3
CB 413 Crown and Bridge Technic	1.2
CJT 412-3 Infectious Diseases	5.0
CJT 413 Caries	2.5
DM 413 Dental Materials	2.0
Op 418 Operative Technic Lecture	2.0
Op 419 Operative Technic Laboratory	2.0
Per 613 Periodontics Clinic	.5
Phy 413 Physiology	6.0
First Year Total	67.7

Second Year

Fall Interval	
An 421 Neuroanatomy	1.3
†CB 420 Crown and Bridge Technic	3.0
DM 421 Dental Materials	1.0
Op 420 Operative Technic Lecture	1.0
Op 421 Operative Technic Lab	2.0
OS 420 Medical Emergency Procedures	1.0
*Per 620 Oral Hygiene Clinic	—
Phy 420 Physiology	3.0
Pth 420 Pathology	4.0
Winter Interval	
†CB 421 Crown and Bridge Technic	2.0
DM 422 Dental Materials	2.0
Op 423 Operative Technic	1.0
Op 424 Operative Technic Laboratory	2.0
Ord 423 Orthodontics	1.0
Ord 428 Orthodontics Technic	1.0
OS 421 Local Anesthesiology Exo.	1.0
OS 423 Intro Oral Surgery	1.0
Pedo 422 Child Development	2.0
*Per 621 Oral Hygiene Clinic	—
Phr 420 Pharmacodynamics I	3.0
Pth 421 Pathology	3.0
Ro 420 Oral Radiology	1.0
Spring Interval	
An 423 Head and Neck Anatomy	3.0
†CB 422 Crown and Bridge Technic	1.0
Endo 423 Endodontics	2.0
OD 429 Oral Diagnosis	1.0
Op 623 Operative Clinic	0
OS 422 Local Anesthesiology Exo.	2.0
Pedo 423 Child Development	1.0
Pedo 429 Pedodontic Technic	1.0
Per 423 Principles of Periodontology	1.0
Per 622 Oral Periodontology Clinic	2.0
Pr 422-3 Prosthetics Conference Lab	2.0
Ro 421 Oral Radiology Lecture	1.0
Ro 422 Oral Radiology Lab	1.0
Second Year Total	54.3

Third Year

Fall Interval	
CB 431 Principles of Crown and Bridge	1.0
CB 630 Crown and Bridge Clinic	1.0
Endo 431 Endodontics	1.0
*Endo 642 Endodontics Clinic	—
OD 430 Oral Diagnosis Treatment	1.0
Op 633 Operatives Clinic	1.0
Ord 431 Facial Growth	1.0
OS 430 Oral Surgery	1.0
Pedo 630 Pedodontics Clinic	1.0
Per 42. Periodontology Lecture	1.0
*Per 631 Periodontology Clinic	—
Pr 430 Principles of Clinical Prosthetics	1.0
Pr 633 Prosthetics Clinic	1.0
Pth 434 Pathology	2.0
*Ro 630 Oral Radiology Clinic	—
Winter Interval	
CB 631 Crown and Bridge Clinic	1.0
*Endo 642 Endodontics Clinic	—
OD 437 Clinical Conference	0
Op 634 Operatives Clinic	1.0
Ord 432 Orthodontics	1.0
OS 431 Oral Surgery	1.0
PD 430 Caries Prevention	1.0
Pedo 631 Pedodontics Clinic	1.0
*Per 632 Periodontology Clinic	—
Phr 430 Pharmacodynamics II	3.0
Pr 634 Prosthetics Clinic	1.0
Pth 435 Pathology	2.0
*Ro 630 Oral Radiology	—
Spring Interval	
CB 632 Crown and Bridge Clinic	1.0
*Endo 642 Endodontics Clinic	—
Med 439 Principles of Medicine	1.0
OD 438 Clinical Conference	2.0
Op 430 Principles of Clinical Operatives	1.0
Op 635 Operatives Clinic	2.0
OS 432 Oral Surgery Lecture	1.0
OS 630 Oral Surgery Clinic	1.0
PA 432 Dental Jurisprudence	1.0
Pedo 632 Pedodontics Clinic	1.0
Per 633 Periodontology Clinic	3.0
Pr 635 Prosthetics Clinic	2.0
Pth 436 Pathology	2.0
Ro 630 Oral Radiology	1.0
Third Year Total	44.0

Fourth Year

Fall Interval	
CB 640 Crown and Bridge Clinic	2.0
DM 441 Dental Materials	1.0
*Endo 640 Endodontics Clinic	—
Med 440 Principles of Medicine	1.0
*Med 443 Hospital Clinic	—
OD 440 Clinical Conference	0
Op 643 Operatives Clinic	3.0
*Ord 447 Orthodontics Conference	—
†PA 433 Professional Adjustment	1.0
†PA 436 Professional Viewpoints	1.0
Pedo 440 Pedodontics Conference	1.0
Pedo 640 Pedodontics Clinic	0
*Per 440 Periodontology Clinic Seminar	—
*Per 641 Periodontology Clinic	—
Pr 643 Prosthetics Clinic	0
*Ro 640 Oral Radiology	—
Winter Interval	
CB 441 Principles of Crown and Bridge	1.0
CB 641 Crown and Bridge Clinic	2.0
Endo 640 Endodontics Clinic	1.0
Med 442 Principles of Medicine	1.0
*Med 444 Hospital Clinic	—
OD 441 Clinical Conference	2.0
Op 644 Operatives Clinic	3.0
*Ord 442 Orthodontics Conference	—
PD 440 Public Health Dentistry	1.0
Pedo 641 Pedodontics Clinic	1.0
*Per 440 Periodontology Clinic Seminar	—
*Per 642 Periodontology Clinic	—
Pr 440 Principles of Clinical Prosthetics	1.0
Pr 644 Prosthetics Clinic	1.0
†Pth 445 Pathology	2.0
*Ro 640 Oral Radiology	—
Spring Interval	
CB 642 Crown and Bridge Clinic	2.0
Med 445 Hospital Clinic	1.0
OD 642 Oral Diagnosis Clinic	1.0
Op 645 Operatives Clinic	3.0
Ord 442 Orthodontics Conference	1.0
OS 440 Clinical Surgery	1.0
OS 640 Oral Surgery Clinic	1.0
OS 644 Hospital Dental Clinic	1.0
PA 401 Dental Psychology	—
PA 445 Ethics Case Study	1.0
Pedo 643 Pedodontics Clinic	1.0
Per 440 Periodontology Clinic Seminar	1.0
Per 643 Periodontology Clinic	1.0
Pr 645 Prosthetics Clinic	1.0
Pth 441 Oral Pathology	1.0
Ro 640 Oral Radiology Clinic	1.0
Fourth Year Total	44.0

Recapitulation

First Year	67.7
Second Year	54.3
Third Year	44.0
Fourth Year	44.0
Totals	210.0

CURRICULUM

MEDICAL SCHOOL 1974-1975

The curriculum in medicine requires a total of seven years' work beyond high school. The first three years must be satisfactorily completed before admission to the Medical School in Portland. Since facilities for instruction provide for the acceptance of only a limited number of applicants, completion of premedical studies does not guarantee admission to the Medical School.

The four years spent in the Medical School in Portland are devoted to subjects of the regular four-year curriculum in medicine required by law.

The prescribed and recommended subjects for the three premedical years are described under *Admissions and Scholastic Regulations*. In the first, second, third, and fourth years at the Medical School there are 5.044 class hours of required work. Descriptions of courses are to be found under the several departmental headings.

Prescribed Work

First Year		Term Hours
Con 410	Cell Organization and Function	5
Con 411	Medical Genetics	2
Con 412	Developmental Biology	2
Con 413	Introduction to Patient Evaluation	3
Con 414	Immunology	2
An 410	Gross Anatomy	12
An 411	Histology	4
An 412	Neuroanatomy	4
BCh 410	Basic Biochemistry	3
MPs 410	Medical Psychology	2
Pth 410	General Pathology	3
Phy 410	Human Physiology	7
Psy 410	The Human Context of Medical Practice	2
PH 410	Public Health and Epidemiology	3
		54

Second Year		
Con 610	Pathophysiology of Skin, Bone and Connective Tissue	3
Con 611	Patient Evaluation	5
Con 612	Cardiovascular Pathophysiology	5
Con 613	Respiratory Pathophysiology	3
Cor 614	Renal Pathophysiology	5
Con 615	Blood and Reticuloendothelial Pathophysiology	5
Con 616	Endocrine Pathophysiology	3
Con 617	Gastrointestinal Pathophysiology	5
Con 618	Reproductive Pathophysiology	5
Con 619	Pathophysiology of the Central Nervous System, Muscle and Special Sensory Organs	8
Mb 610	Microbiology	4
Phc 610	Pharmacology	3
		54

Third Year		
Con 620	Child Health	18
Con 621	Neurosciences	9
Con 630	Law and Medicine (May be taken 3rd or 4th year)	2
Med 620	Third-Year Medicine	18
RadD 620	Radiographic Diagnosis	1½
Special Programmed Instruction		9
		57½

Fourth Year		
ObG 630	Fourth-Year Obstetrics and Gynecology	9
Psy 630	Psychiatry Clinical Clerkship	9
Sur 630	Fourth-Year Surgery	18
Special Programmed Instruction		18
		54

A list of elective courses will be made available to every student.

* Includes holidays

ASSOCIATION OF SCHOOLS AND COLLEGES OF OPTOMETRY

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

December 1974

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This Is The Recommended Content Of The Above Courses As Reported By The Council On Academic Affairs Of The Association Of Schools And Colleges Of Optometry

Pharmacology Curriculum Model

A Report of the ASCO Council on Academic Affairs

The role of the optometrist as a health care practitioner and a primary vision care provider has encouraged a movement in optometry to modify state optometry laws so that pharmaceutical agents can be utilized in the practice of optometry. This has also focused attention on the scope of the pharmacology programs in the schools and colleges of optometry. Sensing this attention, the Council on Academic Affairs of the Association of Schools and Colleges of Optometry (ASCO) selected a committee and prepared the following curriculum model to be utilized by the various schools and colleges in assessing the scope of their individual programs in pharmacology.

We want to thank the members of the committee who devoted considerable time and effort to this project. Dr. David Amos, private practice, Kansas City, Missouri, Dr. Freddy Chang, faculty member, School of Optometry, Indiana University, Dr. Siret Jannus, faculty member, Southern California College of Optometry; Dr. Jerry Rapp, faculty member, State University of New York, State College of Optometry, Dr. Tom Stelmack, faculty member, Illinois College of Optometry; and Dr. Jess Boyd Eskridge, faculty member, University of Alabama in Birmingham, School of Optometry.

GENERAL PHARMACOLOGY

I. Introduction to Basic Principles of Drug Action

A. Definitions
1. General Concepts
a. Definition of a drug
b. Absorption and elimination
c. First order kinetics
d. Biological half-like
e. Volume of distribution
f. Dosing concepts

B. Sources of Drugs
1. Naturally occurring
2. Synthetic
3. Semi-synthetic

C. Drug Classification
1. Site of action
2. Functional group
3. Nomenclature

D. Dosage forms
1. Oral
2. Parenteral
3. Suppositories
4. Sustained release

E. Pharmacodynamics - pharmacokinetics
1. Routes of administration
a. Enteral
b. Parenteral
c. Rectal
2. Absorption
a. Passive versus active transport
b. Acid—base characteristics
c. Lipid solubility
d. Molecular size and charge characteristics
3. Distribution
a. Lipid solubility
b. Free versus bond
c. Blood-brain barrier
d. Protein binding (plasma, tissue)
4. Metabolism
a. Oxidation - reduction
b. Hydrolysis
c. Acetylation
d. Conjugation
e. Other
5. Excretion
a. Renal
b. Lungs
c. Skin

F. Pharmacogenetics
1. Idiosyncratic effects
2. Inborn errors of metabolism

G. Mechanisms of drug action
1. Kinetics of drug action
a. Michaelis—Menten
b. Biological half-life
c. Dose—response curve
d. Volume of distribution
e. Maintenance of dose, dosing interval, loading dose
2. Receptors and acceptors
a. Primary versus secondary
3. Agonist and antagonist
4. Drug tolerance
a. Tachyphylaxis
b. Physiological
c. Psychological
5. Drug—Receptor Interactions
a. Synergism
b. Additivity
c. Potentiation
d. Inhibition

H. Evaluation of Drug Action
1. Animal Studies
a. ED_{50}
b. LD_{50}
c. Therapeutic index
d. Drug efficacy
e. Drug potency
2. Clinical Investigations
a. Host factors
b. Placebo effect
3. Legal Regulations
a. Laws and Rules
b. Agencies (federal and state)
4. Drug Standards
a. Bioassays

I. Prescription Writing
1. Composition of the prescription
2. Laws governing drug dispensing

J. Ethical Factors of Drug Use

K. Psychological Factors of Drug Use

II. Drugs Acting on the Peripheral Nervous System

A. Peripheral chemical mediators

B. Autonomic drugs
1. Drugs acting on the parasympathetic system
a. Parasympathomimetics
1) a) Acetylcholine
b) Methacholine
c) Carbachol
d) Pilocarpine

2) Indirect acting
a) Physostigmine
b) Neostigmine
c) Edrophonium
d) Echothiophate
e) Diisofluorophosphate

b. Parasympatholytic
1) Anti-Muscarinic
a) Atropine
b) Scopolamine
c) Homatropine
d) Cyclopentolate
e) Tropicamide
2) Nicotinic
a) D-tubocurarine
b) Succinylcholine

2. Drugs Acting on the Sympathetic System
a. Sympathomimetics
1) Direct acting—alpha stimulators
a) Norepinephrine
b) Phenylephrine
c) Naphazoline
d) Tetrahydrozoline
e) Ephinephrine
2) Direct acting—beta stimulators
a) Isoproterenol
b) Epinephrine
3) Indirect acting
a) Ephredrine
b) Vasodilator—amphetamines
c) Parahydroxyamphetermine

b. Sympatholytics
1) Alpha blockers
a) Ergot alkaloids
b) Dibenzyline
c) Tolazoline
2) Beta blockers
a) Propranolol

c. Neuronal blocking agents
1) Guanethidine
2) Bretylium
3) Rauwolfia Alkaloids

3. Drugs Acting on Autonomic Ganglia
a. Ganglionic stimulants
b. Ganglionic blocking agents

C. Drugs Modifying Neuromuscular Transmission
1. Stimulating agents for transmission
2. Blocking agents of transmission

III. Autacoids

A. Histamines

B. Kinins

C. Prostaglandins

IV. Drugs Acting on the Central Nervous System

A. Stimulants
1. Amphetamines
2. Non-amphetamines

B. Anti-depressants
1. MAO inhibitors
2. Tricyclic antidrepressants
3. Sympathomimetic agents

C. Anti-convulsants
1. Barbiturates
2. Phenytoins
3. Miscellaneous

D. Anti-Parkinsonism
1. Levodopa
2. Anti-cholinergic

E. Anti-spasmodic agents
1. Anti-cholinergics
2. Gastric antacids

F. Sedatives and hypnotics
1. Barbiturates
2. Non-barbiturates

G. Psychotherapeutic agents
1. Phenothiazine derivatives
2. Thioxanthene derivatives
3. Benzodiazepine drugs
4. Miscellaneous agents

H. Analgesics
1. Narcotics
2. Non-narcotic

I. Alcohol and Related Agents
1. Alcohols
2. Disulfiram

J. Antipyretics and Anti-inflammatory (non-steroid)
1. Salicylates
2. Pyrazolon derivatives
3. Para-aminophenol derivatives

K. Drug Abuse
1. Opiates
2. Barbiturates and sedative-hypnotics
3. Amphetamines
4. Cannabinoids
5. Psychotomimetics

L. Drug Dependence

V. Anesthetics

A. Pharmacology of General Anesthesia
1. History and theory
2. Signs and stages
3. Mechanics
4. Gas anesthetics (nitrous oxide, cyclopropane, ethylene)
5. Volatile anesthetics (ether, holothane, chloroform)

B. Pharmacology of Local Anesthesia
1. Cocaine
2. Procaine

VI. Drugs Acting on the Cardiovascular System

A. Digitalis and allied cardiac glycosides

B. Diuretics
1. Thiazide derivatives
2. Carbonic anhydrase inhibitors
3. Osmotic agents
4. Miscellaneous

C. Anti-arrhythmic drugs
1. Quinidine
2. Local anesthetics
3. Miscellaneous agents

D. Anti-hypertensive drugs
1. Hydralazine
2. MAO inhibitors
3. Diuretic agents

E. Anti-coagulants
1. Heparin
2. Oral anti-coagulants
3. Miscellaneous agents

F. Vasodilators
1. Nitrates and nitrites
2. Theophyline compounds

G. Anti-atherosclerotic agents
1. Hyperlipidemic drugs
2. Female sex hormones
3. Nicotinic acid

VII. Hormones and Drugs Modifying Endocrine Activity

A. Pituitary Hormones and their actions
   1. Anterior pituitary hormones
   2. Posterior pituitary hormones

B. Thyroid hormones and anti-thyroid agents
   1. Thyroid hormone
   2. Anti-thyroid drugs

C. Insulin and other hypoglycemic agents
   1. Insulin
   2. Biguanides
   3. Sulfonylureas

D. Adreno-cortical hormones
   1. Glucocorticords
   2. Mineralocorticords
   3. Androgenic steroids

E. Gonadal hormones—oral contraceptives
   1. Estrogens
   2. Androgens
   3. Progesterone

F. Parathyroid hormones

G. Agents Affecting Immune Systems
   1. Corticosteroids
   2. Cytotoxic agents

VIII. Drugs Affecting Metabolic Activity

A. Antianemic drugs
   1. Iron
   2. Copper
   3. Cobalt
   4. Pyridoxine
   5. Vitamin B12
   6. Folic acid

B. Uricosuric drugs
   1. Colchicine
   2. Allopurinol

C. Vitamins, Minerals and Other Nutrients
   1. Fat-Soluble Vitamins
   2. Water-Soluble vitamins

D. Metals
   1. Heavy metals
   2. Heavy-metal antagonists

IX. Chemotherapeutic Agents

A. Introduction
   1. History of chemotherapy
   2. Mechanisms of action of chemotherapeutic agents

B. Antibiotics
   1. Synergism and antagonism
   2. Classification
   3. Methods of selection for clinical use

C. Sulfonamides
   1. Chemistry
   2. Classification
   3. Toxicity and hypersensitivity

D. Antiviral agents
   1. Idoxuridine
   2. Amantadine
   3. Miscellaneous agents

E. Anti-fungal agents
   1. Nystatin
   2. Amphotericin B
   3. Griseofulvin
   4. Miscellaneous agents

F. Anti-parasitic agents
   1. Ectoparasites
   2. Endoparasites
   3. Antimalarial

G. Drugs used in treatment of tuberculosis and leprosy
   1. Streptomycin
   2. Isoniazid
   3. Para-aminosalicylic acid
   4. Dapsone
   5. Ethambutol

H. Drugs used in the treatment of neoplasia
   1. Alkylating agents
   2. Anti-metabolites
   3. Hormonal agents
   4. Radioactive isotopes

I. Antiseptics and disinfectants
   1. Benzalkonium chloride
   2. Thimerosal
   3. Phenylmercuric nitrate

X. Over the Counter Medications

A. Types of drugs found in OTC preparations

B. Concentrations used

C. Potential hazards

XI. Toxicology

A. Adverse drug reaction
   1. Classification
   2. Frequency of occurrence
   3. Drug factors
   4. Patient factors
      a) Age
      b) Weight
      c) Race
      d) Pathological factors
      e) Other
   5. Drug contraindication in pregnancy and lactation

B. Environmental Factors
   1. Poisons
   2. Carcinogens
   3. Pollutants

XII. Principles of Immunopharmacology

A. Immunosuppressive agents

B. Cellular aspects of the immune response

C. Effector mechanisms and mediators in immune injury

D. Immunosuppressive and anti inflammatory drug action

OCULAR PHARMACOLOGY

I. Properties of Ophthalmic Preparations

A. Physical properties of ophthalmic solutions
   1. Tonicity
   2. PH
   3. Stability
   4. Sterility
   5. Viscosity
   6. Surface activity

B. Physical properties of ophthalmic ointments
   1. Tonicity
   2. PH
   3. Stability
   4. Sterility
   5. Viscosity
   6. Surface activity

C. Other dosage forms
   1. Suspension
   2. Time release systems

D. Packaging
   1. Single dose
   2. Multiple dose

II. Routes of Drug Administration

A. Topical
B. Subconjunctival injections
C. Retrobulbar injections
D. Intracameral and intravitreal injections
E. Iontophoresis
F. Other

III. Ocular Drug Pharmacodynamics and Pharmacokinetics

A. Absorption and penetration
B. Distribution
C. Metabolism
D. Routes of removal

IV. Techniques and Procedures in Clinical Administration

A. Pre-instillation
   1. Case history
   2. Ocular tissue integrity
   3. Angle evaluation
   4. Tonometry

B. Installation Techniques
   1. Solution
   2. Ointments
   3. Miscellaneous

C. Injections
D. Ophthalmic Prescription Nomenclature

V. Drugs Affecting the Autonomic Nervous System of the Eye (Mechanisms of Action, Indications, Precautions, Contraindications, Dosage, Adverse Reaction, and Side-Effects)

A. Sympathomimetics (Mydriatics)
   1. Direct acting
      a. Norepinephrine
      b. Epinephrine
      c. Phenylephrine
      d. Isoproterenol
   2. Indirect acting
      a. Cocaine
      b. Hydroxyamphetamine
      c. Ephedrine

B. Sympatholytics
   1. Alpha blockers
   2. Beta blockers

C. Neuronal blockers

D. Parasympathomimetics (Miotics)
   1. Direct acting
      a. Acetylcholine
      b. Methacholine
      c. Pilocarpine
      d. Carbachol
   2. Indirect acting (Anticholinesterases)
      a. Reversible (short acting)
         1) Physostigmine
         2) Edrophonium
         3) Neostigmine
      b. Irreversible (long acting)
         1) Demecarium
         2) Echothiophate
         3) Isofluorophosphate

E. Parasympatholytics (Cycloplegics—Mydriatics)
   1. Atropine
   2. Scopolamine
   3. Homatropine
   4. Cyclopentolate
   5. Tropicamide
   6. Oxyphenonium

VI. Pharmacological Diagnosis and Treatment of Neuro Muscular Disorders

VII. Local and Topical Anesthetics (Mechanisms of Action, Indications, Precautions, Contraindications, Dosage, Adverse Reactions, and Side Effects)

A. Cocaine
B. Procaine
C. Lidocaine
D. Tetracaine
E. Proparacaine
F. Benoxinate
G. Piperocaine
H. Butyn-Sulfate (Butacaine)

VIII. Miscellaneous Ophthalmic Preparations

A. Hyperosmotic Agents
B. Antihistamines
C. Ocular lubricants
D. Decongestants
E. Dyes
F. Irrigating Solutions
G. Vitamins
H. Ophthalmic Preparations in Contact Lens Wearing
I. Preservatives
J. Antiseptics

IX. Corticosteroids and Other Anti-Inflammatory Agents (Mechanisms of Action, Indications, Precautions, Contraindications, Dosage, Adverse Reactions, Side Effects)

X. Ocular Chemotherapeutic Agents (Spectrum, Mechanisms of Action, Indications, Precautions, Contraindications, Dosage, Adverse Reactions, and Side Effects)

A. Antibiotics
B. Sulfonamides
C. Antiviral
D. Anti-fungal
E. Antiparasitic
F. Germicidal

XI. Therapeutic Management of Ocular Disorders (Mechanisms of Action, Indications, Precautions, Contraindications, Dosage, Adverse Reactions, and Side Effects)

A. Diseases of the eyelids
B. Diseases of the lacrimal apparatus
C. Diseases of the conjunctiva
D. Diseases of the cornea
E. Diseases of the sclera
F. Glaucoma

22nd Annual Examination

NATIONAL BOARD OF EXAMINERS IN OPTOMETRY

Question Sheet for Part II, Section 6, OCULAR PHARMACOLOGY
Number of Test: 9

Tuesday, May 1, 1973 (1 hour) 9:00 - 10:00 p.m.

Instructions: Read carefully before starting. See also general instruction sheet. This examination consists of one group of 40 questions. On the answer sheet supplied with this examination, blacken the proper box to indicate the single best answer for each question. Be sure to indicate that this is test number 9.

1. The mechanism whereby neostigmine (Prostigmin) in small doses induces a pupillary constriction is because neostigmine
   a. stimulates formation and release of acetylcholine.
   b. reacts directly with receptor groups in the same fashion as acetylcholine.
   c. reacts with receptor groups to block them.
   d. blocks cholinesterase so acetylcholine can accumulate.
   e. activates cholinesterase to destroy acetylcholine more rapidly.

2. Epinephrine and norepinephrine are both released by stimulation of the sympathetic nervous system. To distinguish between them experimentally small doses may be intravenously injected into a suitably prepared experimental animal. Which effect list below would be seen with epinephrine, but not with norepinephrine?
   a. An increase in blood pressure
   b. A cutaneous vaso-constriction
   c. An increase in heart rate
   d. A decrease in gut tone and motility
   e. Bronchiolar dilitation

3. Which of the following mydriatics has the shortest duration of action when applied topically to the normal eye?
   a. homatropine
   b. atropine
   c. epinephrine
   d. phenylephrine
   e. oxphenonium

4. Which of the following side-effects might result from the topical application of epinephrine preparations?
   a. a decrease in heart rate
   b. palpitations
   c. rebound hyperemia
   d. both b. and c. above
   e. all of the above

5. Cocaine exhibits which two types of pharmacological activities?
   a. local anesthesia and miosis
   b. miosis and cycloplegia
   c. local anesthesia and mydriasis
   d. tachycardia and miosis
   e. none of the above

6. Which of the following pharmacological activities is (are) common to phenylephrine but not to atropine?
   a. mydriasis
   b. conjunctival decongestion
   c. cycloplegia
   d. both a. and c. above
   e. none of the above

7. When applied topically, drugs such as pilocarpine, isofluorphate and echothiophate can be expected to produce
   a. mydriasis
   b. cycloplegia
   c. mydriasis and cycloplegia
   d. miosis
   e. none of the above

8. Used in the management of ocular hypertension, acetazoleamide, dichlorphenamide and methazolamide are classed as
   a. carbonic anhydrase inhibitors
   b. anticholinesterases
   c. direct-acting cholinergic stimulants
   d. cholinergic inhibitors
   e. adrenergic stimulants

9. Prolonged use of topical corticosteroids is known to
   a. induce open-angle glaucoma in normal eyes and aggravate pre-existing glaucoma.
   b. intensify ocular inflammation of allergic origin.
   c. promote corneal scarring subsequent to traumatic injury.
   d. cause corneal pitting.
   e. none of the above

This examination consists of 4 pages. See that your copy is complete and that no questions are overlooked.

10. Which of the following drugs can be classed as a corticosteroid?
    a. phenylephrine
    b. tetrahydrozoline
    c. dexamethasone
    d. piperocaine
    e. antazoline

11. Many ophthalamic solutions contain small amounts of benzalkonium chloride (Sephiran) in order to
    a. solubilize the active drug.
    b. buffer the preparation to pH 7.
    c. render the preparation isotonic with tears.
    d. inhibit the growth of contaminating microbes.
    e. none of the above.

12. The term potency refers to
    a. the margin of safety of a drug
    b. the amount of drug required to produce a certain effect
    c. the ratio between the toxicity and efficacy of a drug
    d. the toxicity of a drug
    e. none of the above

13. The term therapeutic index refers to
    a. a classification of drugs by usage
    b. a measure of drug potency
    c. a measure of drug efficacy
    d. the ratio between the number of times a drug is used and the toxicity observed
    e. none of the above

14. Most drugs are broken down in the
    a. skin
    b. kidneys
    c. liver
    d. lungs
    e. none of the above

15. The term synergism refers to
    a. an effect greater than additive produced when two or more drugs are combined
    b. drug antagonism
    c. an additive effect produced by the combination of two or more drugs
    d. a long duration of drug action
    e. none of the above

16. Drugs cross biological membranes by the process(es) of
    a. active transport
    b. passive diffusion
    c. filtration
    d. all of the above
    e. none of the above

17. Local anesthetics act by
    a. producing an irreversible depression of neuronal conduction.
    b. facilitating neuronal depolarization.
    c. preventing neuronal influx of sodium ions.
    d. increasing the permeability of neuronal membrane to sodium ions.
    e. none of the above

18. Vasoconstrictors are often added to solutions of local anesthetics which are intended for injection in order to
    a. retard absorption.
    b. prolong the duration of action.
    c. decrease the chance of systemic toxicity.
    d. all of the above
    e. none of the above

19. The absorption of excessive amounts of topical anesthetic from mucosal surfaces may lead to
    a. marked sedation
    b. bronchial constriction
    c. hypertension
    d. central nervous system stimulation
    e. none of the above

20. Which of the following is not true concerning the use of tetracaine (Pontocaine) as a topical local anesthetic?
    a. duration of action is 10-20 minutes
    b. can produce superficial corneal epithelial lesions
    c. can be safely prescribed for routine home use by patients
    d. allergic reactions are known to occur
    e. all of the above

21. Which of the following is not true concerning cocaine?
    a. can produce marked topical anesthesia when applied to the cornea
    b. topical application produces miosis
    c. has been used in the differential diagnosis of Horner's syndrome
    d. can produce damage to the corneal epithelium
    e. all of the above

22. Drugs administered in the subconjunctival space cross through the sclera and into the eye primarily by
    a. facilitated diffusion
    b. active transport
    c. filtration
    d. passive diffusion
    e. phagocytosis

This examination consists of 4 pages. See that your copy is complete and that no questions are overlooked.

23. If a patient came to you and was lethargic and had pinpoint pupils, you might suspect that he had recently taken
    a. pentobarbital
    b. LSD
    c. marijuana
    d. morphine
    e. amphetamine

24. Methyl mercury, a compound which is causing great concern today as an environmental pollutant, can cause many diverse symptoms involving the eye. Which of the following has been soundly established as a characteristic of poisoning with this agent?
    a. pigmentary retinopathy
    b. concentric constriction of visual fields
    c. nystagmus
    d. oculogyric crisis
    e. glaucoma

25. Pilocarpine reduces intraocular pressure by the following mechanism:
    a. Drug inhibits the enzyme acetylcholinesterase.
    b. It inhibits the formation of aqueous humour.
    c. Drug acts directly on the ciliary muscles and iris sphincter. The contraction of these muscles helps to open canal of Schlemm. Hence, the pressure is reduced.
    d. It inhibits choline acetylase, the enzyme involved in the formation of aqueous humour.
    e. The drug causes a fall in intracranial pressure which helps to reduce IOP.

26. Miotic effect of echothiophate results from
    a. depletion of the neurotransmitter acetylcholine.
    b. irreversible inhibition of the enzyme acetylcholinesterase.
    c. short lived inhibition of the enzyme acetylcholinesterase.
    d. irreversible inhibition of monoamine oxidase.
    e. depletion of the neurotransmitter norepinephrine.

27. Which of the following drugs produce mydriasis without significant loss of accommodation?
    a. homatropine
    b. scopolamine
    c. tropicamide
    d. eserine
    e. phenylephrine

28. Side effects from the systemic absorption of atropine will include
    a. central nervous system stimulation, tachycardia, dry mouth.
    b. diuresis, salivation, marked fall in blood pressure.
    c. piloerection.
    d. fall in body temperature, diarrhea and vomiting.
    e. sweating.

29. Which of the following drugs acts through liberation of endogenous norepiphrine and recently was introduced for the diagnosis of Horner's pupil?
    a. P-OH-amphetamine
    b. methacholine
    c. procaine
    d. neostigmine
    e. D.F.P.

30. Chronic administration of which of the following drugs is reported to cause a rise in intraocular pressure?
    a. aspirin
    b. oral contraceptive
    c. epinephrine
    d. isoproterenol
    e. propranolol

31. All of the following groups of drugs are used in the treatment of hypertension. Which group of drugs is likely to produce miosis?
    a. Ganglionic blockers, like pentolinium
    b. Monoamine oxidase inhibitors, like Pargyline
    c. Diuretics, like chlorthiazide
    d. Norepinephrine depletors, like reserpine.
    e. Veratrum alkaloids, like Protoveratrines

32. Large, repeated doses of tranquilizers, like chlorpromazine used in psychiatry, can cause
    a. mydriasis.
    b. marked rise in IOP.
    c. complete loss of accommodation.
    d. vasoconstriction in iris.
    e. corneal pigmentation, stellate form cataract and retinopathy.

33. If 10% solution of phenylephrine is applied topically as a mydriatic in children, the systemic side effect will include
    a. central nervous system depression.
    b. marked rise in the systemic blood pressure.
    c. marked relaxation of skeletal muscle.
    d. loss of hair.
    e. urination, vomiting and diarrhea.

34. Acetazolamide, given orally, reduces intraocular pressure by
    a. reducing the formation of aqueous humour.
    b. its vasoconstrictor action which reduces the permeability of blood aqueous barrier.
    c. its action like physostigmine.
    d. opening the canal of Schlemm.
    e. reducing the protein content of aqueous.

35. A local anesthetic agent used in the differential diagnosis of Horner's syndrome and Raeder's paratrigeminal syndrome is
    a. procaine
    b. Holocaine
    c. cocaine
    d. Pontocaine
    e. Dorsacaine

36. Of the following agents, which one is not used in o-t-c ophthalmic decongestant preparations?
    a. naphazoline
    b. phenylephrine
    c. zinc salts
    d. tetrahydrazoline
    e. All are used for this purpose.

37. Which one of the following statements is true? Anticholinergic drugs such as Belladonna group of alkaloids used in the treatment of peptic ulcers
    a. have no ocular effects.
    b. may cause constriction of pupil.
    c. may induce spasm of accommodation.
    d. may produce conjunctival congestion.
    e. produce temporary loss of accommodation.

38. Which one of the following statements is not true?
    a. Acetazolamide or Diamox inhibits carbonic anhydrase.
    b. Diamox reduces intraocular tension in a glaucomatous eye.
    c. Diamox is a diuretic used in the treatment of glaucoma.
    d. Diuretics are generally useful in the treatment of glaucoma.
    e. Diamox produces myopia in some individuals.

39. Which one of the following statements is true?
    a. Chlorpromazine or thorazine is a drug with a wide safety margin and because of this reason, it is used extensively.
    b. Chlorpromazine and other drugs belonging to its group are used in the treatment of open angle glaucoma.
    c. Chlorpromazine does not cause any damage to the retina.
    d. Chlorpromazine is known to cause cataract.
    e. Chlorpromazine is stored in the choroid and pigment epithelium of the retina and may cause irreversible retinal damage.

40. In the case of a known open-angle glaucoma being treated with miotics, which one of the following drugs should be used to dilate the pupil for ophthalmoscopy?
    a. cyclopentolate
    b. phenylephrine
    c. homatropine
    d. scopolamine
    e. atropine

This examination consists of 4 pages. See that your copy is complete and that no questions are overlooked.

22nd Annual Examination

NATIONAL BOARD OF EXAMINERS IN OPTOMETRY

Question Sheet for Part II, Section 4, OCULAR PATHOLOGY
Number of Test: 3

Monday, April 30, 1973 (2 hours) 3:30 - 5:30 p.m.

Instructions: Read carefully before starting. See also general instruction sheet. This examination consists solely of multiple-choice questions. There are 100 test items. On the answer sheet supplied with this examination, blacken the proper box to indicate the single best answer for each question. Each question has a point value of 1. Total value is 100 points. Be sure to indicate that the number of this test is 3.

1. Which of the following is the most valid method of detecting acute glaucoma?
   a. tonometry (indentation type)
   b. ophthalmodynanometry
   c. tonometry (applanation type)
   d. visual-field testing
   e. ophthalmoscopy

2. Magnification of a visual-field defect can be obtained by
   a. viewing it with an indirect, binocular ophthalmoscope
   b. increasing the testing distance
   c. having the patient wear a +2.50 D lens
   d. having the patient wear a meridional magnifier axis 90
   e. none of the above is correct

3. The best biomicroscope illumination for discovery of posterior corneal endothelial opacities is
   a. retro-illumination
   b. direct illumination
   c. specular illumination
   d. indirect illumination
   e. sclerotic-scatter illumination

4. A patient has a bilateral field defect in which the left eye field has an inferior-nasal quadranopia and the right eye has a nasal hemianopia. The pathology is most likely located in or near the
   a. optic nerve
   b. retinal ganglion cell layer
   c. lateral geniculate body
   d. optic chiasma
   e. anterior optic tract

5. Which of the following is NOT a field defect associated with glaucoma?
   a. baring of the blind spot
   b. nasal step
   c. Gullstrand extension of the blind spot
   d. Seidel scotoma
   e. arcuate scotoma

6. A patient with a chemical burn of the eye should generally receive the following treatment: immediate
   a. referral to an ophthalmologist
   b. examination with the biomicroscope
   c. instillation of a miotic and lid closure
   d. irrigation of the eye with water or, if available, saline
   e. instillation of a mydriatic and anesthetic

7. Observation of the fundus with the yellow-green ophthalmoscopic filter is used for detecting
   a. hemorrhages
   b. drusen of the disc
   c. macular degeneration
   d. pigment spots
   e. venous pulsation

8. Which of the following hemorrhages is located near the ganglion-cell layer of the retina?
   a. circular-shaped
   b. subhyaloid-shaped
   c. flame-shaped
   d. streak or circular-shaped
   e. star or fan-shaped

9. Ptosis may occur in
   a. myasthenia gravis
   b. Horner's syndrome
   c. 3rd nerve paralysis
   d. senile patients
   e. all of the above are correct

10. Epicanthus inversus is
    a. an inversion of the outer canthal folds
    b. a recessively inherited autosomal characteristic
    c. a redundant skin fold originating from the lower lid
    d. associated with blepharochalasis
    e. a genetic defect of the temporal plica semilunaris

11. A hordeolum is a staphylococal infection of which glands?
    a. Zeis and Moll
    b. Meibomian
    c. Kraus
    d. Wolfring
    e. a and b both are correct

This examination consists of 9 pages. See that your copy is complete and that no questions are overlooked.

12. Nodular episcleritis usually
    a. is located deep to the conjunctiva which can be shown by movement of the conjunctiva
    b. is a chronic and recurrent condition
    c. doesn't affect vision even with prolonged duration
    d. is bilateral
    e. all of the above are correct

13. A patient with a progressive nuclear sclerosis generally will have
    a. iridodenesis
    b. increasing myopia
    c. increasing hyperopia
    d. increasing astigmatism
    e. increased long-wavelength absorption

14. Which of the following is characterized by retinal changes of cotton-wool patches, focal constrictions, hard exudates, retinal edema, and right-angle vessel crossings?
    a. arteriosclerosis
    b. diabetes
    c. hypertension
    d. polycythemia
    e. all of the above are correct

15. Asteroid hyalitis
    a. occurs in the posterior chamber and thus vision is not disturbed
    b. consists of dark spots that move when the eye moves
    c. has a dull appearance with focal illumination
    d. is another name for synchysis scintillans
    e. none of the above is correct

16. Cotton-wool exudates are
    a. pigment epithelium secretions
    b. microinfarcts in the nerve-fiber layer
    c. lamina vitrea changes which occur with age
    d. soft arteriolar secretions
    e. soft venule secretions, associated with cell-wall changes

17. Diabetic changes in the eye may include
    a. lens opacities
    b. neovascularization of retinal vessels
    c. degenerative changes in vessel walls
    d. microaneurysms
    e. all of the above are correct

18. There is profuse mucous discharge in
    a. catarrhal conjunctivitis
    b. vernal conjunctivitis
    c. follicular conjunctivitis
    d. purulent conjunctivitis
    e. allergic conjunctivitis

19. In retinal detachment
    a. the location is usually peripheral
    b. vessels in the detached area are normal in color
    c. there is usually progression in the temporal direction
    d. an associated retinal tear presents a greenish color
    e. all of the above are correct

20. Regarding tonography
    a. in normal eye the Po/C ratio will exceed 100
    b. the tonometer remains on the cornea for about 2 minutes
    c. a majority of untreated open-angle glaucomatous eyes will have a Po/C ratio of 140 or higher
    d. tonography is performed with an applanation tonometer
    e. all of the above are correct

21. Seborrheic blepharitis differs from staphlococcic blepharitis in that
    a. the former exhibits remissions and exacerbations
    b. loss of eye lashes is present in the latter
    c. the latter is associated with dandruff
    d. the former is usually caused by Morax-Axenfeld bacillus infection
    e. none of the above is correct

22. Dislocation of the lenses is a characteristic finding in
    a. Von Recklinghaussn's syndrome
    b. thyrotoxicosis
    c. Marfan's syndrome
    d. Sjogren's syndrome
    e. none of the above is correct

23. Regarding Hassal-Henle bodies,
    a. they are present in a majority of young persons
    b. they are best detected by use of the specular reflection technique in slit-lamp biomicroscopy
    c. they are caused by degeneration of corneal stroma
    d. they are caused by infiltration of fat droplets in Bowman's membrane
    e. both a and c are correct

This examination consists of 9 pages. See that your copy is complete and that no questions are overlooked.

24. Bilateral cecocentral scotoma with no other ocular symptoms or signs of fundus pathology is most likely caused by
    a. pituitary tumor
    b. cavernous sinus thrombus
    c. posterior cerebral hemorrhage
    d. tobacco amblyopia
    e. multiple sclerosis

25. Fundus examination of an infant's eyes shows a whitish macular area with a cherry-red fovea and a white, atrophic disc. This appearance could be caused by
    a. occlusion of central-retinal artery
    b. occlusion of central-retinal vein
    c. Tay-Sachs disease
    d. all of the above are correct
    e. only a and c are correct

26. A patient 40 years old complains of blurring. Fundus examination shows the foveal reflex is missing, and the macular area is slightly elevated. Field tests show a central scotoma. The contralateral eye is normal in appearance and function. The probable pathology is
    a. senile macular degeneration
    b. central serous retinopathy
    c. retrobulbar neuritis
    d. syphilitic uveitis
    e. retinitis pigmentosa

27. The visual aura in migraine is
    a. present in about 10 percent of migraine cases
    b. caused by vasodilation
    c. usually accompanied by recognizable fundus changes
    d. all of the above are correct
    e. none of the above is correct

28. Fundus examination shows a marked narrowing of retinal arteries and veins, a yellowish disc, and scattered pigment masses resembling bone corpuscles in shape. The patient complains of poor vision at night. The probable diagnosis is
    a. chorioretinitis
    b. retinoblastoma
    c. retinitis pigmentosa
    d. choroideremia
    e. all of the above could cause these signs and symptoms

29. Ophthalmoscopy shows a pale fundus in which arteries and veins are distended, tortuous, pale yellow in hue, and difficult to tell apart. Hemorrhages of various sizes occur, some with white centers. The diagnosis is
    a. leukemic retinopathy
    b. diabetic retinopathy
    c. occlusion of the central retinal artery
    d. nephritic retinopathy
    e. none of the above is correct

30. Fundus examination shows that the disc has hazy margins, an irregular surface, and is greyish in color. Field tests show no visual loss. The retinal blood vessels and the retina appear normal. The probably cause of the abnormally appearing disc is
    a. papillitis
    b. papilledema
    c. retrobulbar neuritis
    d. pseudopapillitis
    e. none of the above is correct

31. A patient complains of deep pain in one eye. The eye is sensitive to palpation. The optic disc is reddish and moderately elevated with indistinct margins. Field tests show a central scotoma. The probable diagnosis is
    a. glaucoma
    b. papillitis
    c. papilledema
    d. pseudo-optic neuritis
    e. occlusion of central retinal artery

32. Secondary glaucoma is frequently caused by
    a. iridocyclitis
    b. occlusion of central-retinal artery
    c. papillitis
    d. keratitis
    e. toxoplasmosis choroiditis

33. A patient exhibits fever, general malaise, and glossy red, edematous, demarcated patches involving the eyelids and adjacent facial skin. Probable diagnosis is
    a. dacryocystitis
    b. dacryoadenitis
    c. erysipelas
    d. atopic dermatitis
    e. obital cellulitis

34. After a few weeks of mild bilateral conjunctivitis, a severe conjunctivitis follows with swollen eyelids, opaque follicles on the upper palpebral conjunctiva. A vascular membrane invades the upper cornea. The patient probably has
    a. follicular conjunctivitis
    b. swimming-pool conjunctivitis
    c. vernal conjunctivitis
    d. trachoma
    e. syphilis

35. Sattler's veil refers to hazy vision caused by
    a. scratching of the corneal epithelium
    b. corneal subepithelial edema resulting from oxygen deprivation
    c. corneal stromal edema resulting from high intraocular pressure
    d. tears in Descemet's membrane
    e. Fuch's endothelial dystrophy

This examination consists of 9 pages. See that your copy is complete and that no questions are overlooked.

36. A patient complains of severe pain on one side of the face. Small vesicles are found on the skin of the upper eyelid. Corneal examination shows punctate white dots and reduced corneal sensitivity on the same side of the face. The probable diagnosis is
    a. chicken pox
    b. small pox
    c. Herpes Zoster ophthalmicus
    d. Herpes simplex
    e. tic douloureux

37. The Kayser-Fleischer ring
    a. is a circle of blood and pigment in the cornea
    b. indicates a dystrophy of endothelium of the cornea
    c. is caused by faulty sugar metabolism
    d. indicates a hereditary excessive absorption of copper by the alimentary tract
    e. all of the above are correct

38. A mature senile cataract is
    a. likely to cause increased intraocular pressure
    b. appears shrunken, with soft, milky cortex
    c. shows fine dust-like opacities scattered throughout the lens
    d. appears opaque, dull grey, amber or brown in color
    e. shows radiating opaque streaks from periphery toward the center of the lens

39. A layer of pigment granules deposited on the anterior lens surface after trauma is called
    a. Kayser-Fleischer ring
    b. Maxwell's ring
    c. Vossius' ring
    d. Soemmering's ring
    e. Krukenberg's spindle

40. Hittendorf's dot, situated on the posterior surface of the lens, is
    a. the earliest sign of posterior subcapsular cataract
    b. an unimportant congenital anomaly
    c. a significant sign of vitreous detachment
    d. a sign of synchysis scintillans
    e. a sign of retrolental fibroplasia

41. A patient has noticed for several weeks a gradual deterioration of vision. There is no ocular pain. The vitreous is cloudy; the fundus shows small yellow-grey, ill-defined foci of inflammation. The diagnosis is
    a. retinitis pigmentosa
    b. retinitis proliferans
    c. disseminated choroiditis
    d. diabetic retinopathy
    e. hypertensive retinopathy

42. A patient over 60 years of age has numerous white spherical bodies in the vitreous, which move when the eye moves and return to their original position when the eye is at rest. There are no signs of present or past inflammation. These bodies are
    a. cholesterol crystals
    b. muscae volitantes
    c. synchysis scintillans
    d. calcium-lipid soaps
    e. mutton-fat bodies

43. An aqueous flare would lead one to suspect
    a. glaucoma
    b. iritis
    c. posterior uveitis
    d. cyclitis
    e. brain tumor in the medulla

44. Which of the following ocular symptoms does NOT occur in multiple sclerosis?
    a. weak convergence
    b. ptosis
    c. loss of accommodation
    d. diplopia
    e. none of the above is correct

45. Severe deficiency of vitamin A in the diet or in intestinal absorption may cause
    a. Bitot spots on the conjunctiva
    b. grey indolent corneal ulcer
    c. xerophthalmia
    d. keratomalacia
    e. all of the above are correct

46. Retrobulbar neuritis often occurs as a complication of
    a. multiple sclerosis
    b. sinusitis
    c. pernicious anemia
    d. acquired syphilis, secondary stage
    e. all of the above are correct

47. A patient complains of seeing double, lids drooping, and difficulty in swallowing, particularly towards the end of the day. The probable diagnosis is
    a. Marfan's syndrome
    b. myasthenia gravis
    c. Graves' syndrome
    d. myotonic dystrophy
    e. multiple sclerosis

48. Itching eyes, stringy exudate containing eosinophiles, and many papillae on the upper tersal conjunctiva indicate
    a. catarrhal conjunctivitis
    b. membranous conjunctivitis
    c. vernal conjunctivitis
    d. gonorrheal conjunctivitis
    e. epidemic keratoconjunctivitis

49. The patient exhibiting bilateral congruent inferior hemianopia probably has a lesion in the
    a. ventral fibers
    b. upper lip of both calcarine fissures
    c. area between proximal parts of both optic nerves
    d. posterior communicating artery
    e. optic chiasma

50. Simple chronic glaucoma
    a. occurs most frequently in individuals whose IOP varies diurnally by 3-4 mm/Hg
    b. causes loss of vision by pressure on the fovea
    c. occurs in all individuals who have an IOP over 30 mm/Hg
    d. all of the above are correct
    e. none of the above is correct

51. In optic nerve atrophy associated with Leber's disease, the expected field defect is
    a. peripheral field contraction
    b. ring scotoma
    c. bitemporal hemianopia
    d. concentric blind spot enlargement
    e. centrocecal scotoma

52. One of your elderly patients complains of the transient loss of vision in one eye. His blood pressure is normal. His fundus appears normal on examination. The loss of vision
    a. was probably imaginary
    b. can be ignored
    c. was probably due to infarction
    d. may be a warning of possible central-retinal artery occlusion
    e. may be a warning of possible retinal detachment

53. You see a central-retinal artery occlusion a day after it occurred. The statement that "there is no need to refer this case because the damage has been done and nothing can be done for the patient" is
    a. true because a referral would be a waste of time and money
    b. false because vision may return with treatment
    c. false because with care the patient's other eye and perhaps life may be saved
    d. true because treatment is only effective if given within one hour

54. Bacterial conjunctivitis is most likely cause
    a. profuse tearing
    b. purulent discharge
    c. marked itching
    d. follicular formations
    e. membrane formations

55. A contact-lens patient telephones to say that his left eye is red, sore, and blurred. The right eye is without symptoms even though both lenses were overworn by six hours at a party. You should recommend
    a. leaving the lenses out a day before trying again
    b. rest, aspirin, closer adherence to the wearing schedule
    c. an eye exam to rule out iritis or glaucoma
    d. a refitting of the left lens
    e. none of the above is correct

56. Optic neuritis results in
    a. central scotoma
    b. peripheral constriction of the visual field
    c. cecal scotoma
    d. enlarged blind spot
    e. both a and b are correct

57. Your patient says he sees better in bright sunlight than indoors. He is also having increased difficulty reading. Which of the following cataracts is most likely to produce these symptoms?
    a. cuneiform cataract
    b. nuclear cataract
    c. cupuliform cataract
    d. nuclear sclerosis
    e. posterior polar cataract

58. A patient says he sees sparks and flashes in the lower field of the right eye. He also says that everything is cloudy in that area. If both symptoms are of recent origin, you would suspect
    a. retinitis
    b. Coats' disease
    c. angiospastic retinopathy
    d. retinal detachment
    e. atypical migraine

59. On fundus examination you notice whitish spots edged with pigment clumps scattered about the fundus. Visual-field examination shows multiple scotomas that are absolute. Your diagnosis is
    a. drusen deposits
    b. old, inactive disseminated chorioretinitis
    c. active, central choroiditis
    d. old, inactive central choroiditis
    e. active, disseminated chorioretinitis

This examination consists of 9 pages. See that your copy is complete and that no questions are overlooked.

60. The grayish or yellowish coloration of the lens seen using oblique illumination in most eyes in old age is due to
    a. discoloration of lens capsule
    b. sclerosis of lens fibers
    c. nuclear cataract
    d. reflection from the iris
    e. all of the above are correct

61. Diabetic retinopathy and retinal vein occlusion are alike in that both
    a. occur following hypertension
    b. result in blindness in 50% of the cases
    c. are the first signs of systemic diseases
    d. may result in neovascularization of the fundus and rubeosis iridis
    e. all of the above are correct

62. Using the direct ophthalmoscope and viewing through a red lens you would enhance which item in the fundus the most?
    a. hemorrhages
    b. edema
    c. pigment
    d. blood vessels
    e. optic nerve fibers

63. The prognosis of a retinal detachment is best if the cause of the detachment is
    a. vitreous detachment and traction on the retina
    b. retinal tear
    c. edema from toxemia of pregnancy
    d. diabetic retinopathy
    e. choroidal tumor

64. Which tumor primarily occurs before the age of 6 years?
    a. malignant melanoma
    b. lid epithelioma
    c. retinoblastoma
    d. all of the above are correct
    e. none of the above is correct

65. A conjunctival nevus should be referred for consideration of removal if it
    a. enlarges and becomes vascular
    b. produces irritation
    c. is chronically inflamed
    d. is cosmetically poor
    e. all of the above are correct

66. Which of the following is NOT true of choroidal nevi?
    a. frequently becomes malignant
    b. the retinal area appears flat
    c. often cause a field defect
    d. all of the above are correct as none are true statements
    e. none of the above is correct as all are true statements

67. Which of the following is NOT seen in absolute glaucoma?
    a. optic atrophy
    b. iris atrophy
    c. corneal edema
    d. vitreous hemorrhage
    e. intense pain

68. A lid pathology including hyperemic and swollen lid margins, foamy secretion, and which yields yellowish fluid with pressure on lid margin, indicates
    a. meibomianitis
    b. hordeolum
    c. angioneurotic edema
    d. tarsitis
    e. acute blepharitis

69. Occlusion of the central retinal vein may result in
    a. blanching of the retina
    b. pain at the onset
    c. hemorrhagic glaucoma
    d. all of the above are correct
    e. none of the above is correct

70. The most significant ophthalmoscopic finding in chronic simple glaucoma is the
    a. depth of the cup
    b. vessel displacement
    c. clarity of the disc margins
    d. size ratio between arteries and veins as they cross the disc margin
    e. width of the cup

71. The major cause of diplopia in the over 60 age group is
    a. orbital tumor
    b. multiple sclerosis
    c. cerebrovascular accident
    d. diabetes mellitus
    e. luxation of the lens

72. A patient has recently experienced a severe infection of an upper molar tooth. He now has swelling of the eyelids, exophthalmos, impaired ocular motility, and high fever. The probable diagnosis is
    a. thyrotoxicosis
    b. tenonitis
    c. iritis and secondary glaucoma
    d. orbital cellulitis
    e. scleritis

73. Aqueous flare, photophobia, and keratic precipitates indicate
    a. posterior uveitis
    b. anterior uveitis
    c. scleritis
    d. intraocular parasitic infestation
    e. angle-closure glaucoma

This examination consists of 9 pages. See that your copy is complete and that no questions are overlooked.

74. According to the Keith-Wagener-Barker classification of hypertensive retinopathy
    a. edema residues are first seen in group 2
    b. arteriovenous ratio may be 1:3 in group 2
    c. hemorrhages are present in group 1
    d. papilledema is present in group 3
    e. all of the above are correct

75. The usual first arteriovenous crossing defect in arteriosclerotic retinopathy is
    a. depression or elevation of the vein
    b. deviation of the vein
    c. concealment of tapering of the vein
    d. ~~banking of the vein distal to artery crossing~~
    e. increased arterial tortuosity near the crossing

76. Administration of large doses of corticosteroids over an extended period may cause
    a. nuclear cataract
    b. posterior subcapsular opacities in lens
    c. fine, superficial cortical lens opacities
    d. dense, disc-like opacity of the lens
    e. stromal opacities of the cornea

77. Which of the following may be a sign or symptom of malignant melanoma?
    a. hyperopic shift of refraction error
    b. relative scotoma
    c. metamorphopsia
    d. both a and b are correct
    e. all of the above are correct

78. The fundus reveals hemorrhage, edema, cotton-wool patches, generalized attenuation of the arterioles and papilledema. The diagnosis is
    a. hypertensive retinopathy grade IV
    b. arteriosclerotic retinopathy grade III
    c. diabetic retinopathy stage III
    d. hypertensive retinopathy grade III
    e. diabetic retinopathy stage IV

79. Retinal arterial pulsation seen in the fundus
    a. may be a normal variation
    b. may be associated with aortic regurgitation
    c. occurs when intraocular pressure is less than diastolic pressure
    d. occurs with retinal vein occlusion
    e. none of the above is correct

80. With regard to pseudo-optic neuritis
    a. the eye is usually highly myopic
    b. venous engorgement is present
    c. the blind spot is enlarged
    d. the cause is excessive glial tissue in the disc
    e. all of the above are correct

81. Disciform degeneration of the macula
    a. occurs most frequently in young people
    b. is caused by degeneration of the neuroglia cells of the retina
    c. does not affect visual acuity
    d. causes progressive contraction of the peripheral field
    e. none of the above is correct

82. Retinitis proliferans often occurs in
    a. syphilitic retinopathy
    b. diabetic retinopathy
    c. recurrent retinal hemorrhage
    d. all of the above are correct
    e. none of the above is correct

83. A patient has moderate conjunctival inflammation with the greatest injection in the lower fornix region. There is a nonprofuse watery or mucoid discharge, tearing, and itching. This is most likely
    a. bacterial conjunctivitis
    b. viral conjunctivitis
    c. fungal conjunctivitis
    d. chronic atopic (allergic) conjunctivitis
    e. ocular phemphigoid

84. Which of the following is true of perforated detachments of the retina?
    a. result from penetration of fluid from the vitreous space into the subretinal space
    b. rarely occur in a healthy eye, but do occur in an eye suffering from degenerative changes of myopia or aging
    c. only rarely occur at the macula even when a hole in the macula exists
    d. all of the above are correct
    e. only a and c are correct

85. Bitot's spots
    a. are found primarily in children as a result of malnutrition
    b. appear to be hard, dark masses deep to the conjunctiva in the episclera
    c. may be followed by marked corneal changes of softening, exfoliation of the epithelium, development of ulcers, and loss of transparency
    d. all of the above are correct
    e. only a and c are correct

86. Which of the following is NOT true of keratoconus?
    a. usually becomes manifest in youth
    b. is usually unilateral
    c. slit-lamp observation shows marked corneal thinning at the apex
    d. there is often a ring (Fleischer's ring from deposition of iron) around the cone
    e. none of the above is correct as all are true statements concerning keratoconus

87. Which of the following is NOT a senile or aging change of the cornea?
    a. Hassall-Henle bodies
    b. lipid arcus
    c. white limbus girdle
    d. all of the above are correct as none are aging changes
    e. None of the above is correct as all are aging changes

88. The patient's eye shows conjunctival swelling with considerable red hyperemia near the fornices; has a watery discharge mixed with mucus and leucocytes; and small papillae in the tarsal region of the lids. The patient reports a "foreign body" sensation. The probable diagnosis is
    a. acute catarrhal conjunctivitis
    b. chronic catarrhal conjunctivitis
    c. purulent conjunctivitis
    d. pseudo-membranous conjunctivitis
    e. acute angle-closure glaucoma

89. A vitreous detachment
    a. causes the patient to see floaters and occasional light streaks, usually in the temporal field
    b. ophthalmoscopically may appear as a hole in a membrane floating in front of the retina
    c. leads to retinal detachment in a majority of cases
    d. both a and b are correct
    e. a, b, and c are all correct

90. Vitreous detachment most commonly occurs
    a. anteriorly separating the vitreous from the lens
    b. posteriorly separating the vitreous from the posterior pole of the eye
    c. laterally separating the vitreous from the temporal ora
    d. superiorly separating the vitreous from the superior ora
    e. inferiorly separating the vitreous from the inferior ora

91. Which of the following is true of cataracts with diabetic patients?
    a. senile cataracts occur more frequently and at an earlier age as compared to nondiabetics
    b. the specific diabetic cataract occurs primarily in young persons
    c. the specific diabetic cataract typically shows opacities in the anterior and posterior cortex
    d. both a and c are correct
    e. a, b, and c are all correct

92. An early choroidal tumor or early serous pigmentary epithelial detachment is most likely to be revealed by a
    a. peripheral field loss detected by perimetry examination
    b. relative scotoma detected with the multiple pattern screener
    c. relative scotoma detected by tangent screen examination
    d. relative scotoma detected on the Amsler grid
    e. metamorphopsia detected on the Amsler grid

93. With regard to the swinging light test
    a. it is also called the pupillary release test
    b. a flashlight beam, in a dark room is passed alternately before the two eyes
    c. dilation of the pupil of the right eye as the light is shown into the right eye indicates that the direct light reflex for the right eye is weaker than the consensual light reflex from the left eye
    d. dilation of the pupil of the right eye as the light is shown into the right eye indicates that the retina or optic nerve of the right eye is deficient and possibly undergoing pathological changes
    e. all of the above are correct

This examination consists of 9 pages. See that your copy is complete and that no questions are overlooked.

94. With regard to topical anesthetics,
    a. the use of anesthetics retards repair of the corneal epithelium
    b. corneal anesthesia is produced by blockage of impulse conduction at nerve synapses
    c. while uncommon, allergic reactions are severe and require medical treatment
    d. both a and b are correct
    e. a, b, and c are all correct

95. Congenital ptosis is
    a. often associated with superior rectus palsy
    b. often associated with a miotic pupil
    c. usually unilateral
    d. all of the above are correct
    e. none of the above is correct

96. The Schirmer test measures
    a. corneal sensitivity
    b. corneal sensibility
    c. rate of aqueous production
    d. rate of aqueous outflow
    e. rate of tear formation

97. A chalazion
    a. is a painless swelling of the lid without gross inflammatory signs
    b. may disappear upon massage of the lids
    c. requires immediate removal if secondary infection is to be avoided
    d. a and b are both correct
    e. a, b, and c are all correct

98. Which of the following is true of closed-angle glaucoma?
    a. is most likely to occur in hyperopic eyes with a shallow anterior chamber
    b. may occur either as the result of an iris bombe or as the result of mydriasis bunching the iris into the filtration angle
    c. acute attacks usually occur suddenly without prodromal symptoms
    d. both a and b are correct
    e. a, b, and c are all correct

99. Studies by Armaly and other investigators indicate that there is a genetic basis for
    a. ~~high increase in intraocular~~ topical steroids pressure from topical steroids
    b. the cup-disc ratio of the optic nerve
    c. open-angle glaucoma
    d. both a and b are correct
    e. a, b, and c are all correct

100. Which of the following would counterindicate the use of neosynephrine for facilitating ophthalmoscopy?
    a. an aqueous space at the limbus equal to the corneal thickness
    b. an aqueous space at the limbus less than one-half of the corneal thickness
    c. a family history of open-angle glaucoma
    d. both a and b are correct
    e. a, b, and c are all correct

This examination consists of 9 pages. See that your copy is complete and that no questions are overlooked.

UNITED STATES

OPTOMETRIC COLLEGES

1. University of Alabama in Birmingham (School of Optometry at the Medical Center)
2. University of California (School of Optometry)
3. University of Houston (College of Optometry)
4. Illinois College of Optometry
5. Indiana University (Division of Optometry)
6. Southern California College of Optometry
7. Massachusetts College of Optometry
8. Pacific University (College of Optometry)
9. Pennsylvania College of Optometry
10. Southern College of Optometry
11. State College of Optometry (State University of New York)
12. Ohio State University (College of Optometry)
13. Ferris State College (College of Optometry)

OSU

CORVALLIS, OREGON 97331

OREGON STATE UNIVERSITY

SCHOOL OF PHARMACY
Reply to: OFFICE OF THE DEAN
Area code 503; telephone 754-3191; 754-3283

Statement of
Charles O. Wilson
Dean Pharmacy
Oregon State University

My interest in this bill is in the provision which it provides for a health professional, in this case the optometrist, to utilize his special knowledge to the fullest extent in order to benefit the patient.

As a pharmacist, and Dean of Pharmacy at Oregon State University, I have observed a primary service of a pharmacist lies in his ability to recognize disease states and to urge his ill customers to see a physician.

The need for services of a physician is not always known by an individual. This is the reason for today's mass testing for diabetes, hypertension, heart disease, and the reason why women are instructed to check themselves for breast cancer. These activities are all designed to bring the patient into the health-care system.

Optometrists can, through this legislation, offer a diagnostic service to eye patients and facilitate their entrance into the health-care system. There must be many people who, having a pathological eye condition unknown to them, seek the services of an optometrist for the fitting of glasses.

This Bill will make it possible for optometrists to carry out diagnostic procedures to identify any pathological condition during

the course of the examination for the fitting of glasses. On those accasions when a pathological condition is identified, the patient will be referred to an ophthalmologist for treatment.

I see in this Bill a very positive effect upon the practice of optometry and another means of mass eye examination for the prevention of blindness.

Charles O. Wilson

IV.

TESTIMONY

BY

PETER P. LAMY, PH.D., F.C.P.

Professor and Director
Institutional Pharmacy Programs
Chairman, Department of Pharmacy
Practice and Administrative Science

UNIVERSITY OF MARYLAND
SCHOOL OF PHARMACY

SENATE ECONOMIC AFFAIRS COMMITTEE

March 8, 1979

I am pleased to support the request by the Maryland Optometric Association for legislation which would allow board certified optometrists to use certain specified classes of topically administered pharmaceutical agents for diagnostic purposes.

Some Background Information:

I think it will be helpful to review very briefly the professional practice of optometrists in at least one other country:

In Britain, optometrists have been trained in and accustomed to the use of certain drugs in eye examinations for more than 50 years. In 1949, a select Committee under Lord Crook, a committee which included five physicians, unanimously concurred in the use of certain specified drugs by optometrists for eye examinations. British optometrists perform over 80% of the eye examinations in that country. The British position was reveiwed in 1970 by a joint committee of ophthalmologists and optometrists and they concluded that "it is proper for an optometrist to use appropriate drugs for eye examinations."

What is Needed:

The citizens of Maryland are entitled to a continuum of care, ranging from primary to specialized care, delivered in the best and most cost-efficient manner. As far as eye examinations are concerned, it is reasonable to envision a cycle with optometrists providing initial examination and triage, ophthalmologists having the opportunity to exert the full range and benefit of their extensive medical education in the treatment of eye diseases. As a matter of fact, a similar course of events is already taking place, with the great majority of patients already seeking out optometrists for an initial eye evaluation. Passage of this bill would give optometrists the opportunity to deliver more careful and valuable care to our citizens.

As a health professional greatly interested in the fields of geriatrics and gerontology, I might point out that the National Center for Health Statistics, in 1975, reported that approximately 50% of our elderly citizens suffer from impaired vision. Many of these do not seek help, often owing to economic constraints. As a matter of fact, the Central Maryland Health Systems Agency has reported that in Baltimore City, approximately 25% of the population would be classified as "gray area" persons, that is those who do not qualify for medical assistance but are simply too poor to look for adequate health care. An enlarged role for optometry which does not encroach on the role of ophthalmology would probably be greatly helpful to those citizens.

What Questions Must Be Answered?

It is clear that this bill must be viewed from a benefit-risk point of view. What would be patient benefit, what would be patient risk? As already outlined the benefits would seem to be large, both from an economic point of view and a health care point of view.

What about risk? The eye is a very sensitive organ. Blindness, precipitation of angle-closure glaucoma, and infection are probably the greatest risk when eye preparations are administered. YET, very few cases of glaucoma precipitated by dilation of the pupil are reported, in the range of 1:15,000 patients. It is difficult to envision blindness caused by a one-time application of the classes of drugs which are being discussed.

Sodium fluorescin solution, which is known to support the proliferation of bacteria easily, was routinely used by optometrists as well as ophthalmologists without causing a high incidence of eye infections.

On the other hand, the benefits from the topical use of drugs for diagnostic purposes far outweigh the risk to vision. There is simply no good way to obtain a satisfactory view of the interior of the eye unless the pupil is dilated. In addition, it is highly probable that optometrists, properly trained, and being able to practice in a more efficacious manner, will be able to recognize more eye abnormalities, which can and will then be referred to ophthalmologists, increasing public benefit and the level of public health.

Is This Bill Reasonable?

I believe it is.

The bill asked only that certain drugs could be used by optometrists in eye examinations. It does not ask that optometrists be granted the right to treat eye diseases.

The bill asked that only properly trained, and qualified optometrists be given this professional privilege. It specifically does not ask for a grandfather clause and, indeed, asks that optometrists can only be qualified after they have been trained and educated in the pharmacological action and proper use of these drugs.

Thus, weighing risks and benefits, I must believe that the benefits to the citizens of Maryland far outweigh the risks, and that is the reason why I support this bill.

Sincerely,

Peter P. Lamy, Ph.D., F.C.P.

STATEMENT

ALASKA BOARD OF EXAMINERS IN OPTOMETRY

ALASKA STATE

MANPOWER

regarding

VISION AND EYE HEALTH CARE

The optometrists of Alaska are geographically more evenly distributed so as to meet the needs of the people. Ophthalmologists are primarily concerned with eye surgery and, therefore, are concentrated around larger population areas where more extensive hospital facilities are available.

As the National Health Care program emerges, along with other increasing group insurance programs, the need for better referral channels must be established. Diagnostic agents can make pathology detection more effective and those referrals more accurate.

Enclosed are:

1. Alaska Distribution Map on Vision and Eye Health Care.

2. 1979 listing on:

    a. Resident Optometrists in Alaska (32)
    b. Resident Ophthalmologists in Alaska (17)

PRIVATE PRACTIONERS

OPTOMETRISTS

by cities (32)

FAIRBANKS

Hammond
Johnson
LeFevre
Lounsbury
Schmidt

ANCHORAGE

Bach, E.
Bach, P.
Bigelow
Falconer, M.
Falconer, J.
Faulkner
Hall
Harbour
Miller
Rosselius
Sternberg
Walker
Albert
Gonnason

JUNEAU

Box
Kemp
Matson

KENAI

Swarner
O'Connel

NORTH POLE

Cobbett

KETCHIKAN

Craig
Smith
Swearingen

BETHEL

Demskey

EAGLE RIVER

Keene

SITKA

McLaughlin

VALDEZ

Mastolier

KODIAK

Swank

Through branch offices, these communities are served by optometrists:

Petersburg
Wrangel
King Salmon
Naknek
Galena
Seward
McGrath
Unalaklett
Kotzebue
Barrow
Cordova
Haines
Skagway
Kake
Yukutut
Nome
Prudhoe
Deadhorse
Delta Junction
Homer
King Cove
Sand Point
Wasilla
Dillingham
Yakutat

OPHTHALMOLOGISTS

by cities (17)

ANCHORAGE

Skille
Dippe
Harrison
Patterson
Grendahl
Richardson
Nyboer
Rigg
Sheisl
Shoff

FAIRBANKS

Kinn
Wolf
Dicksheet
McConkey

JUNEAU

Page

SOLDOTNA

Canava

ANCHOR POINT

Fritz

KETCHICAN

Tokar

PROBABLE OBJECTION

Based on experience elsewhere opposition will probably come from ophthalmologists based on the alleged:

1. Adverse side effects of drugs and the incapacity of optometrists to deal with them.
2. Lack of qualification of optometrists in the use of these diagnostic agents.

AMERICAN ASSOCIATION OF OPHTHALMOLOGY

PUBLIC RELATIONS PAMPHLET "WHY DROPS"

Typically this pamphlet is displayed in ophthalmologists offices or handed out to other interested persons or groups.

1. The pamphlet states that drops must be used in order to perform an adequate visual and eye health examination.

   The following are quotes from the pamphlet:

   DROPS TO ENLARGE THE PUPILS:

   -"to look through the open door instead of through the keyhole".
   -"drops make it possible for him to study not only the lens through which the light must pass, but also the retina where the image is formed, and the optic nerve which transmits the picture to the brain."

   RELAX THE FOCUSING MUSCLE:

   -"This is often necessary to determine the TRUE degree of refractive error that has to be corrected by glasses."
   -"The use of these drops is especially important when examining children."
   -"When a physician examines a young child with strabismus (crossed eyes), it is essential..."

   ANESTHETIZE THE EYE:

   -"They are required for the all-important testing for glaucoma."

2. The pamphlet alleges that drops can not be used by optometrists but only by an ophthalmologist.

   The following quotes make their points:

   -"Of course, all drops are medicine and they can be prescribed only by a physician..."
   -"You should never let anyone else put anything in your eye."

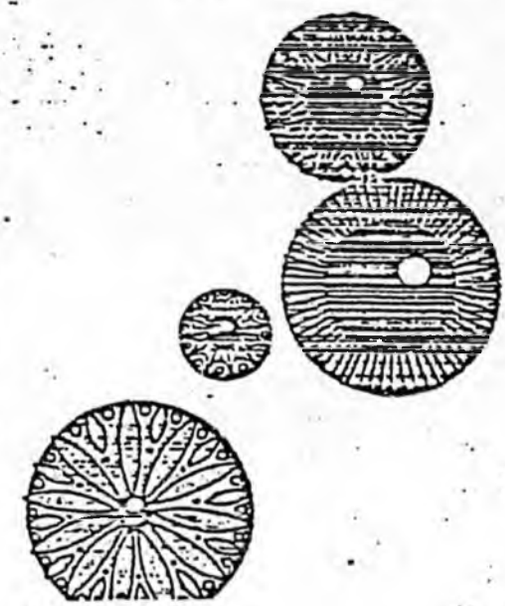
3. The final statement from this pamphlet says: Drops..."are often the key to the prevention of blindness and even the saving of the eye itself."

   If the American Association of Ophthalmology feels strongly about all those points made in this pamphlet, and is able to recognize that 70% of the people in the United

States are seen by optometrists for eye care, what conclusions must have been reached? Are all those 70% seen by optometrists receiving poor eye care? Are plans being made to train more ophthalmologists? What positive efforts has ophthalmology made to correct this? If the answers to those questions are disheartening, is the only basis for this pamphlet one of economics, self esteem, or P.R.?

Alaskan optometrists are sincerely interested in improving the scope of their eye care to Alaskan residents. They are prepared to encompass quality educational standards as insurance that the usage of diagnostic agents by Alaskan optometrists will result only in improved vision and eye health care for the people of Alaska.

why drops?



Patients sometimes ask their eye physician, "Why do you use 'drops' when you examine my eyes?"

A clear answer to this question will help one understand the fundamentals of medical eye care and the relationship of his eyes to the health of his body.

"Drops" are of several kinds and they serve several important medical purposes.

One of the commonest uses of drops is to enlarge the pupils, so that the physician may examine more thoroughly the interior of the eye—to "look through the open door instead of through the keyhole." There, for the trained medical man to see, may be the first sign of disease elsewhere in the body. Drops make it possible for him to study not only the lens through which the light must pass, but also the retina where the image is formed, and the optic nerve which transmits the picture to the brain.

Such drops are particularly important in examining older people, who are prone to eye diseases, and often have a small pupil that becomes even smaller under the light of the examining instrument. Dilation of the pupil is necessary in examining the eye for suspected cataract, diabetes, hardening of the arteries, high blood pressure—to name a few examples. The effect of drops used merely to dilate the pupils lasts only a matter of hours, and frequently causes little or no blurring of vision.

A second common use of drops is to relax the focusing muscles in the eye. This is often necessary to determine the true degree of refractive error that has to be corrected by glasses. Because the focusing muscles in the eye are relaxed by these drops, the eye cannot focus and the vision is blurred until the effect of the drops wears off. These drops also cause the pupil to dilate; however, it is not the dilated pupil but the relaxed focusing muscle that causes blurring of vision. The use of these drops is especially important when examining children. When a physician examines a young child with strabismus (crossed eyes), it is essential to use drops that relax the focusing muscles in order to determine what corrective glasses are required.

A third use of drops is to anesthetize the eye, to permit the physician to perform certain diagnostic tests without discomfort to the patient. These drops cause little or no blurring of vision. They are required for the all-important testing for glaucoma. Anesthetic drops are also necessary for the relief of pain resulting from injury.

Finally, there are several ways in which drops are used in the treatment of the eye. Some drops are used to destroy bacteria, some to relieve inflammation within the eye, others to relieve a bloodshot condition, and still others to make the pupil small in order to lower the pressure within the eye. Drops to dilate the pupil are used in certain diseases to keep the muscles resting while the eye recovers, or to prevent complications which might develop if the muscles controlling the focus and the pupil were not kept at rest.

Of course, all drops are medicine and they can be prescribed only by a physician, who is licensed to practice medicine and surgery, and administered only by him or someone acting on his order. You should never let anyone else put anything in your eye. Sometimes drops are prescribed by your family doctor, to whom you can always turn for advice about your eyes. He or any other Doctor of Medicine can also tell you of a Doctor of Medicine who specializes in the eye—an ophthalmologist.

Whether or not drops of any kind are to be used is a decision for the attending physician. Only the Doctor of Medicine who examines your eyes can say whether drops are needed.

• • •

Why drops? Because they are useful medicines in the modern scientific care of the eyes—as useful in their place as any other drug or instrument that physicians have at hand for the relief of pain and the restoration of health. They are often the key to the prevention of blindness and even the saving of the eye itself.

American Association of Ophthalmology
1100 17TH STREET, N.W. • WASHINGTON, D. C. 20036

SUPPORTIVE LETTERS

from

MEDICAL DOCTORS OUTSIDE OF ALASKA

These letters speak directly to the minimal adverse side affects and maximal benefit to the patient.

JAMES S. JORDAN, M. D.
SUITE 209-210
225 NO. WASHINGTON AVENUE
SCRANTON, PENNSYLVANIA 18503

May 8, 1973

Senator Robert J. Mellow
Mears Building
Scranton, Pennsylvania

Dear Senator Mellow:

I have been in practice as a Board Certified Ophthalmologist for 39 years. In all this time, I have never seen, nor have I read about, cardiac arrest due to the application of topical anesthetics, mydriatics, cycloplegics, atropine or miotics. In all my 39 years, I have never seen an Angle Closure Glaucoma due to the use of any of the dilator drugs, when used properly.

In doing some research, I have found the arguments against the use of drugs cannot possibly hold any truth with the exception of Angle Closure Glaucoma. However, with proper training in the educational requirements currently in effect at Optometric Colleges, the rick is minimal. The risk to the undetection of Glaucoma, however, is sizable when anesthesia is not used. If any Ophthalmologist were to be called to the stand to testify under oath, I am certain that he in all honesty would have to say that there are no risks to the topical use of these drugs.

Occasionally an eye may become injected, but the injection leaves within a matter of half an hour or so and I can't help but wonder how the test for Glaucoma can be performed comfortably and accurately without the use of topical anesthesia. I also wonder how you can get a very thorough look at the Fundus without the use of mydriatics in very small pupils. This is significant when one considers the fact that optometrists see 70% of the population.

In consulting Cardiologists, they are unaware of any incidents after the application of any of the above drugs wished to be used by the Optometrists. In researching the education of Optometrists, I have found out that they have had a Pharmacology course for many years and were taught the effect of drugs on the eye. They have been taught in most instances by Medical Doctors. An additional safety factor is written into the bill which will necessitate any

Optometrist who wishes to use these drugs routinely to take a transcript quality course in Pharmacology and Gonioscopy to "bone up" on their past training.

In the last year's entering class, approximately 80% of the Optometric students have had four years of college education with a Bachelor's or Master's degree before entering the Optometric College, which is in itself a four year program. Their program consists of General Anatomy, Ocular Anatomy, Physiology, General Ocular with a minimum of three years training in recognition of referal of pathological cases plus Histo Pathology. At present, the Pathology courses are taught by two Board Certified Ophthalmologists, Dr. Herbert Nevyas and Dr. Joseph Towland.

The Pennsylvania Academy of Ophthalmology and Otolaryngology has raised some opposition regarding Senate Bill 570 which provides for the use of diagnostic pharmaceutical agents by optometrists.

This opposition is not well founded, nor in my opinion for the general public's welfare. Patients, not individual or group self-esteem, should come first.

I would like to re-emphasize once again that there has never been a single death reported in the entire world's literature of a fatal reaction in a diagnostic office procedure of the type we are requesting in this legislature to my knowledge.

Sincerely,

James S. Jordan, M. D.

JSJ/jmf

cc: Donald H. Evans, O.D.
Patrick Kennedy, M.D.
Alfred C. Lucier, M.D.

JAMES S. JORDAN, M. D.
SUITE 203-210
228 NO. WASHINGTON AVENUE
SCRANTON, PENNSYLVANIA 18503

In 1931, I received my Medical Degree from Jefferson Medical College. While at Jefferson, I was a member of the Alpha Omega Alpha Honor Society and upon graduation I received the HENRY M. PHILLIPS Award for the highest honors and excellence in medicine.

While serving my internship at Scranton State Hospital, I first became interested in diseases of the eye and pursued my interest at the University of Pennsylvania. I finished my residency at Wills Eye Hospital in 1935 and was President of the Wills Eye Hospital Society in 1948.

I was the founding President of the Diocesan Council of Catholic Men and have been on the executive committee of the National Council of Catholic Men at Washington, D. C. For my many accomplishments in this capacity, I was given the ST. THOMAS MORE Award by the national council, the 11th man to be so honored in the United States.

I was made a Knight of the Equestrian Order of the Holy Sepulcher of Jerusalem by the late Pope John XXIII and in June of 1972 I was invested into the Order of Malta by Pope Paul VI.

In 1956, I was named Chief of Surgery at Mercy Hospital in Scranton and served in that capacity until 1965. I am Chief of Ophthalmology at Mercy Hospital. In 1962 I was awarded the honorary degree of DOCTOR OF LAWS by the University of Scranton, in 1966 was elected President of the Advisory Board of Marywood College. Since 1969 I served as a member of its Executive Committee.

I am a member of the American Academy of Ophthalmology and Otolaryngology, a fellow of the American Board of Ophthalmology, the American Medical Association, and the Lackawanna Medical Society.

On February 2, 1973, I was presented with THE SILVER TRAY by Wills Eye Hospital on the occasion of the 25th silver anniversary of the annual clinical conference by the staff and society of Ex-Residents of the Wills Eye Hospital Society.

On April 30, 1973, I was awarded and admitted into the ALPHA SIGMA NU HONOR SOCIETY at the University of Scranton

M. M. GOLDSTEIN, M.D.
EYE AND EAR BUILDING
WILLOW AND FLORAL
VISALIA, CALIFORNIA

July 29, 1974

The Honorable Howard Way
California Legislature
State Capitol
Sacramento, California

Re: Senate Bill 1989

Dear Mr. Way:

This letter concerns Senate Bill 1989. Since you have had cataract surgery in your family in the past I feel you will have more than passing interest in this bill.

As I understand this bill permits optometrists to instill certain drops into their patients' eyes for diagnostic purposes only. I am strongly in favor of this bill; as a matter of fact several years ago on my own initiative I wrote to Assemblyman Gordon Duffy about proposing such a bill but apparently there was not much interest at the time.

The reason I am so strongly in favor of this bill is briefly this: fifth to sixty percent of all patients consult optometrists regarding their eyes and the fitting of glasses. In order to do a thorough examination of the retina, i. e. the posterior portion of the eye which is the all important anatomical segment, it is necessary to have a wide pupil so that the examining doctor can look around the corners, etc. It permits them to do as thorough an examination as the ophthalmologist can do. There are several conditions of the retina, which if recognized early can prevent serious sequela.

The ophthalmologists are of course opposed to this bill. However, I wish to go on record as saying that such opposition must be based on human frailities of jealousy and monetary consideration rather than the welfare of the

M. M. GOLDSTEIN, M.D.
EYE AND EAR BUILDING
WILLOW AND FLORAL
VISALIA, CALIFORNIA

Re: Senate Bill 1989

patient. I know they will state that if you dilate certain eyes it is possible to produce an acute attack of glaucoma. In my thirty eight years of dilating tens of thousands of eyes I have never had this occur. Furthermore, if it did occur, it would be a blessing in disguise because such a patient would undoubtedly develop an acute attack of glaucoma later on under certain circumstances. Besides, this is no catastrophe because recognized reasonably early it can be corrected with medication and then surgery.

After all, optometrists are licensed by the State of California to perform certain aspects of eye examinations and why not help them do the best examination possible. It just makes good common sense.

If there is any further information you desire please let me know.

Very sincerely,

M. M. Goldstein, M. D.

MMG:kh

ROBERT E. ROWELL, M.D.
LEXINGTON PROFESSIONAL ARCADE BLDG.
10728 E. RAMONA BLVD.
EL MONTE, CALIFORNIA 91731
448-9854

August 1, 1974

George N. Zenovich
State Capitol
Sacramento, California

Dear Senator Zenovich:

As a practicing M.D., I would like to voice my support for SB 1989. Optometrists are members of a highly trained profession and at this time are doing an excellent job without the use of topically applied diagnostic drugs. Their diagnostic capabilities, however, would be greatly enhanced with the use of the above mentioned diagnostic drugs.

Prohibiting Optometry this addi_ion to their diagnostic capabilites is in some respects similar to denying a dentist the use of X-rays in his daily routine.

I urge serious consideration and passage of this bill. It is for the public benefit that the optometrist be able to use whatever he needs to diagnose ocular problems and refer to the proper medical practitioner. It should be remembered that approximately 70% of all visual examinations in California are done by optometrists and that the optometrist is many times the only Health Care Professional that is regularly seen.

Sincerely,

Robert E. Rowell, M.D.

GLYER MEDICAL GROUP

Founded by R. T. Glyer, M. D.

280 Hope Street, Mountain View, California 94040 (415) 967-5701

Offices of

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Joachim H. Buchholz, M.D.
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James B. LeRoy, M.D.
Douglas E. Downey, M.D.
Curt E. Peterny, M.D., F.A.C.O.G.

John R. Young, M.D.
George J. Kricorian, M.D.
Seymour A. Rapaport, M.D.
S. B. Fee
Administrator

June 3, 1974

Senator George N. Zenovich
State Capitol
Sacramento, CA 95814

Dear Senator Zenovich:

I have been asked by an optometrist acquaintance of mine to write you concerning SB 1989 (definition of optometry).

I support SB 1989. I am particularly interested in their ability to use pharmaceutical agents topically to assist in diagnosing disease. They should be permitted to do this. They do an excellent and professional job at the present time without the capability of using these pharmaceutical agents and permitting them the use of these agents would enable them to do their job even better. This is for the benefit of society and any argument that this bill could be construed to benefit optometrists and harm ophthalmologists or physicians is, to my mind, ridiculous.

Limiting optometrists from diagnosing disease by the use of topical pharmaceutical agents in the eyes would be like asking dentists to diagnose disease without x-ray. The optometrists are highly trained professionals and certainly have a great deal more knowledge about the eye plus much more sophisticated equipment than the average non-ophthalmologist physician who is permitted to use all sorts of agents in both diagnosis and treatment of eye disease, and I therefor cannot see why optometrists should not be permitted the use of pharmaceutical agents for diagnosis.

In summary, for the above reasons I support SB 1989.

Sincerely,

F. R. Williams, M.D.
FRW:st

cc. Senate Health & Welfare Committee; California Optometric Association

JOSEPH C. TOLAND, M.D.
PROFESSIONAL CORPORATION

5927 N. FIFTH STREET
PHILADELPHIA, PA. 19120

LIVINGSTON 8-2323

1270 MILL ROAD
MEADOWBROOK, PA. 19046

June 15, 1973

Dear Representative:

I would appreciate it if you would support Senate Bill 570, Printers No. 810. This bill would amend the Optometry Act to permit optometrists the use of diagnostic pharmaceutical agents when examining the patients' eyes.

I have been trained both as an optometrist and an ophthalmologist. As such, I am well informed as to the training of both eye care practitioners. I can assure you that the present day trained optometrists are well qualified, by virtue of their training in pharmacology and practical therapeutics, in the use and effects of diagnostic drugs.

By being permitted to use diagnostic pharmaceutical agents, optometry will be enabled to join with the other health care professions, such as dentistry and podiatry, to provide a more complete service to the citizens of the Commonwealth.

Please ask your friends to support this bill.

Sincerely,

Joseph C. Toland, M. D.

JCT:js

CEDARS-SINAI MEDICAL CENTER

Reply to:

Mount Sinai Hospital Division
Box 48750
Los Angeles, California 90048

July 19, 1974

Preston B. Ervin, O.D.
138 South Golden Mall
Burbank, Calif.

Dear Dr. Ervin:

I am writing to you in support of Senate Bill # 1989 presently being considered by the legislatures in Sacramento. It is my hope that you will pass on my views to whomever you deem appropriate.

Because of my experience in the treatment and epidemiologic aspects of high blood pressure control I have had the opportunity to work closely with optometrists trying to guide their efforts in detecting and referring patients with high blood pressure. The information gained from our recent experience as well as from the medical literature strongly demonstrates the importance of a funduscopic examination by whomever examines the patient's eyes. High blood pressure which is often not associated with any physical symptoms can be detected early on by changes in the retinal vessels. It is essential that optometrists who have the knowledge and experience in funduscopic examination be allowed to examine retinal vessels in the most appropriate way possible. Often this necessitates the use of medication for dilation of the pupils.

I will not mention the numerous other medical conditions that can be diagnosed through proper examination of the fundus, I will leave this for other authorities on the subject. It is obvious to all interested observers and those with knowledge of systemic disease that early detection for many conditions, hypertension being a prime example, often can delay or prevent the development of complications. It is essential, therefore, that those providing professional services for the patients be able to use all the available tools at their disposable.

Sincerely, yours,

Andrew Lewin

Andrew J. Lewin, M.D.
Deputy Director
Hypertension Detection and Follow-Up Program
Assistant Professor of Medicine
UCLA

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF THE GOVERNOR
HARRISBURG

April 27, 1973

Donald H. Evans, OD
Administrative Director
Pennsylvania Optometric Association, Inc.
218 North Street
Box 3312
Harrisburg, Pennsylvania 17105

Dear Dr. Evans:

Thank you very much for sending me a copy of Senate Bill 570. I have also been asked to analyze this bill by Lieutenant Governor Kline.

I believe that Senate Bill 570 is in the best interest of the people of Pennsylvania and have suggested to the Governor and Lieutenant Governor Kline that they support this legislation.

Best personal regards.

Sincerely,

Leonard Bachman, M.D.

Leonard Bachman, M.D.
Governor's Health Services
Director

LB/sjs

SPENCER I. RICHMOND, M.D.
64 NO. HANOVER STREET
POTTSTOWN, PENNSYLVANIA 19464

Telephone 326-9306

April 27, 1973

Elmer S. Friedberg, O.D.
130 King St.
Pottstown, Pa. 19464

Dear Elmer:

This is to inform you that I have no objection to Senate Bill 570 P. N. 599. I support its passage.

I certainly do believe that optometrists should be permitted to use diagnostic drugs provided they have the proper training. Otherwise many types of ocular pathology could go undetected to the great detriment of the patient. This, I feel, makes passage of the bill definitely in the public interest.

Allergic or anaphylactic reactions to local anesthetics, mydriatics or cycloplegics are so rare that when it does occur, it is reported as an interesting case in the ophthalmological journals.

Naturally, I strongly maintain that the medical and surgical treatment of any and all types of pathologic conditions should remain in the domain of the ophthalmologist by virtue of his training in these fields.

Cordially,

Spencer I. Richmond, M.D.

Spencer I. Richmond, M. D.

SIR/jsd

WILLIAM R. NELSON, M.D. F.A.C.B.
1400 Florida
Modesto, California 95350

Telephone: 524-3726

July 5, 1974

Senator George N. Zenovich
State Capitol
Sacramento, CA 95814

Dear Senator Zenovich:

This letter is in support of SB 1989 which would give optometrists the right to use topical pharmaceutical agents for the sole purpose of the examination of the human eye or for any disease or pathological conditions. I am an ophthalmologist, certified by the American Board of Ophthalmology and a fellow of the American College of Surgeons, and I have been in private practice in California for twenty years.

In my experience, optometrists do a conscientious job in examination of the eye and do the best that they can, considering the fact that they are not allowed to use diagnostic medications, in the recognition of present pathological conditions that might require treatment. I think that the commongood would be served if they were allowed to use topical pharmaceutical agents for diagnostic purposes. One of the main benefits would be in the recognition of glaucoma which causes more irreversible blindness than any other condition in this country. Although optometrists now have instruments to test for glaucoma; nevertheless, this test is ordinarily uncomfortable or slightly painful unless a topical anesthetic is used on the cornea. The accuracy of the test is considerably improved if the patient cannot feel it and is therefore relaxed.

In my opinion, the possible benefits to the population from the use of dilating drops for diagnostic purposes by optometrists would far outweigh the dangers. There are a number of pathological conditions of the eyes as well as some ocular manifestations of systemic conditions which in many cases cannot be satisfactorily visualized and recognized without the use of dilating drops. I would be remiss, however, not to mention the fact that there would be an occasional adverse reaction in the form of an acute congestive glaucoma which can occur from the use of such drops. Due to the specialized nature of my practice, I have seen ten such cases during my twenty years of practice. I am sure this is far more than the ophthalmologist with the average type of practice would see. Of these ten cases, the vision was lost completely in one eye and two others required emergency surgery. The other seven all responded satisfactorily to medical treatment. Although thousands of cases would benefit for each possible adverse reaction; nevertheless, adverse reactions do occasionally occur and therefore adequate training of optometrists in prevention of such adverse reactions and in other recognition of them, so a prompt referrel to an ophthalmologist could be made, would be a must. I am sure that there would be several hundreds of thousands of people benefitted by the use of this and other types of diagnostic eye medications. There are some risks with the use of all types of drugs or medications, and in this case, the possible benefits would far outweigh the possible adverse reacions.

In summary, it is my opinion that the citizens of California would materially benefit, if optometrists were allowed to use topical pharmaceutical agents for the sole purpose of examination of the human eye for disease or pathological conditions and that the benefits from such use would far outweigh the danger of occasional adverse reactions.

Sincerely yours,

William P. Nelson, M.D.

WRN:sm
cc: Senate Health & Welfare Committe
Dr. Stanley Hinkley

H. JAMES WALL, M.D.

PHYSICIAN - SURGEON

TELEPHONE
DAY OR NIGHT
479-7400

2400 LAS GALLINAS AVENUE
CNR. LAS GALLINAS & MILLER CREEK ROAD
MARINWOOD, SAN RAFAEL
CALIFORNIA 94903

July 12, 1974

Honorable Randolph Colier, Senator
California Legislation
State Capitol
Sacramento, California 95814

Dear Senator Collier,

As a member and chairman of the Senate Finance Committee, I would like to urge you to give favorable consideration to Senate Bill 1989 (Zenovich). This bill would permit, under careful regulation and administration, the use of topical pharmaceutical agents by optometrists in the examination of the eye for any pathological condition.

This bill would allow more comprehensive eye evaluation by optometrists and appropriate referrals for further definitive study and treatment by the appropriate provider. I understand only those optometrists who have satisfactorily completed the appropriate courses will be eligible to use the topical pharmaceuticals.

I ask your support for SB 1989.

Sincerely,

H. J. Wall, M.D.
Fellow of the American College of Emergency Physicians- candidate to the American College of Surgeons

VI.

THE TOPICAL USE OF DRUGS FOR DIAGNOSTIC PURPOSES BY OPTOMETRISTS

ALBERT N. LEMOINE, JR., M.D., F.A.C.S.

My opinions and conclusions, as you will read, are not those of most ophthalmologists or organized medicine. These opinions are based on more than thirty years of experience in the practice of ophthalmology and medical education. Since 1950, more than half of my time has been devoted to academic ophthalmology as Professor and Chairman of the Department of Ophthalmology at the University of Kansas School of Medicine, with the remainder of the time in the private practice of ophthalmology, but involving a medical school environment. I do feel that it is important to realize that I have not limited my practice to a subspeciality in ophthalmology and that my associates and I have been more than ninety five (95) percent self supporting, receiving no federal funds and very little state monies. I am well aware of the problems of private practice, earning an income from patient care and not being limited to an Ivory Tower. Since 1971, I have not performed surgery nor had a private practice, but have devoted full time to administration, primarily in ophthalmology, and teaching. My teaching of ophthalmology over the past thirty years, has involved direct contact with paramedical students, nurses, undergraduate medical students, residents in ophthalmology and other specialities that relate to ophthalmology. I have also been involved in continuing education of physicians and ophthalmologists. I have had somewhat limited but direct experience in undergraduate and continuing education of optometrists.

It should be obvious that with this background my perception of the issues and problems of health care, health care delivery systems and the use of drugs by optometrists may be quite different from those of the average ophthalmologist in private practice. The opinions and conclusions that are expressed concerning the use of drugs for diagnostic purposes by optometrists are mine and should not be interpreted as those of the University of Kansas, the University of Kansas College of Health Sciences or any other organization of which I am a member.

Based on the testimony of previous hearings concerning the use of drugs by optometrists, and articles that have been published, there are in general seven areas that are repeatedly considered. I will list these areas and express my opinions and conclusions in each area followed by a brief summary.

I. THE TYPE OF DRUGS USED AND THE REASONS FOR THE USE OF THE DRUGS: I am in favor of the topical use of anesthetics, mydriatics and cycloplegics by optometrists for diagnostic purposes. I am unequivocally opposed to the topical or systemic use of drugs for therapeutic purposes by optometrists. In my opinion, there should not be a "grandfather clause" in legislation permitting the use of drugs by optometrists for diagnostic purposes. All optometrists who use such drugs should pass an examination that encompasses both the pharmacological action of the drugs, but in particular the clinical effects and side effects.

II. THE RISK TO THE PATIENT WHEN OPTOMETRISTS USE TOPICAL DRUGS FOR DIAGNOSTIC PURPOSES TO LIFE AND VISION: **In my personal experience, involving over one million outpatient and hospital patients, the majority involving the direct supervision of medical students and residents, I have never seen nor heard of a death or critical side effect when topical drugs were used for diagnostic purposes.** In addition, I have talked to many private practitioners and colleagues who are directors of ophthalmology training programs and have been unable to find anyone who has seen or heard of a verified death from the topical use of anes-

thetics, mydriatics or cycloplegics for diagnostic purposes. I am certain that somewhere there has been a death, but considering the millions of persons given topical drugs for diagnostic purposes, the risk is extremely low. The most common adverse side effect is an epithelial corneal abrasion following the topical use of an anesthetic for the measurement of the intraocular pressure, especially when the Schiotz tonometer is used. Although this will produce a temporary period of blurred vision and pain, I have never seen permanent loss of vision. This **must not** be confused with the use of a topical anesthetic for the removal of a foreign body that may produce a corneal ulcer and vision loss because this use of the topical anesthetic is for **therapy and not diagnosis.** The most serious threat to vision or blindness is acute closure glaucoma following pupil dilatation with the use of topical mydriatics or cycloplegics. It is unusual for blindness to result if an early diagnosis of angle closure glaucoma is made and treatment is provided. This condition is rarely difficult to diagnose, if one considers the possibility, and especially if one is limiting his practice to ocular and visual problems. The incidence of angle closure glaucoma, following pupil dilatation, is probably in the range of one in forty to fifty thousand persons who have had their pupils dilated. To me there are no other blinding conditions, secondary to the topical use of drugs for diagnostic purposes, that occur with any significant frequency. One of the most common objections to the topical use of drugs for diagnostic purposes by optometrists is that they will not recognize disease and seek consultation for definite diagnosis and therapy. **To me this is not germane to the issue of the use of drugs for diagnostic purposes because only the health care provider makes the diagnosis.** A failure of recognition of conditions where referral for definite diagnosis and/or treatment is serious. In my opinion, when an optometrist uses topical drugs for diagnostic purposes, he assumes exactly the same medical/legal responsibility as any other health care providers using drugs for the same purpose. In no manner can he or she be excused from the diagnostic error because he or she is an optometrist.

III. THE RISK OF COMPLICATIONS AS AGAINST BENEFITS: In my opinion, the benefits from the topical use of drugs for diagnostic purposes far outweigh the risk to life or vision. Despite all new instrumentation, there is no good way to obtain a satisfactory view of the interior of the eye unless the pupil is dilated. One area of controversy is the measurement of intraocular pressure by the use of a noncontact tonometer. In my opinion, the $4,000 cost of the instrument is not insignificant when one can obtain more accurate intraocular pressure measurements with one of the contact tonometers in a majority of the patients. In my experience, and that of the majority of ophthalmologists whom I have asked, the applanation contact tonometer is the most accurate instrument available to measure intraocular pressure.

IV. THE USE OF THE TERM **DIAGNOSIS**: It is my opinion that this word causes more difficulty than all other issues combined when there is a discussion of optometrists using topical drugs for diagnostic purposes. The basic difficulty is the failure for both groups to recognize and accept the fact that they use the term diagnosis in a different manner. The word itself covers a broad spectrum of concepts. One can correctly use the term diagnosis when defining what may be wrong with an automobile engine, the economic system, the weather, etc. To the physician and ophthalmologist the term diagnosis is used in a very restrictive manner. It is used to define a disease or process, usually as the initial step in treatment or ordering other diagnostic tests. Despite this restrictive use of the word in medicine, there frequently is not agreement as to the specific diagnosis in a particular patient. One of the most obvious examples in the area of ocular diagnosis is the term glaucoma. Although there is agreement that

there is nearly always an increase in the intraocular pressure (low tension glaucoma being an exception), there is not uniform agreement as to just what is abnormal pressure or what, if any other parameters, are necessary to make a specific diagnosis of glaucoma. While physicians and ophthalmologists use the word diagnosis as above, in my experience, most optometrists use the term diagnosis and the diagnostic terms (glaucoma, iritis, keratitis, etc.) in a different framework. The optometric diagnosis of disease may more accurately be defined as a deviation from the normal with referral indications for definitive diagnosis and therapy. In other areas, the optometric diagnosis may be just as definitive as the ophthalmologist, e.g. refractive errors, muscle paralysis, muscle imbalance, etc. To me the fact that a diagnostic term is not preceeded by a qualifying word, such as presumed, probable, possible, etc., does not present a serious problem. This is not true for most ophthalmologists and physicians who believe that to use specific diagnostic words is an invasion of their sphere of practice and expertise, which is definite diagnosis and therapy of ocular problems or problems of the visual system. It is at this point that I have strong personal convictions that many, if not most, of my colleagues in ophthalmology do not accept. **It is my firm belief that ophthalmologists have a serious obligation to the public in providing educational opportunities to all health care professionals, including optometrists, at both the undergraduate and continuing education level.** I am unable to comprehend that many of my colleagues do not wish to accept this responsibility in view of the ophthalmologists educational experiences in the diagnosis and treatment of problems involving the eye and visual system. **It is imperative that we educate all health care providers to recognize abnormalities where referral to an ophthalmologist for definitive diagnosis and therapy is indicated if needless blindness is to be avoided.** One cannot ignore the fact that there are more than 20,000 optometrists in active practice in the United States who are providing the initial or total eye care of a majority of the citizens. In rural states, the percentage is quite high because of the distribution of eye health care providers. Whether ophthalmologists like it or not, optometrists do and will continue to make diagnosis after an examination of a patient.

V. LEGISLATION PERMITTING OPTOMETRISTS TO USE TOPICAL DRUGS FOR DIAGNOSTIC PURPOSES IS THE FIRST STEP IN LEGISLATION TO USE DRUGS FOR THERAPY: I fail to see that this statement is germane to the present issue of the use of drugs for diagnostic purposes. In my opinion, the legislation permitting optometrists to use drugs for both diagnostic and therapeutic purposes, enacted in West Virginia, is not in the best interest of the public. There is no doubt that this law has provided a strong stimulus for organized medicine and ophthalmologists to unite against any legislation that will permit the optometrist to use drugs for any purposes. In my opinion, the present educational programs in optometric schools or their continuing education programs **do not** provide the necessary knowledge to use drugs for therapeutic purposes in any manner. I believe that the public will be endangered if optometrists are permitted to use drugs for therapeutic purposes, unless their education is essentially the same as that of a physician or osteopath. At the same time, I do believe that optometrists, at this time, should be able to use topical drugs for diagnostic purposes in order to enhance their ability to recognize ocular conditions where referral is indicated.

VI. LEGISLATION PERMITTING THE TOPICAL USE OF DRUGS FOR DIAGNOSTIC PURPOSES BY OPTOMETRISTS WILL OPEN THE DOORS TO USE OF DRUGS BY NONPHYSICIANS: It is obvious that this statement is not true because already legislation permits dentists and podiatrists to use both medicine and surgery for therapeutic purposes.

It is also true that nurse clinicians and physician assistants, in some states, are permitted to prescribe drugs, change drug dosage and perform minor surgical procedures. In each of the above instances there have been significant changes in the educational process of each group. In all instances there are definite restrictions as to what can be done and in none of these situations is there an open license to practice the healing arts as is true for the physician and surgeon or osteopath. Whether the future will bring about an alteration in the optometric education that would justify entering the areas of medical and surgical therapy of ocular problems, only time will tell. Because the eye and visual system may be involved in nearly, if not all, disease processes in the body, any type of restrictive license, such as in dentistry and podiatry, would be difficult to justify. In my opinion, the educational programs, to protect the public, would need to be essentially the same as an ophthalmologist. When one considers the vast demand for eye service is in the area of refraction and contact lenses and not medical and surgical treatment, the type of eye health care provider is significant. What is needed is more cooperative efforts to provide a team approach to eye health care, at least in the area of dense population concentration.

VII. THE DISTRIBUTION OF OPTOMETRISTS AND OPHTHALMOLOGISTS: Although this issue is rarely considered as a distinct entity beneath all discussions, it is important in the present legislative conflicts. All data indicates that there is a significant difference in the distribution of optometrists and ophthalmologists. Opthalmologists, in general, practice in urban and suburban areas, whereas, percentage-wise more optometrists practice in rural areas and the inner city. It is in the areas where there is a surplus of ophthalmologists and optometrists for the population that conflicts occur. If one is honest the primary conflict in this latter situation is economic.

In summary, on the issue of legislation for the use of drugs by optometrists, I support the following positions:

I. The topical use of drugs for diagnostic purposes, in specific anesthetics, mydriatics and cycloplegics by optometrists may provide significant benefits to the public with minimal danger to either life or vision. I find it difficult, if not impossible, to justify the inclusion of miotics for diagnostic purposes.

II. I am unequivocably opposed to the use of drugs, either topical or systemic, for the therapeutic purposes by optometrists.

III. I am opposed to any legislation that would "grandfather" the optometric use of drugs for diagnostic purposes by optometrists.

IV. Legislation should require the passage of an examination on the action of drugs and **in particular the clinical effects and side effects of drugs** used for diagnostic purposes before an optometrist is licensed to use them.

I hope that this lengthy response to the question of the use of drugs by optometrists is justified, because this is a highly complex issue, of concern to the public that has evoked extreme emotional response from both ophthalmology and optometry. In my opinion, the time has passed when we can retain the status quo and it behooves all involved (health care providers and members of the legislature) to carefully examine the facts and provide the best possible legislation for the public welfare at this time. If I can be of further assistance in this matter, please feel free to contact me.

Sincerely yours,

Albert N. Lemoine, M.D.

VII.

DR. HOWARD C. LUCAS, FLORIDA OPHTHALMOLOGIST TESTIMONY BEFORE THE SENATE ECONOMIC AFFAIRS COMMITTEE

Mr. Chairman, Members of the Committee:

Briefly my background is a medical degree from the Cornell Medical College in 1951 followed by two years rotating internship at Genessee Hospital, Rochester, New York. I then practiced general medicine for three years in Winter Haven, Florida. In 1957, I served a three year residency in Ophthalmology at the Institute of Ophthalmology, Columbia Presbyterian Medical Center, New York City. In 1960 I started my private practice of Ophthalmology in Winter Haven, Fla. and in 1961 was certified by the American Board of Ophthalmology.

You are here to decide the question of who has the right to use mydriatics, cycloplegics, and topical anesthetics, referred to as diagnostic pharmaceutical agents. The medical doctors claim squatters rights to the territory of diagnostic pharmaceutical agents, demand an absolute monopoly in their use. The optometrists feel that their patients would also benefit by using diagnostic pharmaceutical agents to make the eye examination more precise and complete.

The diagnostic pharmaceutical agents belong neither to the optometrists or the medical doctors. They are the property of the patients and should be used to benefit the patients who are your constituents. The proper question here is "Who is to be awarded the exclusive use of these agents to be administered for the benefit of the patients?" Both medical doctors and optometrists use the same tools, lenses, prisms, tonometers, biomicroscope, and ophthalmoscopes to determine the presence or absence of disease and the correct prescription for glasses. Enlarging the pupils with drops makes the examination easier and more precise in many cases. The use of topical anesthetics makes the measurement of intraocular pressure more accurate, and this facilitates the diagnosis of glaucoma.

The prime consideration here is what is best for the patient. Since both optometrists and medical doctors are performing similar examinations with the ultimate goal of arriving at the best refraction and diagnosis then both medical doctors and optometrists should be using the diagnostic pharmaceutical agents.

The next question is safety or danger of these diagnostic agents. I have been practicing ophthalmology for twenty-two years. I have not had any serious reaction to diagnostic pharmaceutical agents. The serious and lethal reactions as described by the medical doctors are not subtle or difficult to recognize. They describe convulsions, anaphylactic shock, strokes, cardiac arrest and death due to these agents. I have never had to do cardio-pulmonary resuscitation, call an ambulance, or send one of my patients to the morgue as a result of using diagnostic pharmaceutical agents.

It is true that these agents are dangerous if improperly administered such as being swallowed or injected, or multiple drops being used over a period of one hour or more. One or two drops in each eye, with the excess being blotted out with a tissue will not cause a serious reaction. This is not difficult to do. The optometrists know how to do this properly.

Here, the proper question is:

Why are certain medical doctors getting so many dangerous reactions to these diagnostic pharmaceutical agents?

The majority of medical doctors do not get serious reactions when using diagnostic pharmaceutical agents. Therefore, the ones who are getting the bad reactions must be doing something wrong. They should carefully and critically examine their techniques and take a refresher course in pharmacology to discover the cause of these bad reactions.

Diagnostic pharmaceutical agents, when properly used, are safe and essential to an adequate eye examination. Optometrists should use them.

Respectively submitted,

Howard C. Lucas, M.D.
560 Ave. K, S.E.
Winter Haven, Florida 33880

Distinguishing among eye specialists

dr. lester coleman

In this morning's mail were letters from two readers in different parts of the country. Both asked questions about optometrists and how they differ from medical eye specialists.

Ophthalmologists are medical doctors who have had special training in the medical and surgical aspects of diseases of the eye.

Optometrists are not M.D.s, yet they, too, have had excellent training. Their field is limited to the diagnosis and correction of defective vision. It does not include any aspect of surgery.

The eye is a remarkable index of diseases that may exist elsewhere in the body. Vascular disturbances, neurological problems and diabetes are only a few of the many conditions that are diagnostically recognized by a careful inspection of the eye. Intrinsic diseases of the eye itself — infections, glaucoma, cataract formations, viral infections, allergies and tumors — are treated by the ophthalmologist.

It should be pointed out that many skilled optometrists recognize when a problem exists and immediately refer their patients to an eye specialist for confirmation and treatment.

Dr. Coleman welcomes questions from readers. Please write to him in care of The Daily News, Pouch 6616, Anchorage 99502.

SUPPORTIVE LETTERS

from

MEDICAL DOCTORS AND OPTOMETRISTS INSIDE ALASKA

These letters speak of authorized use of diagnostic agents by optometrists throughout Alaska.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Alaska Native Medical Center
P.O. Box 7-741
Anchorage, Alaska 99510
DATE: October 21, 1977

TO : SEE BELOW

FROM : ANC-EYE

SUBJECT: Use of Diagnostic Medications by Staff Optometrists

Drs. Donald E. Bigelow and James N. Matson, Staff Optometrists, conduct field eye clinics as part of the Eye Care Program. Often is is necessary to use cycloplegics in order to obtain a refraction on certain individuals and anesthetic drops to take ocular pressures. Both doctors are aware of the possibilities of provoking an acute angle closure glaucoma, or an allergic reaction by the use of these drugs. They have my permission to use these ocular diagnostic medications when they feel the mediaations are needed, and I take full responsibility for any adverse reactions that might occur.

Should an acute angle closure be provoked, the following steps should be initiated:

1. Pilocarpine Ophthalmic Solution, 4% 1 gtt. installed q. 15 min. 4 doses; then, q. hour x4 doses, or until pupil constricts. Once constricted, the patient should be maintained on Pilocarpine 1 gtt. O.U. q.i.d. until referred in for surgery.

2. Simultaneously, at the initiation of Pilocarpine, the patient should be given Diamox 250 mg. I.M. and Osmoglyn (if available) 6 oz. mixed with grapefruit juice P.O.
DIAMOX ONE TABLET EVERY SIX HOURS BY MOUTH-
3. He should be referred to ANMC as soon as possible for evaluation and surgery.

Donald W. Dippe, M.D.
Chief, Ophthalmology

DIST: Clinical Directors - All Service Units
Chief, A-OPCSSE
Eye Care Coordinators and Assistants
Public Health Nurses and Community Health Aides

7-320B "I" Street
Elmendorf AFB, AK 99506
1 March 1978

Dr. Box
611 W. Willoughby
Juneau, AK 99801

Dear Dr. Box,

I was asked to write to you and give you the latest information from the Air Force that I have concerning the use of diagnostic drugs that we can use.

Air Force Regulation 36-1 (dated 1 March 1977) states on Page A27-37: OPTOMETRIST

2. Duties And Responsibilities
   a. Conducts Examinations of Eye: With or without the use of diagnostic drugs, examines eyes..... etc.

I know of no other regulation since then that states anything different. There is no place in the regulation that <u>any</u> of our professional activity is under the direct supervision of an ophthalmologist or other physician.

As you know, there are many places where the optometrist functions where there is no ophthalmologist assigned. At those locations the optometrist usually is called upon by the professional staff to do many of the more routine ophthalmological duties, because he knows more about these functions than do the other medical corps specialties. Even at locations such as Elmendorf where we have ophthalmological services, we can use diagnostic drugs and do minor ophthalmological services on our own, but we usually let the ophthalmologist or his technicians do these services.

I am licensed here in Alaska, and would appreciate being on the mailing list of any material associated with the changing of the optometric laws within the state. I am still a few years from retirement, but plan on coming back up here when I retire.

ROGER C. FITCH, Lt Col, USAF, BSC
Chief, Optometry Services
Elmendorf AFB, Alaska

2320 Palos Verdes Drive
Eagle River, Alaska 99577
May 2, 1978

Rep. Randy Phillips
Pouch V
Juneau, AK 99811

Dear Rep. Phillips:

I am presently practicing with the Public Health Service at the A.N.S. Hospital in Anchorage and anticipate going into private practice in the very near future. I am interested in the progress of House Bill #664 and would like to urge you to support the passage of this legislation. I am a graduate of Pacific University, College of Optometry, which is in Forest Grove, Oregon. Oregon has had similar legislation to House Bill #664 for several years which, of course, is mandated that Pacific University provide experience in the use of these agents along with a complete pharmacological background for its graduating students. I've also been a medic in the Army and have had some experience with the various drugs and agents used in emergency medical treatment. It has been my experience with the Public Health Service and in the military that there are no serious adverse reactions from the agents optometrists will use and I've had experience as an observer in the military and, of course, first hand with the Public Health Service where the Alaskan Public Health Service optometrists have had directive from Dr. Dippé to use these agents both at the hospital clinic in Anchorage and whenever we are on bush eye clinics. These agents are used in the bush eye clinics by the optometrist as an independent practitioner with only telephone and mostly not very good radio contact with the Public Health Service Hospital in Anchorage which would be much poorer in case of emergency than the in office setting most private practicing optometrists in Alaska now enjoy. I also work directly with the ophthalmological staff at the A.N.S. Hospital in Anchorage and have heard the various arguments that have been presented concerning optometrists' ability to manage patients when they use these drugs and can say from personal experience that these arguments are a smoke screen and that the few minor side effects caused by some of these agents are relieved by either reducing the dosage or stopping the cycloplegic agent in the case of cycloplegia. I have had an opportunity to also work with the Public Health Service optometrist who has served with the Public Health Service for many years and have had discussions with the military optometrist in Anchorage and can find no instances where patients have suffered serious adverse affects from these drugs, but know from personal experience that they do aid in earlier detection

of eye disease. I also know from my close association with the ophthalmological community in Alaska that if any serious effect had occured in either the Public Health Service or military use of these agents your committee would have heard about it. The unexplainable morbid fear ophthalmologists have from optometrists granting the use of these drugs is ridiculous in my opinion and can only result in their possible fear of losing patients which I also don't understand because as I viewed the situation as a non-private practicing optometrist the ability of the doctor to make people like him and provide good services are what draw patients to offices and not whether or not they use eye drops. If the fear is based on loss of patients from ophthalmology offices, which is the only thing I can see could be the real source of their concern, then it certainly should not be a concern of the legislature. Again I would like to urge you to support the passage of House Bill #664 as it will aid the private sector optometric patient as it has aided the Public Health Service and military optometric patient.

Yours very truly,

James N. Matson, O.D.

JNM:jc

DEPARTMENT OF THE ARMY
HEADQUARTERS, US ARMY MEDICAL DEPARTMENT ACTIVITY, ALASKA
FORT WAINWRIGHT, [redacted]
ALASKA 99703

AFZT-MD-CL

28 February 1978

STATEMENT

I am presently an Alaska licensed optometrist (#85) practicing in the U.S. Army at Fort Wainwright, Alaska. I have been here over three years, and in the military for over seven years. During all my years as a practicing optometrist in the U.S. Army, I have been authorized to use diagnostic pharmaceuticals in my practice. The use of diagnostic anesthetics, mydriatrics, miotics, and cycloplegics are required for flight physicals, tonometry, internal examinations, cycloplegic exams, etc., required by military regulations.

Upon arriving at Bassett Army Hospital here at Fort Wainwright in 1974, I submitted a request to the hospital Credentials Committee to use certain diagnostic drugs in my practice of optometry which was approved by the committee and endorsed by the Hospital Commander. In my experience in using diagnostic drugs on thousands of patients, I have never had an adverse drug reaction.

Robert P. Hammond

ROBERT P. HAMMOND, O.D.
CPT, MSC
Chief, Optometry

RECOMMENDATION OF

LEGISLATIVE ADVISORY COMMITTEE OF

THE MUNICIPAL HEALTH COMMISSION

Primary Legislative Contact: _____
(907)

LEGISLATIVE REVIEW

fee - do pass

BILL NUMBER AND TOPIC: Senate Bill 75
House Bill 79

BRIEF SUMMARY: An Act relating to the practice of optometry. These bills are the same. They define the term "optometry" and define what is included in the practice. The bill also outlines the use of drugs for diagnosis.

BILL STATUS: House Bill 79 was introduced by Representatives Martin, McKinnon, Meekins, Miller and Parr, and was referred to Health, Education and Social Services and Judiciary Committees.

Senate bill 75 was introduced by the Rules Committee by request, and was referred to the senate Health, Education and Social Services and Judiciary Committees.

The series of questions below are presented to assist persons responsible for reviewing proposed legislation. Answering each question will help the reader to better understand the intent or meaning of a specific bill. Question #12 asks the Legislative Advisory Committee to formulate a recommendation, which will then be forwarded to legislators, lobbyists, other review bodies, etc., as appropriate. Action taken by this committee automatically sends the bill and comments through 1) Municipal Legal Department, 2) Municipal Administration, and 3) Municipal Health Commission, time permitting.

1. What is the time frame for influencing the bill's outcome by this committee or Commission? This legislative session

2. What does the bill do? Defines the term "optometry" and defines what is included in the practice; and outlines the use of drugs for diagnosis.

3. Who does it affect? Both the medical and consumer areas.

4. How much does it cost? Unable to determine

5. Is it directed to a specific geographic area? No
What area? _____

6. How would enactment of this bill effect Anchorage? IT WOULD INCREASE THE AVAILABILITY, IT ALSO ACTAS A ALTERNATIVE INITIATIVE TO IMPROVE THE HEALTH SYSTEM, IT WOULD ALSO HELP REDUCE COST. IT WOULD ALLOW THE USE OF TOPICAL drugs TO OPTOMETRISTS

September 2, 1979

7. Is it directed to a specific group? Yes
Which group? Optometrist.

8. How does it affect others? IT DOES NOT EFFECT OTHERS

9. What are its strengths? (1) ALLOW. USE OF TOPICAL DRUGS IN OFFICE, (2) IT WOULD BE COST EFFECTIVE, (3) EDUCATIONAL REQUIREMENTS (4) INCREASE AVAILABILITY, (5) WOULD ACT AS AN ALTERNATE ENTERING POINT INTO HEALTH SYSTEM.

10. What are its drawbacks, weaknesses? NONE

11. Is the concept new? NO Are there precedents? YES
Where? IN THE LOWER 48 (24 STATES HAS PASSED THIS LAW)

12. Is there pending or existing legislation which is similar in focus, and/or which would impact implementation of this bill? proposed drug Bills is STATE LEGISLATION

13. How would this bill affect the Anchorage Health Services Plan? IT WOULD INCREASE AVAILABILITY, IT WOULD ACT AS AN ALTERNATE NATION ENTERING INTO THE HEALTH SYSTEM.

14. What is the Committee's recommendations? do PASS

15. What agencies or bodies should this committee notify regarding action on this Legislation? State RULES, HEALTH SOCIAL SERVICE MUNICIPAL ADMINISTRATN. HSA

✓ HSA
BILL FAULKNER Committee Chairman of the following Committees
A BARBEN, B. FAULKNER J UNUSED
R MCGEE, C HEINKE, C RIDEN
L SHERWOOD, L ICE SADDEGEN, K AUTOR
A. CONNOSSA, K BRUNNSBERG EK

_____ Individual Committee Members of the following Committees

_____

_____

_____

_____

_____ State Health Coordinating Council
_____ Governor
_____ Bill Sponsor
_____ Other: list

Committee procedure automatically sends the bill through:

1. Municipal Legal Department
2. Municipal Administration
3. Municipal Health Commission, if timely

REFERENCE QUOTATIONS FROM AUTHORITATIVE AND QUALIFIED PERSONS REGARDING USAGE OF DIAGNOSTIC AGENTS BY OPTOMETRISTS

A. SUBSTANTIATING MINIMAL RISKS TO ADVERSE DRUG REACTIONS

1. "In a series of more than 1000 patients anesthetized with benoxinate, no toxic effects were encountered, either locally or systemically."

   Havener, William H., M.D., M.S. (Ophth.), Ocular Pharmacology, P. 51.

2. "There have been no reported systemic toxic reactions in amounts used for topical anesthesia for the eye."

   Leopold, Irving, M.D., Ocular Therapy Vol. 1, p. 16

3. "None of the drugs I shall be discussing were available fifty years ago...they are all less toxic, less irritating and shorter acting than their predecessors."

   Garston, Mathhew J., O.D., "A Closer look at Diagnostic Drugs for Optometric Use", Massachusetts College of Optometry Boston, Mass.

4. "After having seen the use of local anesthetics discussed here in over 20,000 patients I have yet to see any adverse reactions. I have seen the dilating agents discussed here in over 10,000 patients and likewise have seen no ill effects. (this includes not causing an angle-closure glaucoma)."

   Garston, Matthews, J., O.D., ibid.

5. Seventy to eighty percent of drug reactions are predictable and most are preventable."

   "New England Journal of Medicine" Vol. 285, pg. 1361, June 1971 cited by Lyle W.M., O.D., "Relationship of Pharmaceuticals to Optometry", American Academy of Optometry, 1971.

6. "Abraham in 1933 surveyed the literature for reports of acute glaucoma produced after the use of mydriatics in patients previously free from clinical signs of glaucoma. He calculated an incidence of one case of acute glaucoma for each 18,400 instances of application of anticholinergic eyedrops for refraction of other eye examination.

In Abraham's data it was strikingly evident that age was an important factor in determining susceptibility to acute glaucoma from topical application of anti-cholinergic drugs. In nearly all instances of acute glaucoma the patients were over 30 years of age. Among patients younger than 30 years, Abraham found only four instances of this type of adverse effect in the literature. Also, it must be emphasized that the above one case in 18,400 patients was from a population group who were dilated without the aid of angle evaluation techniques."

Leopold, Irving, M.D. (ed.) Ocular Therapy, Vol. III, Chapter 4 "Conservatism in Glaucoma Management" by Robert Shafferf, M.D. and John Hetherington, Jr., M.D. p. 63

7. "Beach noted that increased intraocular tension from the use of a mydriatic does not occur one in 10,000 examinations."

   Lyle, W.M., O.D. Op. Cit.

8. "Havener says that a physician who dilates many eyes may expect to precipitate not more than one case of acute glaucoma in his lifetime."

   Havener, W. H., Synopsis of Ophthalmology cited by Lyle, W.M., O.D. ibid.

9. "It was reported in Australia that in only one case out of 12,000 can glaucoma be precipitated and then only in people who have a predisposition to react in that way to the drug."

   Parliament, 2nd Session, Vols. 59, 60, 73, Act. No. 34, 1963 the Optometrists Act. 1963, Cited by Lyle W.M., O.D. ibid.

10. "After the child is first examined, the doctor usually tells the mother to instill atropine drops or ointment into the child's eye...Atropine is used because it is the most powerful cycloplegic drug...One in 500 children develops a sensitivity reaction to this cycloplegic drug... The mother should not become alarmed; she should simply discontinue the drug."

    Abrahamson, Ira A. Jr., M.D. Know your Eyes, Medcom Press, 1972, pp. 76-77.

B. ESTABLISHING THE LARGER RISK TO THE PUBLIC HEALTH IF THESE DRUGS ARE NOT ADMINISTERED BY OPTOMETRISTS:

1. "Newell reports that there is more danger of missing a significant ocular of systemic disease by failing to dilate than there is of precipitating glaucoma by dilation."

   Newell, F.W. Ophthalmology, Principles and Concepts, 2nd Edition, C.V. Mosby Co. 1969, p. 140, cited by Lyle W.M., O.D., "Relationship of Pharmaceuticals to Optometry", American Academy of Optometry, 1971.

2. "In their role as the first line of defense against glaucoma and other vision-threatening conditions (Optometrists) must be free to utilize all appropriate tests if they are to continue to bear these responsibilities."

   "Should the patient be deprived of a variety of tonometry test, or of gonioscopy or of tonography because his optometrist was not permitted to utilize a broad spectrum of diagnostic procedures?" Cited by Lyle, W.M., O.D. Ibid p.6

3. "A recent opinion of the attorney general of New York State affirms that it is the duty of the optometrist to use his training to uncover any need for the patient to seek further medical advice."

   Forgotson, E.H. et al Report of the National Advisory Commission on Health Manpower, Vol II, Nov. 1967, U.S. Gov't Printing Office, cited by Lyle W.M. O.D., Ibid p.7

4. "...In view of the unavailability of appropriate medical services, for example in remote areas and in other unusual circumstances, there appears to be a need for optometrists to employ topical anesthetics...optometrists...in many cases... are the first trained person consulted."

   Anon, Joint Declaration on Behalf of Ophthalmologists and Ophthalmic Opticians (optometrists). The Ophthalmic Optician, Feb., 21, 1970 p. 173, cited by Lyle W.M., O.D. Ibid p.7.

5. "In those parts of the world where high quality vision care is generally available, 60% to 80% of this health service is the responsibility of optometrists."

   Lindsey A. Socialized Medicine in England and Wales, National Health Service, 1948-1961, University of North Carolina Press 1962.

6. Woodruff, M.E. "Statement Relating to the Effective Utilization of Optometry and Optometric Services in Fulfillment of the Aims and Objectives of the United States Dept. of HEW", American Optometric Assoc, 1964 cited by Lyle W.M., O.D., Ibid p. 11

7. "With regard of mydriatics, most ophthalmologists agree that any risk produced by employment of mydriatics is far outweighed by the potential risk from failure to see more of the fundus."

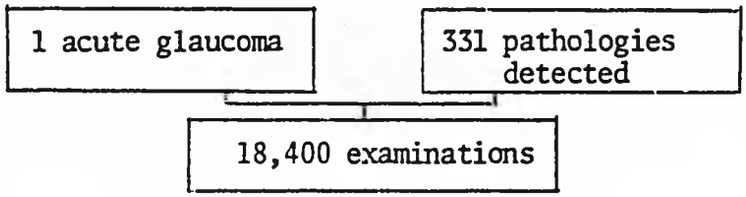
   Lyle, W.M., O.D., Ibid p. 13

8. "Teachers and research workers in the field of vision use mydriatics, miotics, cycloplegics, topical anesthetics and other drugs."

   School of Optometry, Faculty of Science, University of Waterloo, Optometry Education, "The practice and Services of Optometry in Ontario" Part 3 of a Brief supporting and supplementary to the College of Optometry's Brief Submitted to the Committee on the Healing Arts, Nov. 1967, cited by Lyle, W.M., O.D., "Relationship of Pharmaceuticals to Optometry", American Academy of Optometry, 1971.

ABRAHAM: One case of acute glaucoma for each 18,400 instances of application.

HEW: 1.79% of all eye examinations yield an eye pathology.



Safety factor for the one case of glaucoma precipitated:

include in the bill:

"Miotics for emergency use only."

NOT FOR PUBLICATION

THE USE OF DIAGNOSTIC DRUGS IN RHODE ISLAND - A SURVEY

by

Herbert L. Moss, O.D., F.A.A.O.
Associate Professor of Optometry
Pennsylvania College of Optometry

Additional remarks regarding the use of DPAs:

1. Greatest advantage to patients, pathology referrals increased, integrity of the profession increased.
2. Mydriatics and binocular ophthalmoscopy are the greatest benefit.
3. Uses ophthaine only for tonometry, hard contact lenses, and first aid.
4. Applanation tonometry with anesthesia is accurate and reliable. Stops over-referrals and promotes proper referral. Perfectly safe in trained hands.
5. Beneficial to patients. Speeds referral to proper practitioner without delay.
6. Patient acceptance is gratifying. I.O.P. measurements are easier, smoother, and faster.

SUMMARY

In summarizing the results of this survey, several generalizations seem to stand forth:

1. From the optometrists' viewpoint, the overall impact on practice and professional status has been positive to very positive.
2. The overall effect upon most segments of the public and other professions has been positive although not as much so with public health and elected officials.
3. The use of DPAs is higher as the age bracket of the patients increases and this could be anticipated because of the high usage of topical anesthetics in tonometry.

4. The 9.5% usage of mydriatics seems to be in keeping with the statistics on the usage of mydriatics in general ophthalmological practice.

5. The very low incidence of the use of miotics as a post-mydriatic also reflects the state of the art today.

6. In regard to the effect upon practice, it appears that DPAs tend to simplify optometric practice, but increased the time spent per patient in collateral activities.

7. DPAs seem to have increased the number of procedures and the variety of equipment that optometrists utilize.

8. One crucial issue raised during the legislative hearings was the supposed adverse reactions to DPAs that would occur. The responses to this survey indicate that those claims were totally unfounded.

9. One area that should be stressed is the increase in the referral rate across the board and particularly the increase in the referral for suspected glaucoma by more than two thirds of the responding optometrists.

10. The question of whether optometrists should become involved in limited ocular therapy brought a 72% favorable response. However, five of those responding in the affirmative made an unsolicited point that additional education and clinical training should be part of this activity.

In substance, it appears that the use of DPAs by optometrists in Rhode Island has been beneficial to all parties involved, even those who opposed the legislation, and that the concerns raised by the opponents were exaggerated.

CONCLUSION

We, the optometrists of Alaska at this point in our development, submit our qualifications in an effort to protect our patients against preventable eye disease. We must now close the gap between what the courts are demanding of us and what the laws are allowing of us.

With emerging national health care, we see only a future of increased visual and eye health care needs. We enthusiastically accept that with a sincere dedication. Yet, in so doing, we find ourselves in need of some diagnostic tools.

The optometry motto remains clearly in the minds of all Alaskan optometrists: "Next to life itself, God's greatest gift is sight."

1979--TESTIMONY BEFORE

HOUSE HES COMMITTEE

TESTIFYING

Dr. Sam McConkey: Physician and surgeon, diplomat of the American Board of Ophthalmology, Fellow in the American Academy of Ophthalmology, Practicing ophthalmologist in Fairbanks.

Dr. Marvin Grendahl: Physician and surgeon, Ph.D. in Physiology, Practicing ophthalmologist in Anchorage.

Dr. Roger Page: Physician and surgeon, board certified ophthalmologist, practicing ophthalmologist in Juneau.

Dr. Boyd Walker: Optometrist, private practice in Anchorage.

NO ALASKA OPTOMETRIST HAS BEEN TAUGHT BY A M.D. OR PH.D. OR OPHTHALMOLOGIST

Dr. McConkey speaking: "After reviewing the professionals and staff of their schools, I can tell you that not one optometrist in Alaska has had any pharmacology training from any M.D. or Ph.D. in pharmacology. I can tell you that not one optometrist in Alaska has had any instruction in anything that a full time M.D. on any staff and not one optometrist in Alaska has had any full or part time instruction either in class or in clinic study by an ophthalmologist."

Answer by optometric legislative committee--not on tape

University of Alabama Optometry Faculty (total instructors 65)

Jerry Christensen, B.Sc., M.Sc., Ph.D.
Kenneth Cinffreda, B.A., Ph.D.
Boyd Eskridge, B.Sc., M.Sc., Ph.D.
Jack Geer, B.S., M.D.
Thomas Johnson, B.S., M.S., Ph.D.
Robert Kleinstein, B.S., M.P.H., Ph.D.
Homin Lin, B.S., Ph.D.
Michael Loop, B.S., Ph.D.
Andrew Lorincz, Ph.D., B.S., M.D.
Jerry McGhee, B.S., Ph.D.
John McKibbin, B.A., M.S., Ph.D.
Thomas Norton, B.A., Ph.D.
Clyde Oyster, B.S., Ph.D.
John Pierce, B.S., M.S., Ph.D., O.D.
William Rosenblum, B.S., M.S., Ph.D.
Harold Schnuper, A.B., M.D.
James Sheetz, M.S., Ph.D.
Richard Shoemaker, B.S., M.S., Ph.D.
Ellen Takahuski, B.S., M.Opt., Ph.D.
David Whikehart, B.S., Ph.D.
Bradford Wild, A.B., B.S., M.S., O.D., Ph.D.
Graeme Wilson, M.Sc., O.D., Ph.D.

University of California School of Optometry (total instructors 96)

Irving Fatt, Ph.D.
Darrell Carter, O.D., Ph.D.
Hans J. Bremeumann, Ph.D.
Russell L. DeVolvis, Ph.D.
Merton Flem, O.D., Ph.D.
Ernest K. Goodner, M.D. (ophthalmologist)

Monroe J. Hirsch, O.D., Ph.D.
Russell Jones, Ph.D.
Robert Mandell, O.D., Ph.D.
Elwin Marg, O.D., Ph.D.
Robert Mishell, M.D.
Meredith Morgan, O.D., Ph.D.
Lawrence Stark, M.D.
Anthony Adams, O.D., Ph.D.
Richard Brand, Ph.D.
Theodore Cohn, Ph.D.
Ralph Freeman, O.D., Ph.D.
Wayne Hubbell, Ph.D.
Kenton Kerr, O.D., Ph.D.
Robert Stamper, M.D.
Howard J.D. Abreva, Ph.D.
Julie Jose, O.D., Ph.D.
Sheldon Miller, Ph.D.
Clifton Schor, O.D., Ph.D.
Richard Van Sluyters, O.D., Ph.D.
Howard Cohen, M.D.
Robert Johnson, O.D., M.D.
Leon Metz, M.D.
Robert Litwin, M.D.
Joseph F. Terdiman, M.D.
Tommy Y. Hayashi, Ph.D.
Gary Liberman, O.D., Ph.D.
Frank Zisman, O.D., Ph.D.

THE TREND IS CLEAR, INFORMED PUBLIC AND LEGISLATURE WILL DECIDE. 31 STATES ALLOW DPA'S

Dr. McConkey speaking: "In 1977, 17 states defeated this form of legislation. There were four states that allowed it. In 1978, fifteen states said no. Two allowed. The trend is clear. That once an informed public and legislature is aware of the fact, it has been overwhelmingly defeated in legislature across the country."

Answer by optometric legislative committee--not on tape

Name of State	Date of Enactment
Rhode Island	July 16, 1971
Pennsylvania	March 1, 1974
Tennessee	May 8, 1975
Oregon	May 20, 1975
Maine	June 24, 1975

Louisiana	July 6, 1975
Delaware	July 10, 1975
*West Virginia	March 4, 1976
California	July 9, 1976
Wyoming	February 17, 1977
New Mexico	March 4, 1977
Montana	April 12, 1977 (at 10:10 a.m.)
Kansas	April 12, 1977 (at 2:00 p.m.
*North Carolina	June 3, 1977
Kentucky	March 29, 1978
Wisconsin	April 29, 1978
Nebraska	February 13, 1979
South Dakota	March 15, 1979
Utah	March 21, 1979
North Dakota	March 22, 1979
Arkansas	April 2, 1979
Nevada	May 25, 1979
Iowa	June 8, 1979

*Both diagnostic and theraputic

In addition, there are eight (8) other states that do not statutorily prohibit the use of DPAs by optometrists; several of these states have attorney general opinions (+favorable) (-unfavorable) on this point:

Alabama (AG-)
Florida (AG+)
Idaho (State Board Statement +)
Indiana (AG+)
Michigan
Minnesota
New Jersey (AG+)
Virginia (AG-)

DIALATING THE EYES IS NOT NECESSARY IN MAKING A DIAGNOSIS OF EYE DISEASE OR SUPPLYING CHILDREN WITH PROPER GLASSES CORRECTION. (CONTRARY TO DR. GRENDAHL'S TESTIMONY)

Dr. McConkey speaking: "Dialating the eyes is not a prerequisite of making a diagnosis of eye disease. The truth is that general practitioners and other physicians across the country routinely exam eyes thousands of days without dialating eyes that are quite capable of diagnosing problems that they see. Dialating the eye with drops is not a prerequisite to supplying children with the proper glasses correction.

WHY DO YOU DIALATE THE PUPIL?

Legislator's question to Dr. McConkey: "Can an adequate examination be made of the eye without dialating pupils, and if it can, as I think you indicated here, then why do you use, why do you dialate the pupil when you are examining the eye?"

MY OBLIGATION IS TO DETECT ANY ASPECT OF DISEASE AND DIALATING THE EYE GIVES ME A BETTER CHANCE.

Dr. McConkey's Answer: "To the first question, the answer is yes, an adequate exam can be done but the second part, why do I dialate the eye? My obligation is to detect any aspect of disease that might be present and in some cases of decreased vision, sometimes I can't even tell that even if dialating the eye but it would give me a better chance. You're suppose to know what to look for. Some of these conditions are very far peripheral and can't be seen easily but their vision is decreased. It certainly helps us in evaluating what the problem is, and I think I have an obligation with the first time patients to make sure that's what kind of base we are starting on."

DIAGNOSIS NOT IN OPTOMETRY LAW.

Dr. Grendahl speaking: "The state statutes in Alaska specifically limit the definition of optometry. Not only do they not use drugs, no language is put in there about diagnosis."

Answer by optometric legislative committee--not on tape

Sec. 08.72.300 Definitions.

(3) "Practicing optometry" means the diagnosis by mean 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, prism or ocular exercises for the correction or relief of the human eye or the holding of oneself out as being able to do so;

IF DROPS ARE SO HAZARDOUS, WHY DO YOU USE THEM?

Legislator's question to Dr. Grendahl: "I hear considerable testimony on the hazardous nature of the drops in question and the question I have for you is that if, in fact, they're such a hazardous nature at the present time that you elect not to use it on many of the natives, why do you use it on anyone?"

YOU HAVE TO DIALATE TO SEE IF THE BACK OF THE EYE IS FREE OF DISEASE.

Dr. Grendahl's answer: "Let me describe the eye as a sphere, okay? Front aspect of it is a lens system. Back surface is a film. If a person comes in with a complaint of flashing lights or seeing spots, or a white curtain comes down over the eye. We have to dialate the eye with, like with the element in neosynophrin, in order to see that retinal detachment, okay? In order to see that retinal detachment you have to get way out to the periphery, way out to the front edge of the film. . . . So by dialating the eye fully we can get way out to the periphery but we need to know their systems. . . . That's why we use dialating drops in the eye for that instance."

YOU HAVE TO USE DROPS TO GET A PRESCRIPTION FOR A CROSS-EYED CHILD.

Another instance why we use dialating drops is that the patient comes in, a little child comes in with a crossed eye, okay? If a child has a crossed eye, we have to do a psychoplegic refraction. All that means is we put a drop in the eye not to dialate the pupil but to put the lens at the primary station. That way we can determine the whole

refractive error of the eye and determine the therapy. Number one would be to prescribe the whole psychoplegic refraction of the glasses. If they have the eye deviating in after the full psychoplegic refraction, with glasses prescribed, then surgery has to be done. . . . So that's why we as ophthalmologists use dialating eye drops.

IF DROPS ARE DANGEROUS, WHY DOES MY EYE DOCTOR USE THEM EVERYTIME ON MYSELF AND MY CHILDREN.

Legislator's question to Dr. Grendahl: "I wear glasses. I've had drops several times. My two children that I've taken in have their eyes examined. There was no black curtain or crossed eye or any of these particular things you've described and every, every time I've gone in, their eyes have been dialated, and I guess what I'm hearing is that the drops are very dangerous. All sorts of things can happen. . . . They've been used very frequently when I've gone in."

DIALATE EVERYONE OVER 52 YEARS OLD.

Dr. Grendahl's answer: "If you come into my office, if I don't see any indication to use the drops, I don't use them. I will use it though in someone that's over age, like 52 or 53. Why? Because the incidence of pathology in a 52 year old and older is higher, namely methostatic breast cancer, prostatic cancer, lung cancer. So in those cases, I will dialate everyone over that particular age, but for routine refraction, and if you were not in that age group, I wouldn't probably dialate your eye unless I saw some real reason to: visual imbalance, field imbalance, pupil abnormality, pigmentation of the iris. My only comment is that other physicians have other feelings about it."

PHYSICIAN ASSISTANTS DIAGNOSE AND PRESCRIBE MEDICINE.

Legislator's question to Dr. Page: "Is it not a fact that physician assistants in this state do diagnose and prescribe medicine without the same benefit of training as the medical doctor?"

Dr. Page's Answer: "That's true."

HOUSE BILL #79

"PRACTICE OF OPTOMETRY"

To Include

DIAGNOSTIC AGENTS

TABLE OF CONTENTS

I. WRITTEN TESTIMONY

II. SUPPLEMENTARY INFORMATION REGARDING HB #79 (OPTOMETRISTS DIAGNOSTIC AGENTS USAGE)

A. The Usage of Topical Eye Examination Drugs by Optometrists

By: Darrell B. Carter, O.D., Ph.D.
Clinical Professor of Optometry
School of Optometry
University of California

This paper was prepared to present to members of state legislatures and to other interested persons the reasons why optometrists desire legislative authorization for the use of ocular examination drugs.

B. Questions and Answers on the Optometry Bill (HB #79)

This summarizes and briefly answers the key questions most frequently asked.

C. Some Points Relative to the Use of Drugs by Optometrists

By: Leonard Levine, Ph.D.
Professor
College of Optometry
Pacific University, Oregon

Dr. Levine has received numerous grants to research the chemistry and physiology of diseases such as muscular dystrophy. He is highly respected as a professor as well as researcher in the areas of physiology and neurophysiology. In order to be effective as such, a special understanding of pharmacology is inherent.

He makes a number of important points relative to the use of drugs by optometrists.

D. Statutory and Judicial Aspects

1. House Bill #79

This bill would re-define A.S. 08.72.300(2) "OPTOMETRY" and (3) "Practicing Optometry".

Addition of a new A.S. § 08.72.305 "USE OF DRUGS FOR DIAGNOSIS".

A.S. 17.15 is amended by adding to Article 1, § 17.15.055 "Sales to Optometrists".

2. Complete Alaska Revised Statutes

3. Supreme Court of Oregon, 1947

State ex rel. Sisemore v. Standard Optical Co., 182 Or. 452-467

The following are some points made in this case:

a. An optical company cannot employ an optometrist because this interfers with the optometrists' trusted and fiduciary relationship with his patient.

b. Optometry must be classified a true "profession" and not a "trade".

". . . an optometrist . . . training enables him to diagnose pathological conditions . . . The fact that he is trained to diagnose pathological conditions in itself indicates that the optometrist is not a mere skilled craftsman or mechanic."

(The entire Supreme Court case may be obtained upon request.)

4. Civil Action No. F 76-35 Civ.

Ferdinard v. Board of Dispensing Opticians (page 104 and 105) defines "routine visual examination" as given by optometrists. The extensiveness the optometrist must examine for eye pathology is expressed.

d. External Examinations (lids, cornea, sclera, etc.)

e. Internal Ophthomoscopic Examination (media, fundus, etc.)

f. Ocular motility

g. Neurological integrity

k. Confrontation fields

l. Tonometry

5. Diagnostic Drugs Terminology Clarification from Oregon Law

a. Oregon Attorney General Opinion #5807 (1964) clarification regarding the term: DIAGNOSIS.

This Oregon Attorney General Opinion states that the "Practice of Optometry" includes pathology diagnosis. In addition, Oregon statutes governing the practice of medicine, do not prevent diagnosis by optometrists

after reference to the 1947 Supreme Court case, State ex rel. Sisemore v. Standard Optical Co., 182 Or. 452, Attorney General Thornton says:

". . . an optometrist, as a part of his services . . . has a duty to use his professional training, skill and knowledge, while he is performing his primary function, to determine whether his patient is afflicted with an abnormal or pathological condition of the eye . . . ."

b. Alaska Statutes Clarification regarding the term: DRUGS.

The inclusion into the Optometry Statutes of the term diagnostic pharmaceutical agents does not conflict with Chapter 64, Medicine.

Section 08.64.380 definitions:

(2) "Practice of medicine" or "Practice of Osteopathy" means:

(D) for a fee prescribing, directing, or recommending for the use of a person, a drug or medicine for the treatment, cure or relief of a disease, infirmity, bodily injury or defect; . . . .

Diagnostic drugs are not mentioned in the practice of medicine, only drugs or medicine for treatment are spoken to.

6. Report from the Secretary of the Department of Health, Education and Welfare (HEW), 1971

This report concerns itself with the optometrists' responsibilities for disease detection.

E. How the Diagnostic Agents relate to:

1. Other States:

Thirty-one states allow optometrists to use diagnostic agents. Other states are making legislative efforts.

2. Other Countries:

a. Within the large english speaking countries of Canada, Australia, and England, optometrists may use diagnostic drugs.

b. England's joint declaration February, 1970, by optometrists and ophthalmologists confirm the many beneficial years and announce the continuation for the usage of diagnostic agents by optometrists in the future.

3. The United States Armed Forces:

All branches of the military either allow or specify in their regulations that optometrists shall be permitted the usage of diagnostic drugs.

F. Educational Qualification by Oregon Optometrists

1. Statement on Pharmacology Training in Optometry in Oregon, 1975
By: L. Levine, Ph.D.

2. Curriculum Comparison on Pharmacology between:

Oregon Medical School
Oregon Dental School
Oregon College of Optometry

3. Association of Schools and Colleges of Optometry (ASCO)

This study suggests pharmacology curriculum guidelines for continuing education courses for practicing optometrists. Should legislation pass, this guide would serve as a framework for setting up such a program.

4. 1973 National Board of Examiners in Optometry

All applicants for Board certification to practice optometry in Alaska must pass all of the written sections of the National Boards with a minimum score of 70%.

Enclosed copies of sections related to diagnostic agents:

	Hours of Testing
Ocular Pharmacology	1 hr.
Ocular Pathology	2 hrs.

Other sections of the Boards not included but available upon request:

	Hours of Testing
Ocular Anatomy	2.0 hrs.
Visual Science I	2.5 hrs.
Visual Science II	2.5 hrs.
Theory and Practice of Optometry	2.5 hrs.
Theoretical Optics	3.0 hrs.
Ophthalmic Optics	2.5 hrs.
Social, legal, ethical, economic and professional aspects of optometry	1.0 hrs.
	19.0 hrs. testing

5. List of the United States Optometric Colleges and Schools

G. Oregon State University, School of Pharmacy statement

By: Charles O. Wilson, Ph.D.
Dean of Pharmacy
Oregon State University

Emphasis is on the importance of bringing the patient into the Health-Care System. He states:

> "This Bill will make is possible for optometrists to carry out diagnostic procedures to identify any pathological condition during the course of the examination . . ."

University of Maryland, School of Pharmacy statement

By: Peter P. Lamy, Ph.D., F.C.P.
Director of Pharmacy Programs
University of Maryland

Dr. Lamy concludes saying:

> "The benefits from the topical use of drugs far outweighs the risk to vision. There is simply no good way to obtain a satisfactory view of the interior of the eye unless the pupil is dilated."

H. Alaska Board of Examiners in Optometry

Just as all other regulatory responsibility on optometrists is placed with this Board, likewise, it would be charged with the additional responsibility of certification of optometrists for diagnostic drug use. This Board would see that not only the

educational course work had been completed but that through examination, a clear understanding of pathology and disease detection with the use of diagnostic agents does in fact exist.

I. Alaska Manpower Regarding Vision and Eye Health Care

The optometrists of Alaska are geographically more evenly distributed so as to meet the needs of the people. Ophthalmologists are primarily concerned with eye surgery and, therefore, are concentrated around larger population areas where more extensive hospital facilities are available.

As the National Health Care program emerges, along with other increasing group insurance programs, the need for better referral channels must be established. Diagnostic agents can make pathology detection more effective and resulting referrals more accurate.

Enclosed:

1. Alaska Distribution Map on Vision and Eye Health Care
2. 1979 listing on:
   a. Resident Optometrists in Alaska (32)
   b. Resident Ophthalmologists in Alaska (17)

J. Probable Objections to HB #79

K. American Association of Ophthalmology Public Relations Pamphlet on "Drops"

The emphasis is that only a proper examination can be made with eye drops. It then strongly states that only ophthalmologists are allowed to use them. The P.R. results are obvious.

L. Supportive Letters from Medical Doctors Outside of Oregon

These letters speak directly to the minimal adverse side affects and maximal benefit to the patient.

M. Supportive Letter from Medical Doctors and Optometrists Within the State of Alaska

These letters speak directly to the use of diagnostic agents by optometrists in the State of Alaska.

N. Reference Quotations from Authoritative and Qualified Persons Regarding Usage of Diagnostic Agents by Optometrists

1. Substantiating minimal risks to adverse drug reactions.

2. Establishing the larger risk to the public health by not having these drugs administered by optometrists.

O. Long-Term Study of the Use of Diagnostic Agents in Rhode Island by Optometrists

For eight years optometrists have been using diagnostic agents with the overall effect of increased number of referrals, with no adverse effects. The overall benefit to the patient was emphasized because of pathology detection and speedy, proper referrals. (Only summary and conclusion included. Further information can be had on request.)

P. Conclusion

The
ALASKA OPTOMETRIC ASSOCIATION
AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

PRESIDENT

I. My name is George L. Hall, O.D. I am a Doctor of Optometry. My education consists of a B.S. in Math and Biology in 1967 from Regis College, Denver, Colorado, and received my Doctorate of Optometry from the University of Houston in 1971. I have practiced full time in a group practice in Anchorage.

Today you are going to have to make a very difficult decision between two points of view from two well-meaning professions. There may be emotion and accusation in some of the statements made, but I urge you to decide on fact and fact alone.

By introduction of this bill, Optometry is asking to use a very limited number of drugs in furthering its attempt to provide the finest vision care to all Alaskans. We feel passage of this bill will enable early detection of pathology in all patients and at the same time provide a more efficient, less costly eye health care system. We intend to use these only in a limited diagnostic manner, and in no way, or at no time, intend to extend their use to theraputics. Don't be mislead by critics who see in our request to use diagnostic agents the desire of optometrists to treat pathologic conditions. Our sole aim is to improve our detection skills and refer--not treat. Diagnostic agents are not treating agents. We do not wish to practice medicine!

II. Major questions concerning HB 79.

1. Is the legislation necessary?

Statistics from the Health, Education and Welfare Department show that 52% to 58% of the population is estimated to have correctible vision disorders (Myopia, Hyperopia, Astigmatism, etc.).

The Better Vision Institute says that 45% of the population wears glasses and that one-third of those wearing them are in need of re-examination at any given time.

H.E.W. says that 63% of visual examinations last year were conducted by optometrists. Here in Alaska I feel the number may be as high as 75%.

H.E.W. says 17.9 per thousand patients have a condition that requires further medical care.

These statistics point to the need for this legislation since it is well known that many who seek vision care do not routinely seek general medical care, and, therefore, the optometrist is the first to see many pathological conditions which need to be referred for medical care.

It was for these, and other reasons that the Secretary of H.E.W. in 1971, Elliott Richardson, filed a report with the President and Congress which says in part ". . . the Optometrist is a primary entry point into the health care system since he sees the majority of patients seeking eye care in the nation."

In addition, the report contained the following language concerning optometry's role in the health delivery system.

> "Optometrists are trained to detect any departure from the optimally healtny eye. The scope of optometric services has expanded beyond basic clinical refractions, fabricating, and dispensing eyewear; now included are visual screening examinations, clinical instrumentation, contact lens fitting, visual training, orthoptics, low-vision aids for the partially sighted, artificial eyes, industrial vision consultation and public and community health . . . 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."

H.E.W., in its desire to promote the highest quality of health care for the public, has made a number of policy decisions concerning optometry.

In its Health Professional Project Grant for 1975, it has mandated the optometric profession to ". . . devise, demonstrate, and implement provision for inter-discipline training which will encourage the use of health care teams, and to devise projects to develop affiliation between optometric training programs and medical, osteopathic, and other health professions training programs, and academic institutions, . . . including programs for cooperative interdisciplinary training in the use of the team approach to the delivery of health services."

Therefore, to the question "Is there a need for this legislation?", the answer we strongly feel is Yes!

In 1947, the Supreme Court of the State of Oregon in the case of Sisemore v. Standard Optical, 182 Or 452, 460-461, 188 and 309-312-313, has unequivocally answered the question. The court stated on page 460:

> As to the liability of Optometry in the area of diagnosis, the practice of Optometry is undoubtedly one of the subdivisions of the practice of medicine.

The court went on to say on page 461:

> While it is true that an optometrist is not permitted by law to treat diseases of the eye, nevertheless his training enables him to diagnose pathological conditions, and his duty requires him to refer the patient to a practitioner who is qualified to treat such conditions. The fact that he is trained to diagnose pathological conditions in itself indicates that the Optometrist is not a mere skilled craftsman. His failure to diagnose a pathological condition, with resultant delay or neglect in proper treatment therefore, might result in serious impairment of the patient's eyesight, or even in blindness.

In a letter from Robert Thornton, Attorney General, State of Oregon, dated May 12, 1964, to Mr. Howard Bobbitt, Executive Secretary, State Board of Medical Examiners, citing the same decision he says:

> It thus appears that the term practice of optometry as construed by our Supreme Court contemplates that an Optometrist as a part of the services he renders his patient, has a duty to use his professional training, skill and knowledge while he is performing his primary function, to determine whether his patient is afflicted with an abnormal or pathological condition of the eye which may require treatment by a person legally qualified to render such service. He is also required to advise such patient if he finds what appears to be a pathological condition so that the patient may seek treatment from a legally qualified person.

Therefore, the answer to the question of whether we as optometrists are qualified to detect pathology has been already, very explicitly, answered by the courts in Oregon and nationwide.

From our early beginnings as a profession, we have over the years vastly improved, through our educational institutions, the state of the art and science of optometry to a place where we are recognized now as a highly specialized member of the health care team devoted to the visual well being of the public.

Use of these drugs can aid in the early detection of both eye diseases such as retinal tears, glaucoma, cataract formation and in the systemic diseases such as diabetes, arterial sclerosis, high blood pressure or cancer, to name a few. According to literature put out by the American Association of Ophthalmology in which they answer the question of the necessity of using drops, the literature answers by stating that it enables the doctor to observe the first signs of eye disease or sometimes the first signs of disease elsewhere in the body. It goes on to say that these drops are especially useful in older people and children and are necessary to test for glaucoma. It closes by saying that these drops are "often the key to the prevention to blindness and even the saving of the eye itself."

It should be clear that <u>both the profession of optometry and the profession of medicine are in agreement on the value of these drops</u> even though there may be a few individuals who feel threatened by passage of this type of legislation.

The issue then stems not from whether these drops are safe or unsafe, good or bad, but on whether an optometrist is sufficiently trained to diagnose eye disease and to use these drugs in a proper manner.

I am certain that you will be told by a few ophthalmologists that only they should be able to use these drugs. They have chosen to ignore our responsibilities and our extensive training in what they refer to as medical subjects. They may tell you that these drugs could have some side affects such as increasing a patient's blood pressure, his heart rate, or result in an allergic reaction.

We do not disagree with the possibility of this happening but wish to point out that these reactions are considered in ophthalmological literature to be extremely rare. I would also like to point out that all optometry

students are being trained in contraindications for the use of these drugs and the bill provides that all practicing O.D.s who wish to use them must return for this additional schooling and re-certification by the State Board of Examiners.

It is also worthy to note that according to ophthalmological literature, one case of angle closure glaucoma will occur in every 18,400 patients whose eyes are dilated in a routine basis. Optometrists who will be dilating eyes, however, are trained to screen out those individuals for whom this procedure could be hazardous.

Along with this extremely minimal risk, however, should be mentioned the great benefits which will result. H.E.W. tells us that in those same 18,400 individuals there will be 329 cases of disease which, if undetected, could cause possible blindness or have other serious consequences. It is also interesting to note that our opponents have chosen not to complain about other professions such as dentistry who have similar training and responsibilities or medical emergencies and yet use stronger injectable drugs.

As stated previously, optometry conducts a great majority of visual examinations: 63% nationwide to possibly as high as 70-75% in Alaska. In my practice alone, there are five optometrists seeing between twenty to sometimes thirty people per day, and there are six to seven other practices in Anchorage just as busy not to mention the rest of the state where ophthalmolical density is even lower than it is in Anchorage. NOTE: Distribution may included.

In 80% of our patients there is little difficulty seeing the back of the pupil, but, in the rest, difficulty in seeing the retina can produce doubt; therefore a referral may be necessary.

On the one hand we are expected to continue to do a most thorough visual examination of our patients and are encouraged by governmental agencies such as H.E.W. to expand our efforts to work with other health care professions in providing wider health care.

On the other hand we are held legally responsible for the detection of pathological conditions but are denied the use of important aids to detect them for the Alaska Optometric Law excludes our employment of valuable tools such as diagnostic agents to aid in the detection of pathologic conditions in the eye.

We ask for relief from that situation.

affiliated with the american optometric association

Oregon Optometric Association

My name is Robert Holcomb, I am a Doctor of Optometry and President of the Oregon Optometric Association. The object of our Association as stated in our constitution is to improve the vision care and health of the public.

Before I get into the Association's reasons for supporting this bill I would like to clear up two areas of confusion. They have to do with the safety of these pharmaceuticals and with an optometrist's training in this area. So that you might have an opportunity to hear and question the top men in these fields, I have asked both the Deans of the College of Optometry Pacific University, Dr. Willard Bleything and the Assistant Dean of the Pharmacy School at Oregon State University, Dr. Ronald Winters, to speak to these points.

You have heard the facts about the relative safety of these drugs and the exstensive training of an Optometrist. I would now like to go into the detail about the two reasons that Optometrists wish to use these drugs. First of all, I am sure that every Doctor of both optometry and medicine would agree that it is in the interest of the public to have their eyes routinely examined for both vision problems and health problems which can be observed within the eye. Ophthalmologists have been saying for years that these drugs are necessary tools for the early detection of disease and for the evaluation of vision problems.

A few of the off hand remarks heard in earlier testimony expressed the opinion that the diagnosis of disease conditions is outside the scope of the practice of optometry. I respect the opinions of these individuals but wish to point out that they are only opinions in direct contrast to the law written as the Optometric Practice Act and interpreted by the highest court in our state, the Oregon Supreme Court. If I may quote from their decision handed down in the case of Sisemore versus Standard Optical "the practice of optometry is undoubtedly one of the subdivisions of the practice of medicine."

The court went on to say "his training enables him to diagnose pathological conditions ... his failure to diagnose pathological conditions with resultant delay or neglect in proper treatment therefore might result in serious impairment of the patients eyesight or even in blindness." The Attorney General has so informed the State Board of Medical Examiners. Despite this opinion of the Optometric Practice Act by the Supreme Court there are a few individuals who insist on issuing their own opinions.

The first reason for this bill then is simply that since Optometrists have the responsibility to detect disease they should have the tools with which to carry it out.

The second reason is that the use of these diagnostic agents would be in the interest of the public. Health Education and Welfare tells us the 63% of all vision examinations in the United States were conducted by O. D. s in 1974. H. E. W.

identifies optometry as an entry point into the health delivery system since we see many patients who routinely get vision examinations — but not physical exams.

The State of Oregon Department of Human Resources tells us that in 1974 85% of all Welfare patients were examined by Optometrists.

Use of these drugs can aid in the early detection of both eye diseases such as retinal tears, glaucoma, cataract formation and in the systemic diseases such as diabetis, arterial sclerosis, high blood pressure or cancer, to name a few. According to literature put out by the American Association of Ophthalmology in which they answer the question of the necessity of using drops, the literature answers by stating that it enables the Doctor to observe the first signs of eye disease or sometimes the first signs of disease elsewhere in the body. It goes on to say that these drops are especially useful in older people and children and are necessary to test for glaucoma. It closes by saying that these drops are "often the key to the prevention to blindness and even the saving of the eye itself."

It should be clear that both the profession of optometry and the profession of medicine are in agreement on the value of these drops even though there may be a few individuals who feel threatened by passage of this type of legislation.

The issue then stems not from whether these drops are safe or unsafe, good or bad, but on whether an Optometrists is sufficiently trained to diagnose eye disease and to use these drugs in a proper manner.

I am certain that you will be told by a few Ophthalmologists that only they should be able to use these drugs. They have in previous testimony chosen to ignore our responsibilities charged by the supreme court and our extensive training in what they refer to as medical subjects. They may tell you that these drugs could have some side affects such as increasing a patients blood pressure, his heart rate or result in an allergic reaction.

We do not disagree with the possibility of this happening but wish to point out that these reactions are considered in ophthalmological literature to be extremely rare. I would also like to point out that all optometry students are being trained in contraindications for the use of these drugs and the bill provides that all practicing O.D.s who wish to use them must return for this additional schooling and re-certification by the State Board of Examiners.

It is also worthy to note that according to ophthalmological literature one case of angle closure glaucoma will occur in every 18,400 patients whose eyes are dilated on a routine basis. Optometrists who will be dilating the eyes, however, are trained to screen out those individuals for whom this proceedure could be hazardous.

Along with this extremely minimal risk, however, should be mentioned the great benefits which will result. H.E.W. tells us that in those same 18,400

individuals there will be 329 cases of disease which if undetected could cause possible blindness or have other serious consequences. It is also interesting to note that our opponents have chosen not to complain about other professions such as dentristry who have similar training and responsibilities for medical emergencies and yet use stronger injectable drugs. If you have any questions we stand ready to answer them.

Robert Holcomb, O.D.
President
Oregon Optometric Association

TESTIMONY

House Bill 2740 Practice of Optometry to include Diagnostic Agents

Willard B. Bleything, O.D., M.S., Dean
Pacific University College of Optometry
Forest Grove, Oregon
April 22, 1975

My name is Willard B. Bleything and I am the Dean of the Pacific University College of Optometry, the only professional institution in the Northwest in the discipline of optometry. In addition to the Bachelor of Science (B.S.) degree I have a Doctor of Optometry degree (O.D.) from Pacific University along with a Master of Science degree (M.S.) in Clinical Optometry. I have been on the faculty of Pacific University and the USAF School of Aviation Medicine, Air University. My experience also includes sixteen years of private practice. Offices held include President of the Oregon Optometric Association, Oregon Board of Optometry (Examiners) and a member of the Professional Development Division, American Optometric Association. I am a Fellow of the American Academy of Optometry.

It is my pleasure to present these remarks on HB 2740. The bill is well constructed, technically sound and is consistent with the well-founded direction that public policy is taking in the other states. Most important of all, it is consistent with the best interests of the public welfare and the ways by which optometry better can serve public need. The legislature of Oregon first caused the profession of optometry to be recognized, licensed and regulated in 1925. The optometry law, much like that in each of the states prescribes the conditions by which a recent graduate from one of the schools and colleges of optometry, following rigorous and well tandardized inquiry by a multi-faceted written and practical board examination, is then licensed to practice

and is regulated in the practice.

Today the curriculum of the thirteen (soon to be fifteen) schools and colleges of optometry consists of an intensive four years of professional collegiate work preceded by a minimum of two years of pre-professional undergraduate collegiate experience. The vast majority of students are entering the optometric colleges with a bachelor's degree. Thus six, and in most instances eight years of university level education and training comprise the very substantial background of the modern optometrist. The number of qualified and acceptable applications for each seat available are better than thirteen to one with outstanding academic and personal credentials.

Our clinical program at Pacific University encompasses care in a variety of social and professional settings including a full scope general and specialty clinic on the main campus and in downtown urban Portland; a general practice clinic in the Albina Action Center and a geriatric-low vision clinic in the Masonic Home, Forest Grove. Students are also exposed to public health optometry in their involvement in visual screening clinics throughout the state serving more than 4,000 citizens annually in this activity alone. Many of these are conducted at the request of County Health Departments and local school districts. Incidentally, I must add that in more than thirty years of clinical operation encompassing hundred of thousands of patient-visits the institution has never experienced a malpractice suit-indeed a remarkable record in the field of health care. More than fifty professionals make up our faculty - all with earned doctorate degrees represent expertise as anatomists, physiologists, microbiologists, neuroanatomists, biochemists, clinical psychologists, optometrists, and ophthalmologists. To follow a general pattern it can be seen that the Ph.D. offers instruction in the basic sciences, the O.D., - Ph.D. combination offers

instruction in the visual sciences, and the O.D. and M.D. offer instruction in the clinical sciences. The optometric student thus gets formal transcript quality university level courses in Human Anatomy, Ocular Anatomy and Physiology, Human Physiology, Microbiology, Neurology, General Pathology and Ocular Pathology and Ocular Pathology Detection and Visual Fields, or a method of examining for and differentiating between various eye disease processes. They also receive a didactic comprehensive course in Pharmacology. All of this material is taught by doctorates in the appropriate disciplines parallel to the same professional positions of any health professions school. In addition to this one of the various specialty clinics during the clinical years is entitled Pathology Detection. Patients suspected of having pathological disorders are referred for consultation to this clinic. Presently this is staffed by a Board Certified Ophthalmologist (M.D.). Patients suspected of having conditions that may benefit from the services of a physician are referred to sources in the community for consultation. For example, over the past years Pacific University Optometric Clinic (Portland) has sent an average of two hundred and fifty patients per year to the Good Samaritan Hospital Devers Eye Clinic for consultation purposes.

During the past generation as optometric education significantly increased its scope of learning and competence with the attendant expansion of all knowledge in the sciences of health care it was recognized that the use of diagnostic pharmaceuticals would add a useful and important opportunity to render more comprehensive visual care services to the public it now serves. In recognition of this newer direction courses for the profession in core areas in the basic sciences were substantially strengthened.

The Bill proposed deserves the support of this legislative body.

1. Optometry is prepared educationally and intellectually to undertake the use of diagnostic pharmaceuticals in the practice of the profession.

2. Passage of the proposed legislation does not advance professional responsibilities of the scope of the license of the optometrist as a vision care practitioner. Rather it offers the public a more rational and intelligent use of the present educational expertise.

3. There is no fiscal implication in this legislation since the methods not the scope of legal responsibility would be advanced.

4. Like our professional counterparts in dentistry and podiatry, two professions outside the discipline of medicine, the use of pharmaceuticals with an appropriate knowledge and educational base have been well established in law and in practice. There is provision in this Bill for additional education. Pacific University College of Optometry stands ready to provide this additional education to the practicing community of optometry.

In looking into the future I close with this comment. Dr. Albert N. Lemoine, a physician, professor and chairman of the Department of Ophthalmology, University of Kansas Medical Center states, "The number of residents in training in ophthalmology programs will be reduced in the near future." He goes on to say,"One year of the optometric students educational experience should be where they can observe patients with disease. Optometry will be recognized as one of the primary care entrances to the eye health care system and especially in rural areas and smaller cities. Optometrists will be able to use topical drugs for diagnostic purposes in all or nearly all states and an increasing number of optometrists will be practicing in the multi-disciplinary setting." Dr. Lemoine goes on to say, and I quote "I realize that many of my

colleagues will not agree with the above position but if we are truly interested in the public welfare this should and can be done."

It seems there is general agreement among the educators in ophthalmology and optometry as to the new trends and mode of practice. We, as an institution, are committed to supplying these educational needs of the future. Legislative assistance is needed to carry out this commitment.

School of Pharmacy

Oregon State University

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29 January 1975

In studying and evaluating the proposed legislation authorizing the use of diagnostic pharmaceutical agents (DPA's) by optometrists, three principal questions have emerged relative to my areas of expertise as an educator specializing in curricular design and as a pharmacologist: 1) is the overall curricular design utilized by the College of Optometry at Pacific University appropriate for the education and training of optometrists to use DPA's in their practice; 2) is the specific curricular component concerned with pharmacology appropriately constructed; 3) from the perspective of a pharmacologist, is the use of DPA's by optometrists a safe procedure likely to result in an overall improvement in patient care?

In the course of my efforts over the past three years to coordinate the redesign of the professional curriculum of the School of Pharmacy at Oregon State University, I have had considerable occasion to review the curricula of a large number of health profession schools, both in Oregon and elsewhere. Further, as my own graduate training in pharmacology was conducted largely at the University of Oregon Medical School in Portland, I am especially familiar with the curriculum of that institution, with emphasis on the pharmacology component. Finally, I have participated in a number of national and international meetings of professionals concerned with curricular design and implementation in many of the health-related fields. In comparing the curriculum of the College of Optometry at Pacific with the curricula of other health profession

schools utilizing a pharmacological component, I am convinced the approach developed by Pacific is both efficient and effective, and is clearly educationally sound. Moreover, that structure includes what I consider to be the sine qua non of proper instructional design--the competency of the graduate is evaluated in a series of prescribed and standardized formats (i.e., institutional, Oregon State Board of Optometry, and national board examinations) prior to the awarding of a license to practice. Thus, individuals who may have succeeded in passing individual courses but who have not adequately integrated the body of knowledge as a whole are not permitted access to the public as professionals. This safeguard, in my view, is instrumental in protecting the public, the institution, and the profession, and should stimulate your confidence in the proposal at hand.

Examination of the pharmacology component of the curriculum has also led me to a favorable conclusion. It is clear that the student is well-prepared for his first exposure to courses dealing with DPA's and other drugs, and is carried through this portion of his coursework in an effective manner. It is my judgment that a program designed to prepare practitioners to utilize DPA's must rest on a sound didactic base, capped by supervised clinical experience in the use of the agents in question. I feel strongly that a quality didactic base is offered at Pacific, and that passage of the proposed legislation will quickly result in the implementation of an appropriate clinical component as already outlined by the school.

The question of the relative safety and productivity of the proposed procedures must be addressed, and in my view, these two issues cannot be rationally separated; that is, neither safety nor efficacy are unidimensional characteristics, but instead are interrelated as a cost/benefit ratio or in medicine, a therapeutic index. Three important considerations relate to the expected safety in the use of DPA's by optometrists: 1) what agents are to be used; 2) what doses of these agents are to be employed; 3) how will these agents be administered? The four principal

categories of DPA to be used are miotics (agents that constrict the pupil), mydriatics (agents that dilate the pupil), local anesthetics (substances that reduce feeling in the cornea), and cycloplegics (agents that alter the ability of the eye to focus on near objects). The most salient pharmacological feature of these compounds is their relatively short duration of action, generally measured in minutes. If nothing else, this characteristic itself tends to minimize the likelihood of an adverse reaction simply because the drug is effectively inactivated by the body in relatively short order. Secondly, the doses to be utilized in diagnostic procedures are indeed very small. Using one to two drops of solutions of one-half to two and one-half percent strength in each eye provides the patient with a total dose far less than is obtained in many over-the-counter cold remedies readily available to the patient on only his/her discretion. Thirdly, by limiting the administration of these compounds to the topical route (dropped in the eye), it is not likely that more than twenty percent of the total dose will be absorbed into the blood for general circulation in the body. At that concentration level, these agents are essentially devoid of pharmacological activity. When coupled with the virtual absence of reported adverse reactions in states where this practice is common, one cannot help but conclude that the use of DPA's in the format proposed is extremely safe.

How much benefit is to be derived from this practice is, as I've said, the other side of the coin. In my judgment, the judicious use of DPA's will permit a substantial increase in the ability of the optometrist to detect potentially harmful diseases of the eye. By allowing this health-care professional to examine the patient more completely, the optometrist will be in a better position to refer to physicians (ophthamologists, internists, pediatricians, and family practitioners) those patients requiring further diagnosis and possible treatment. In view of the established fact that optometrists serve as the primary eye-care professionals for a majority of the population, it is apparent that the anticipated gain for the patient is large.

It would appear, therefore, that a near optimal situation prevails here: the proposed use of DPA's by optometrists is clearly both very safe and likely to be most effective in patient eye care. Further, it is evident that considerable planning has been conducted by the College of Optometry at Pacific, and that the school is ready, capable, and indeed has already begun providing educationally sound classroom instruction in the use of diagnostic pharmaceutical agents, with implementation of actual clinical instruction awaiting legislative approval. Thus, with the cost/benefit or therapeutic ratio a very favorable one to all parties concerned, I respectfully encourage the swift passage of the proposed legislation.

Ronald H. Winters, Ph.D.
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Associate Professor of
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THE USES OF TOPICAL EYE EXAMINATION DRUGS BY OPTOMETRISTS[1]

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Introduction

Eye examination drugs (topical anesthetics, mydriatics, miotics, and cycloplegics) are used by optometrists to facilitate the examination of patients' eyes for the possible presence of disease conditions or to aid in determining the refractive error of the eye. These drugs are for examination purposes only and are not for treatment.

Until about 1960, only a few optometrists in the United States used examination drugs as part of their examination procedure. Optometrists in England have used these drugs for over 25 years.

During the period of 1960 to the present time (1974), some optometrists have started to use these drugs whenever it is in the patients' benefit to do so. However, in only eight states (as of July 1974) are optometrists specifically authorized to use these drugs by either legislative act or by a ruling of the attorney general of the state.

At present, efforts are being made by optometrists in many states to secure legislative authorization of the use of these drugs for examination purposes only. The recent efforts by optometrists in the United States, Australia, Canada, and elsewhere to obtain legislative authorization for the use of examination drugs is not an attempt to enter into the field of therapy for ocular disease.

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[1]This paper was prepared to present to members of state legislatures and to other interested persons the reasons why optometrists desire legislative authorization for the use of ocular examination drugs.

Optometrists recognize the desirability of limiting the scope of their practice to the correction of refractive errors of the eye and anomalies of binocular vision. The use of examination drugs is for the purpose of allowing more effective and earlier discovery of eye disease when such disease exists. Patients with the possible presence of eye disease or general disease are referred to an ophthalmologist or other physician for medical evaluation and care. In this way, the most efficient use of the skills of both optometrists and ophthalmologists is obtained.

Topical Anesthetics

Topical anesthetics are used primarily by optometrists to facilitate tonometry in evaluation of the eye for the possible presence of glaucoma. While tonometry can be done without anesthesia of the cornea, it is usually more accurate when done with anesthesia. Moreover, the most accurate tonometer, the Goldmann applanation tonometer, requires anesthesia of the cornea.

Some ophthalmologists have objected to the use of corneal anesthesia by optometrists. This objection is based on the assertion that these drugs can cause fatal heart or respiratory stoppage. Anesthetics are dangerous when injected.. The death rate in eye surgery by ophthalmologists is apparently about one in every 2000 to 5000 operations. While local injection into tissue is necessary in eye surgery by ophthalmologists, only topical (dropped on the surface) use of anesthetics is employed by optometrists. There are no reports of fatal reactions from eye topical anesthetics.[2]

There are three topical corneal anesthetic agents used by optometrists: tetracaine (trade name, Pontocaine), proparacaine (Ophthaine), and benoxinate (Dorsacaine). None of these three drugs are used for local injection anesthesia

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[2] The real objection of ophthalmologists to the use by optometrists of pharmaceutical agents, including topical anesthetics, arises from economic and prestige reasons. Unfortunately, in the United States, strong economic rivalry over the examination of eyes for glasses and contact lenses have often resulted in economic and prestige considerations playing a major role in the attitudes of many members of both groups

These drugs are toxic and are dangerous if absorbed by the body in large quantities as could happen if these drugs were used topically on the throat. For example, 5 ml. of a 2% solution of tetracaine (the most toxic of the three drugs) is considered to be a potentially lethal dose if completely absorbed.[3] However, it should be understood that 5 ml. is 100 drops and that the strength used by optometrists is 0.5%. Thus, in using one drop of a 0.5% solution in each eye, the optometrist is using 1/200 of the potential lethal dosage. Moreover, drugs placed on the normal eye are very poorly absorbed (approximately one-fifth) into the blood stream. In topical use on the eye, the optometrist thus is using only 1/1000 of the potential lethal dosage. This is a wide safety margin.

Proparacaine and benoxinate are less toxic than tetracaine. According to James R. Householder, M.D., and John E. Harris, M.D.,[4] these drugs are safe for topical application to the eye. On Ophthaine, these authors state "there have been no reported systemic toxic reactions in amounts used for topical anesthesia for the eye." However, "the chemical structure would predict such reactions if large amounts were to be applied to a vascular area such as the upper respiratory tract," (page 100). On Dorsacaine, these two authors state "there has been no reported systemic toxic effects from its use in 1 cc. amounts," (page 99). One cc. is 10 times the dosage that is used by the optometrist in preparation for tonometry.

According to William Havener, M.D.[5] fatal reactions "occur from ignorant use of excessive quantities of anesthetic" (page 47). These rare reactions

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[3] William Havener, M.D. Ocular Pharmacology, Mosby 1970.

[4] In Ocular Therapy, Mosby 1966. Edited by Irving Leopold, M.D.

[5] William Havener, M.D. Ocular Pharmacology, Mosby 1970

have occurred following anesthesia of the throat for throat or lung examination, or from injection of an anesthetic. Havener states "since generalized reactions to the topical application of anesthetic solutions are due to systemic absorption of excessive quantities of drug, such reactions are virtually nonexistent after topical ocular anesthesia," (page 47).

In England, optometrists have been using corneal anesthesia for over twenty-five years. No report of any fatality from ocular anesthesia by optometrists has been received by the British Ministry of Health during this entire period.

On rare occasions, patients faint because of apprehension of something being placed on the eye. Such fainting (syncope), has been mistaken for a toxic reaction. However, the patient quickly regains consciousness. In summary, the use by optometrists of anesthetics applied topically to the eye is an entirely safe procedure. Such use by optometrists will result in the saving of the eyesight of patients by allowing early detection of glaucoma.

Mydriatics and Miotics

Drugs which dilate the pupil are called mydriatics. The common mydriatic drugs are phenylephrine (Neosynephrine), hydroxyamphetamine (Paradrine), and tropicamide (Mydriacyl). The use of these drugs is to facilitate the ophthalmoscopic examination of the inside of the eye for pathological changes. Miotic drugs are used to shrink the pupil following the use of a mydriatic drug. The only miotic used by optometrists is pilocarpine.

Mydriatic drugs can produce an attack of angle-closure glaucoma (a special type of glaucoma) in a person with anatomical predilection. Before the use of mydriatic drugs, the eye should be examined with a biomicroscope for the presence of a narrowed angle, an anatomical abnormality. About two or three persons in 100 of those who are over 50 years of age have an anatomical narrowe angle such that they could have an attack of angle-closure glaucoma under

adverse conditions.[6] This two percent can be detected by prior examination and mydriatics should be avoided or used only under controlled conditions.

The actual incidence of angle-closure glaucoma is approximately 1 in 1000 (4 in 4123) persons in the general population over the age of 50, according to the careful study of Hollows and Graham.[7] The low incidence of actual angle-closure glaucoma compared with those who have narrow angles, 2 or 3 in 100, shows that the vast majority of individuals with a narrowed angle go through life without developing an actual attack, and thus do not suffer from their narrow angle.

Some ophthalmologists do not examine the eyes of patients for the presence of a narrowed angle prior to routine use of mydriatic drugs. The drug is instilled by a nurse prior to the patient seeing the ophthalmologist. This routine is justified on the basis that if a mydriatic drug will trigger an attack of angle-closure glaucoma, the patient is almost ready to experience an attack even without the mydriatic drug. The argument is made that it is better to trigger an attack while the patient is in a professional office and treatment for the attack can be quickly instituted. These ophthalmologists consider this to be a useful provocative test.

It has been estimated by S.V. Abraham, M.D.[8] that the use of a strong mydriatic - atropine or homatropine - (stronger than those used by optometrists) without prior examination for the presence of a narrowed angle would result in a glaucoma reaction in one in 4600 patients over the age of 30 and much less often for patients under 30 years of age. The incidence of glaucoma reaction

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[6] Van Herick, Shaffer and Schwartz. American Journal of Ophthalmology, October 1969.

[7] F. C. Hollows and P. A. Graham. Intra-ocular pressure, glaucoma, and glaucoma suspects in a defined population. British Journal of Ophthalmology, pp. 570-586, 1966.

[8] S. V. Abraham, M.D. Mydriatic glaucoma. Archives of Ophthalmology, pp. 757-762, 1933.

is further reduced when mild mydriatics are used and when a miotic is used following the use of a mydriatic. While the author of this paper does not believe that optometrists should ever use mydriatic drugs without prior biomicroscopy study of the angle of the eye, it is obvious that adverse reactions are rare even without the precaution of prior examination of the eye.

It is possible, although quite rare, for an attack of angle-closure glaucoma to occur after use of a mydriatic drug even with prior screening by the optometrist for narrow angles. In these rare cases an optometrist will send the patient for medical care. The patient will have had the advantage of having his attack under conditions where medical care is available. In optometric use of mydriatics, with prior evaluation of the anterior angle and with use of the milder mydriatics, a glaucoma reaction can be expected no more than once in every 15,000 to 25,000 patients over 30 years of age. These attacks will only occur in persons who are in great danger of such an attack even without the use of the mydriatic drug. Discovery of the potentiality of angle-closure glaucoma will help save the vision of these patients.

The author strongly supports the use of mydriatic drugs by optometrists. The use of mydriatic drugs will enable earlier detection of retinal disease conditions. Such earlier detection will result in the saving of vision or even life. The potential of earlier detection of disease by the use of mydriatic drugs far outweights the very rare situation of a glaucoma reaction.

Cycloplegics

Cycloplegic drugs temporarily paralyze the accommodative mechanism of the eye and thus facilitate measurement of refractive error with some patients, chiefly children less than seven or eight years old. Rarely is the use of a cycloplegic desirable with an adult patient.

The only cycloplegic drug used by optometrists is the 1% solution of Cyclopentolate (Cyclogyl). There have been no reported serious side-effects

with the use of this drug. From its low toxicity, none would be expected. There have been a few literature reports of temporary (up to four hours) of faulty orientation and hallucinations in children following use of several drops of the 2% solution of cyclopentolate or repeated usage on several days of the 1% solution.[9] These temporary psychological disturbances have not been reported to occur with the use of one or two drops per eye of the 1% solution - the mode of usage by optometrists.

Summary

(1) The most efficient use of the skills of optometrists in supplying visi care will be obtained by the use of examination drugs by optometrists.

(2) Use of examination drugs by optometrists will allow earlier detection of eye disease and the saving of vision or even life.

(3) The use of drugs by optometrists is for facilitation of examination and not for treatment purposes.

(4) Patients with the possible presence of eye or general disease are referred by optometrists for medical evaluation and care.

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[9] William Havener, M.D. Ocular Pharmacology, Mosby 1970, page 198.

HOUSE BILL #79

QUESTIONS AND ANSWERS ON THE OPTOMETRY BILL

1. Why was the "Diagnostic Agents" Bill introduced?

   a. In Oregon, May 12, 1964 (Attorney General Opinion No. 5807), the Attorney General said that an optometrist "has a duty to determine whether his patient is afflicted with an abnormal or pathological condition of the eye." (Reference to Supreme Court Case: State ex rel. Sisemore v. Standard Optical, 182 Or. 452.)

   b. In malpractice lawsuits throughout the nation, optometrists have been charged with the responsibility of eye disease detection.

   c. In 1971, the HEW Secretary Elliot Richardson said "Optometrists are trained to detect any departure from the optimally health eye. The scope of optometric services has expanded beyond basic clinical refractions."

   Optometry has been charged with the responsibility of a primary entry point to health care. This bill will increase the examination capabilities to allow better eye or systemic pathology detection for referral for medical diagnosis and treatment.

2. What is the current role of the optometrist in patient care?

   The optometrist is the general practitioner in the field of vision care. His emphasis is on the functional aspects of vision--the ability of a child to learn or a person to function optimally in his occupation or environment. However, in examining a patient he also makes a comprehensive internal and external examination of the eyes to detect evidence of eye or systemic diseases revealed through the eye for referral for medical diagnosis and treatment. This latter feature is particularly important to the many persons who due to various factors do not routinely seek medical care.

3. What is the experience of other states in the use of diagnostic agents by doctors of optometry?

   Since HEW Secretary Richardsons' statement, Rhode Island, Pennsylvania, Oregon, and twenty other states have enacted positive legislation. Other states which previously had no prohibitive laws and thus allow for the usage of diagnostic agents include: Florida, Idaho, Indiana, Minnesota, Nevada, and New Jersey.

New Jersey optometrists have had the right to use these agents since 1919. In that state "there have been no cases reported regarding any problems caused by optometrists using any of the diagnostic drugs." On the contrary, this report states "the use of diagnostic drugs by optometrists is definitely in the public interest."

4. What is the experience of the Armed Forces in the area of diagnostic agents used by optometrists?

All three branches of the military, either in the regulations or at local hospital options, require or allow optometric commissioned officers to utilize diagnostic agents to aid them in their examinations or aid or consult with other commissioned health professionals. In the critically important visual examinations of aviators, diagnostic agents have been widely utilized by optometrists.

5. What is the current educational background of an optometrist?

Alaskan optometrists presently receive eight years education in order to receive a doctor of optometry (O.D.) degree.

4 years undergraduate education
(Some applicants are admitted with a minimum of two years undergraduate.)
4 years professional optometric education
8 years total

Today's optometric education includes such scientific studies as: optics, pharmacology, disease processes, disease detection, microbiology, zoology, neurology, physics, physiology, anatomy, psychology and public health.

6. How do practicing optometrists keep up with advances?

To assure that optometrists who are currently in practice are kept abreast of new developments and techniques, the Alaska Board of Examiners in Optometry requires a minimum of twenty-four hours of continuing education every two years. The quality and certification of these courses is controlled by the state Board.

7. Are optometrists educated in the use of pharmaceutical agents for ocular examinations, including adverse reactions?

Yes. Pacific University, College of Optometry, in Forest Grove, Oregon, educates its students in pharmacology. Adverse reactions are covered in the courses which are taught by qualified experts. In addition, an important portion of the four-year professional curriculum covers pathology and related subjects.

8. Under this bill, would every optometrist be able to use diagnostic agents in eye examinations?

No. There would be no "grandfather" clause. Only those optometrists currently in practice who fulfill educational requirements set by the Board of Examiners in Optometry would be able to use such diagnostic agents.

9. Under this bill, what limited types of diagnostic agents would optometrists be able to use?

Only topically applied (placed on the eye, like "eye drops") diagnostic agents could be used for examination purposes. Other agents such as for treatment purposes could not be used.

Generically, these diagnostic agents would be limited to: dyes, anesthetics, mydriatics, miotics, and cycloplegics.

10. Will this bill permit an optometrist to make a definitive medical diagnosis?

No. The optometrist would retain his professional responsibility to recognize any abnormalities of a pathological nature, make a tentative diagnosis, and then refer the patient for definitive medical diagnosis and treatment.

11. What about adverse reactions to diagnostic agents?

According to medical literature, the possibility of adverse reaction on persons to whom these topical diagnostic agents are applied is considered rare or virtually non-existant. However, should a reaction occur, a physician would be consulted.

12. How often would an optometrist use diagnostic agents in examinations?

These agents would not be used routinely but only in those instances when considered appropriate in the examination for possible visual or pathological defects.

13. Do practitioners other than physicians use diagnostic agents?

Yes. Dentists and podiatrists not only use pharmaceutical agents for diagnostic purposes, but for treatment purposes as well. It may be worthwhile noting that the optometrists' educational foundation regarding pharmacology is comparable to the pharmacology background received by both dentists and podiatrists.

Some Points Relative to the Use of Drugs by Optometrists

by: Leonard Levine, PhD.
Professor
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Dr. Levine has received numerous grants to research the chemistry and physiology of diseases such as Muscular Dystrophy. He is highly respected as a professor as well as researcher in the areas of physiology and neurophysiology. In order to be effective as such, a special understanding of pharmacology is inherent.

He makes a number of important points relative to the use of drugs by optometrists.

SOME POINTS RELATIVE TO THE USE OF DRUGS BY OPTOMETRISTS

Leonard Levine, PhD.

A. Optometrists have been using "drugs" both diagnostically and therapeutically for some time.

1. Optometrists routinely use a corneal dye, fluoroscein, as an aid to facilitate contact lens fitting. This is a substance not normally found in the body, hence a pharmaceutical agent, and its widespread use means that optometrists have already been involved with diagnostic pharmaceutical agents (DPA's).

2. Flexible contact lenses are classified as drugs by the Food and Drug Administration (FDA). Since optometrists fit these lenses, technically they are applying drugs to the eye for <u>therapeutic</u> purposes.

   a. Optometrists may also use flexible contact lenses for diagnostic purposes, as part of a gonioscopic procedure concerned with measurement of the internal angle of the eye.

3. Thus the question is not really the qualitative one of whether or not optometrists are to be allowed to use drugs, but rather the quantitative one relating to which and how much.

B. The public may now buy without prescription, examples of the types of drugs which optometrists wish to be allowed to use.

1. There are a number of ophthalmic preparations which are available to the lay public without prescription <u>ad libitum</u>, for treatment of certain ocular conditions, so-called "over-the-counter" (OTC) drugs. There are also a large number of other preparations for treatment of non-ocular conditions (such as allergies, colds, coughs, insomnia, motion sickness, and surface pain) which the public may buy in unlimited amounts without prescription. These preparations are usually intended for systemic administration, and contain one or more active ingredients which affect the ocular structures and/or vision.

2. The active ingredients of these OTC preparations include examples of all of the types of drug classes which optometrists wish to be allowed to use in a controlled manner for specific diagnostic purposes. The only exception is the drug class which causes the pupil to constrict, and optometrists would use this type only in a limited and specialized way.

C. The classes of DPA's which optometrists wish to use are:

1. Corneal dyes: Fluoroscein is an inocuous, non-prescription drug already used by optometrists in contact lens practice.

2. Local anesthetics: Optometrists wish to be able to use these kinds of drugs to permit them to check intraocular pressure in glaucoma screening, to measure the internal angle of the eye with a gonioscope as part of the check on the possibility of "narrow-angle" glaucoma, and in exceptional cases as an adjunct to contact lens practice. The purpose of the local anesthetic is to eliminate the corneal blink reflex for a few minutes while the diagnostic procedure is performed, and not for the elimination of pain per se, since none of the procedures employed by the optometrist is inherently painful. Optometrists wish to be able to use relatively few local anesthetics of very low risk, to be applied directly to the eye in the form of eyedrops, in a controlled fashion and with observance of any needed precautions to insure their patients' safety. Preferred agents are proparacaine and benoxinate.

   At least one OTC ophthalmic preparation (M-Z eyedrops, Tilden Yates) is available to the public without prescription which contains a concentration of a local anesthetic, piperocaine, which is approximately that sought by optometrists.

3. Mydriatic agents: Optometrists wish to use such drugs to cause the pupils of certain patients to dilate so that the interior of the eye may be examined with special instruments such as the opthalmoscope and the biomicroscope. Such diagnostic examinations are important in cases of cataract, glaucoma, and vision-threatening conditions of the

retina. But they are also important with respect to diagnosis and prognosis of systemic conditions such as diabetes mellitus and arterial hypertension.

Technically there are two classes of drugs which dilate the pupil by different mechanisms. The simpler of these acts directly on the dilating muscle, while the other acts by inhibiting the constricting muscle.

Optometrists need to be able to use drugs belonging to both catagories because the simpler drug type will not work satisfactorily in subjects with very dark eyes. The drug of choice in the first category is phenylephrine, an agent found in low concentration in many OTC ophthalmic preparations. It is also available without prescription in many non-ophthalmic preparations, in concentrations as high as 1% (NeoSynephrine nose drops, Winthrop), which is approximately the level at which optometrists wish to use it.

The other type of drug which optometrists wish to use for causing the pupil to dilate includes the specific agents, cyclopentolate and tropicamide. Both of these are synthetic products developed specifically for the purpose for which optometrists wish to use them, and are much safer and preferred to several naturally occuring substances, which have been widely used by ophthalmologists in the past. It should be noted that these latter, more dangerous drugs are all available to the public without prescription in OTC cough medicines and sleeping aids.

Thus optometrists seek only to use drugs of the types already on the market to the lay public without prescription, and to employ them in a controlled manner for specific diagnostic tests, entailing a minimum of risk to their patients.

4. Miotic Agents: The only other type of drug which optometrists wish to use is one which constricts the pupil. Drugs of this type would be used only to reverse the effect caused by a dilating drug following the diagnostic examination, in select patients. These are the limited number of patients in whom it is not desirable to allow the pupil to remain dilated for the several hours needed for the dilating drug to wear off.

The pupil contricting drugs which optometrists wish to use are physostigmine and pilocarpine. Both drugs have been widely in use as ophthalmic products for over 100 years, and are of low toxicity and high safety margin, especially in the way in which optometrists will use them.

D. British optometrists, whose professional training is on a lower level and less thorough than that of their counterparts in the U.S., have had legal entitlement to use all of the drugs sought here (and more) for many years, and have used them with intelligence and skill, the only effect on their patients being improved vision care.

STATUTORY AND JUDICIAL ASPECTS

1. House Bill #79

   This bill would re-define A.S. 08.72.300(2) "OPTOMETRY" and (3) "PRACTICING OPTOMETRY".

   Addition of a new A.S. § 08.72.305 "USE OF DRUGS FOR DIAGNOSIS".

   A.S. 17.15 § 3 is amended by adding to Article 1, § 27.25.055 "SALES TO OPTOMETRISTS".

2. Complete Alaska Revised Statutes

3. Supreme Court of Oregon, 1947

   State ex rel. Sisemore v. Standard Optical Co., 181 Or. 452-467

   The following are some points made in this case:

   a. An optical company cannot employ an optometrist because this interfers with the optometrists' trusted and fiduciary relationship with his patient.

   b. Optometry must be classified a true "profession" and not a "trade".

      ". . . an optometrists' . . . training enables him to diagnose pathological conditions . . . The fact that he is trained to diagnose pathological conditions in itself indicates that the optometrist is not a mere skilled craftsman or mechanic."

   (The entire Supreme Court case may be obtained upon request.)

4. Civil Action No. F 76-35 Civ., December 7, 1977

   Ferdinand v. Board of Dispensing Opticians (pages 104-105) defines "routine visual examination" as given by optometrists. The extensiveness the optometrist must examine for eye pathology is expressed.

   d. External Examination (lids, cornea, sclera, etc.)

   e. Internal Ophthomoscopic Examination (media, fundus, etc.)

   f. Ocular motility

g. Neurological integrity

k. Confrontation fields

l. Tonometry

5. Diagnostic Drugs Terminology Clarification from Oregon Law

a. Oregon Attorney General Opinion (1964) No. 5807 clarification regarding the term: DIAGNOSIS.

This Oregon Attorney General Opinion states that the "Practice of Optometry" includes pathology diagnosis.

In addition, Oregon Statutes governing the practice of medicine do not prevent diagnosis by optometrists after reference to the 1947 Supreme Court case (State ex rel. Sisemore v. Standard Optical Co., 181 Or. 452), Attorney General Thornton says:

> ". . . an optometrist, as a part of his services . . . has a duty to use his professional training, skill and knowledge, while he is performing his primary function, to determine whether his patient is afflicted with an abnormal or pathological condition of the eye . . ."

b. Alaska Statutes Clarification regarding the term: DRUGS.

The inclusion into the Optometry Statutes the terms: diagnostic agents, diagnostic drugs, or diagnostic pharmaceutical agents does not conflict with Chapter 64, Medicine. (Section 08.64.380 Definitions):

(2) "Practice of medicine" or "practice of osteopathy" means:

(D) for a fee prescribing, directing or recommending for the use of a person, a drug or medicine for the treatment, cure or relief of a disease, infirmity, bodily injury or defect, . . .

Diagnostic drugs are not mentioned in the practice of medicine. Only drugs or medicine for treatment are spoken to.

c. A.S. 17.15 § 3 addition to Article 1 "Sales to Optometrists" § 17.15.055.

Chapter 15, Drugs, is included to show how the addition of the amendment is necessary under Alaskan law.

6. Report from the Secretary of the Department of Health, Education and Welfare (HEW), 1971

This report concerns itself with the optometrists' responsibilities for disease detection.

Introduced: 1/24/79
Referred: Health, Education & Social Services and Judiciary

BY MARTIN, MCKINNON, MEEKINS, MILLER AND PARR

IN THE HOUSE

CS for HOUSE BILL NO. 79

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - FIRST 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, including proper responses to reactions which may result from topical applications

of drugs to the eye.

(b) No person practicing optometry may administer drugs except for recognition of pathology and diagnosis of a vision anomaly.

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

* Sec. 3. AS 17.15 is amended by adding a new section to Article 1 to read:

Sec. 17.15.055. SALES TO OPTOMETRISTS. A person licensed to practice optometry under AS 08.72 who has been authorized by the Board of Examiners in Optometry to use topically applied drugs under AS 08.72.305 may purchase topical anesthetics, mydriatics, miotics and cycloplegics.

ALASKA REVISED STATUTES

STATE OF ALASKA

BOARD OF EXAMINERS IN OPTOMETRY

OPTOMETRY STATUTE, AS 08.72.

OPTOMETRY REGULATIONS, 12 AAC 48.

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Department of Commerce and Economic Development

Division of Occupational Licensing

Pouch D

Juneau, Alaska 99811

CHAPTER 72. OPTOMETRY LAW.

Article. 1. Board of Examiners in Optometry

Sec. 08.72.010. Creation of board of examiners. There is created the Board of Examiners in Optometry. (sec 35-3-132 ACLA 1949)

Am. Jur., ALR and C.J.S. references.-41 Am. Jur., Physicians and Surgeons, sec 28.

Optometrist within statute relating to practice of medicine, 22 ALR 1173.

Constitutionality of stature prescribing conditions of practicing medicine as affected by discrimination against or in favor of optometrists, 37 ALR 682.

Constitutionality of statutes and validity of regulations relating to optometry, 98 ALR 905; 22 ALR2d 939.

Right of corporation, or individual not himself licensed, to practice optometry through licensed employee, 102 ALR 343; 128 ALR 585.

One who fills prescription under reciprocal arrangement with optometrist, as subject to charge of practice of optometry without license, 121 ALR 1455.

What constitutes practice of "optometry," 141 ALR 883.

70 C.J.S. Physicians and Surgeons secs 1, 3, 5, 6, 8, 10, 12.

Sec. 08.72.020. Membership of board and terms of office. The board consists of three persons, appointed by the governor. The term of each member is three years. One member only is appointed each year, except when vacancies for unexpired terms are filled. (sec 35-3-132 ACLA 1949)

Sec. 08.72.030. Source of appointments. The governor shall fill vacancies on the board by appointment for the unexpired term. (sec 35-3-132 ACLA 1949)

Sec. 08.72.040. Qualifications. A board member shall be a licensed, practicing optometrist residing in the state who has been a resident for at least three years. (sec 35-3-132 ACLA 1949)

Sec. 08.72.050. Power of board to adopt rules and regulations. The board shall adopt rules and regulations

(1) necessary for the proper performance of its duties;
(2) governing the applicants and applications for licensing;
(3) for the registration of optometrists;
(4) necessary to govern the practice of optometry. (sec 35-3-133 ACLA 1949)

Chapter contains sole powers of board.-The board, being purely a creature of the legislature, has no powers other than those contained in this chapter. Edmunds v. Board of Examiners in Optometry, 9 Alaska 462, aff'd, 9 Alaska 627, 106 P.2d 904 (1939).

And must be strictly construed.-This chapter and the powers invested in the board are to be stricly construed. Edmunds v. Board of Examiners in Optometry, 9 Alaska 462, aff'd, 9 Alaska 627, 106 P.2d 904 (1939)

Sec. 08.72.060. Miscellaneous powers and duties of board. (a) The board or a member designated by the board, may issue subpoenas, administer oaths and take testimony concerning any matter within its jurisdiction.

(b) The board may adopt a seal.

(c) The board shall elect a president and secretary from among its members.

(d) Repealed by sec 3 ch 59 SLA 1966.

(e) The board may define professional conduct and adopt rules of professional conduct.

(f) Repealed by sec 3 ch 59 SLA 1966. (secs 35-3-133, 35-3-140 ACLA 1949;am sec 3 ch 59 SLA 1966)

Effect of amendment.-The 1966 amendment repealed subsections (d) and (f).

Sec. 08.72.070. Applicability of Administrative Procedure Act. The board shall comply with the Administrative Procedure Act (AS 44.62).

Sec. 08.72.080. Compensation of board and secretary. Repealed by sec 3 ch 59 SLA 1966.

Sec. 08.72.090. Record of proceedings. The Department of Commerce shall keep a record of all proceedings including the name of each applicant for examination and registration. These records shall be open for public inspection. (sec 35-3-133 ACLA 1949;am ch 76 sec 1 SLA 1969)

Sec. 08.72.100. Bond of Secretary. Repealed by sec 3 ch 59 SLA 1966

Article 2. Licensing and Registration.

Sec. 08.72.110. License required. No person not licensed as an optometrist may fit, sell, or dispose of or take, receive or solicit an order for fitting, sale or disposition of spectacles, eyeglasses or lenses for the correction or relief of an optical or visual defect of the human eye or sell spectacles, eyeglasses or lenses from house to house, or in the streets or highways. This chapter does not apply to the sale of toy glasses, goggles consisting of plano-white or plano-colored lenses or ordinary colored glasses, or complete ready-made spectacles and eyeglasses sold only as merchandise, or the sale or repair of eyeglass frames, or repair or replacement of lenses without pretense of adapting them to the eyes (sec 35-3-134 ACLA 1949)

Sec. 08.72.120. Registration. It is unlawful for a person to practice, or attempt, or offer to practice, optometry without first obtaining a certificate of registration from the board, and without filing the certificate with the clerk of the superior court in each judicial district in which he practices. (sec 35-3-135 ACLA 1949)

C.J.S. reference.-70 C.J.S. Physicians and Surgeons sec 10.

Sec. 08.72.125. Registration of branch offices. (a) The board may issue to an Alaskan licensee who maintains a full-time practice in the state but who serves other communities in the state on a part-time basis a branch office certificate of registration.

(b) It is unlawful for a person to practice, attempt or offer to practice, optometry in communities on a part-time basis without obtaining a branch office certificate of registration from the board, and without filing the certificate with the clerk of the superior court in each judicial district in which he maintains a branch office. The board shall prescribe in the regulations the factors to be considered in issuing a branch

office certificate of registration. (ch 76 sec 2 SLA 1969)

Sec. 08.72.130. Optometry register. The clerk of the superior court in each judicial district shall keep a record known as the "Optometry Register" and record the certificate of registration of each optometrist who files his certificate. The clerk shall charge the regular filing fee for registration. When an optometrist dies, or when his certificate is suspended or revoked, the clerk shall note that fact on the record. (sec 35-3-147 ACLA 1949)

Sec. 08.72.140. Qualifications for examination. The board shall admit to the examination a person who furnishes proof that

(1) Repealed (ch 76 sec 3 SLA 1969)

(2) he has normal color perceptions and a visual acuity of a standard of at least 20/40 in at least one eye as corrected;

(3) he is not afflicted with a contagious or infectious disease;

(4) he has had education equivalent to four years attendance at a state high school;

(5) he is a graduate of a recognized school or college of optometry;

(6) he is of good moral character. (sec 35-3-141 ACLA 1949; am sec 1 ch 95 SLA 1966; repealed (1) ch 76 sec 3 SLA 1969; am (2) ch 76 sec 4 SLA 1969; added (6) ch 76 sec 5 SLA 1969)

Effect of amendment.-The 1966 amendment substituted "is a graduate of recognized" for "has had professional training in optometry of not less than 2,000 hours in attendance at a reputable" in paragraph (5) and deleted former paragraph (6), which required a certificate of registration in the basic sciences.

Cited in Edmunds v. Board of Examiners in Optometry, 9 Alaska 627, 106 F.2d 904 (1939)

C.J.S. references.-53 C.J.S. Licenses sec 34; 70 C.J.S. Physicians and Surgeons sec 12.

Sec. 08.72.150. Application for examination and issuance of certificate. An applicant shall apply for the examination by filing an application with the department together with the examination fee at least 15 days before the examination. Upon successful completion of the examination by the applicant and payment of the fee, the board shall issue a certificate of registration as a licensed optometrist to the applicant. After the applicant has properly filed his certificate of registration he may practice optometry in the state. (sec 35-3-141 ACLA 1949;am ch 76 sec 6 SLA 1969)

Sec. 08.72.160. Examination. (a) The examination shall be written, practical, and oral in nature. The oral portion of the examination shall be recorded and retained for two years.

(b) An applicant who fails the practical or the oral portion of the examination may take a re-examination in that portion without paying an additional examination fee.

(c) An applicant who fails the written portion of the exam-

ination may take a re-examination in the written portion upon payment of an additional examination fee.

(d) An applicant who fails more than one portion of the examination must retake the entire examination and pay the full examination fee. (sec 35-3-141 ACLA 1949;am ch 76 sec 7 SLA 1969)

Sec. 08.72.170. Issuance of certificate by waiver of written examination. (a) The board may waive the written portion of the examination requirement to an applicant who:

(1) meets the qualifications of sec. 140 of this chapter;

(2) holds a current license by examination in another state, territory or foreign country and has been established in ethical optometric practice for at least three years before the application, or shows satisfactory evidence of having passed the written portion of the examination given by the National Board of Examiners in Optometry; and

(3) has not had a certificate or license revoked for cause in any state, territory or foreign country.

(b) No waiver of the practical or oral portions of the examinations may be given. (sec 35-3-142 ACLA 1949; repealed and enacted ch 76 sec 8 SLA 1969)

Cited in Edmunds v. Board of Examiners in Optometry, 9 Alaska 627, 106 F.2d 904 (1939).

Sec. 08.72.180. Annual renewal of license. Repealed by sec 7 ch 94 SLA 1968.

Sec. 08.72.181. Renewal of license and application. (a) To remain in force a license must be renewed biennially.

(b) An optometrist licensed in this state and serving in the military service of the United States, while in the discharge of his official duties, may maintain his eligibility to practice in this state without paying a renewal fee by registering his name and place of residence with the department.

(c) An application for license renewal shall contain the name, office and post office address, date and license number of the licensee, and other information the board considers necessary.

(d) Before a license may be renewed the licensee shall submit to the board evidence of 24 hours post graduate education as prescribed by regulations of the board. (ch 76 sec 9 SLA 1969)

Sec. 08.72.190. Fee for license by reciprocity. Repealed by ch 76 sec 10 SLA 1969.

Sec. 08.72.191. Fees. The following fees shall be imposed

under this chapter when applicable:

(1) examination fee	$35
(2) re-examination fee for written portion	25
(3) waiver of examination fee	25
(4) certificate fee	50
(5) biennial renewal fee	50
(6) branch office biennial registration fee	25

(ch 76 sec 11 SLA 1969)

Sec. 08.72.200. Examination fee. Repealed ch 76 sec 10 SLA 1969.

Sec. 08.72.210. Certificate fee. Repealed ch 76 sec 10 SLA 1969.

Sec. 08.72.220. Renewal fee. Repealed ch 76 sec 10 SLA 1969.

Sec. 08.72.230. Fees and disbursements. The department shall collect all fees and keep a record of each transaction, and shall remit to the Department of Revenue all money received. (sec 35-3-138 ACLA 1949; repealed and enacted ch 76 sec 12 SLA 1969)

Sec. 08.72.240. Revocation of registration certificate or exemption. The board may revoke a certificate of registration or exemption granted by it if the holder

(1) has violated a rule, order or regulation of the board; or

(2) has violated this chapter or is guilty of a crime; or

(3) is grossly incompetent, afflicted with a contagious disease, habitually drunk or guilty of unprofessional conduct. (sec 35-3-140 ACLA 1949)

C.J.S. references.-53 C.J.S. Licenses sec 44; 70 C.J.S. Physicians and Surgeons, secs 10, 15.

Sec. 08.72.250. Board action on revocation and renewal. In a proceeding for the revocation of a certificate of registration or for the annulment of registration the board shall make a complete written report of its findings, and if the board finds that any of the charges are sustained, the board may revoke the certificate of the accused, or annul his registration, or both. If the board annuls the registration, it shall transmit to the clerk of the judicial district in which the accused is registered as an optometrist, a certificate under its seal, certifying that his registration has been annulled. The clerk shall, upon receipt of the certificate, file it and mark the registration "annulled." The board may, after the expiration of one year, entertain an application for the renewal of a revoked certificate, in the same manner as an original application for a certificate and may exempt the applicant from the examination. (sec 35-3-140 ACLA 1949)

Full and substantial hearing. It is not necessary that the board follow technical legal procedure. A full and substantial hearing of the charges, where denied, is all that is required. Edmunds v. Board of Examiners in Optometry, 9 Alaska 462, aff'd, 9 Alaska 627, 106 F.2d 904 (1939)

Under this section the board may not entertain an application until the expiration of one year. Edmunds v. Board of Examiners in Optometry, 9 Alaska 627, 106 F.2d 904 (1939)

Order revoking renewal certificate cannot be set aside in a mandamus proceeding. Edmunds v. Board of Examiners in Optometry, 9 Alaska 627, 106 F.2d 904 (1939).

Conduct justifying treatment of charge as confessed.- Where a written complaint and notice were served on an optometrist requiring him to appear and answer charges against him by the board, but where no answer, denial or appearance was ever made, it was not incumbent upon the board to call any witnesses or receive any evidence in support of the charges, and the board was justified in treating the charge as confessed and entering its findings accordingly. Edmunds v. Board of Examiners in Optometry, 9 Alaska 462, aff'd, 9 Alaska 627, 106 F.2d 904 (1939)

Sec. 08.72.260. Revocation of license by court. A license may be revoked by the superior court upon proof of violation of law or for a cause for which the board may refuse admittance to its examination. The attorney general shall prosecute appropriate judicial proceedings upon request of a member of the board. (sec 35-3-146 ACLA 1949)

Sec. 08.72.270. Practice not at place of business. (a) A registered optometrist, who temporarily practices optometry away from his regular place of business, shall display his registration certificate and deliver to each patient or person fitted or supplied with glasses a receipt with his signature showing his permanent place of business or post office address, certificate number, and the amount charged. A licensee who fails to comply with any of the foregoing provisions for six months after issuance of the certificate shall forfeit his certificate.

(b) Nothing contained in this section shall be construed as permitting peddling or canvassing by licensed optometrists. (sec 35-3-136 ACLA 1949)

Article 3. Unlawful Acts.

Sec. 08.72.275. Lenses and frames for eyeglasses and sunglasses. (a) No person may fabricate, distribute, sell, exchange, deliver or have in his possession with intent to distribute, sell, exchange or deliver eyeglasses or sunglasses unless they are fitted with plastic lenses or with glass lenses

which are tempered or case hardened. Glass lenses shall have a minimum thickness of two millimeters.

(b) No person may fabricate, distribute, sell, exchange, deliver or have in his possession with intent to distribute, sell, exchange or deliver eyeglasses or sunglasses having frames manufactured from cellulose nitrate or other highly flammable materials.

(c) A person who violates this section is punishable by a fine of not less than $50 nor more than $100. (1 ch 220 SLA 1968)

Revisor's note.-Section 2, ch 220, SLA 1968, provides: "The provisions of this bill take effect one year after date of passage." Legislative action on SCSHB 68 am (ch. 220, SLA 1968), was completed on April 14, 1968 and the bill was signed by the governor on May 6, 1968.

Sec. 08.72.280. Violations. No person may falsely personate a registered optometrist, nor buy, sell or fraudulently obtain a certificate of registration issued to another or advertise the practice of optometry in violation of rules of the board. Practicing or offering to practice optometry is sufficient evidence of a violation of this chapter. (sec 35-3-144 ACLA 1949)

Sec. 08.72.290. Penalty. A person who violates this chapter is guilty of a misdemeanor and is punishable by a fine of not less than $50 nor more than $500, or by imprisonment for a term of not less than 10 days nor more than 90 days, or by both. (sec 35-3-145 ACLA 1949)

C.J.S. reference.-53 C.J.S. Licenses secs 62 to 65.

Article 4. General Provisions.

Sec. 08.72.300. Definitions. As used in this chapter

(1) "board" means the Board of Examiners in Optometry;

(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 diagnois, 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;

(4) "lenses" means conventional or contact lenses. (sec 35-3-131 ACLA 1949; am sec 2 ch 95 SLA 1966)

(5) "recognized school or college of optometry" is one which is approved by the American Optometric Association or one of its committees;

(6) "department" means the Department of Commerce. (sec 35 3-131 ACLA 1949;am sec 2 ch 95 SLA 1966;am by adding (5) & (6) sec 13 SLA 1969)

Effect of amendment.-The 1966 amendment added paragraph (4).

This chapter is a valid exercise of the legislative power. Edmunds v. Board of Examiners in Optometry, 9 Alaska 462, aff'd, 9 Alaska 627, 106 F.2d 904 (1939).

Sec. 08.72.310. Short Title. This chapter may be cited as the Optometry Law. (sec 35-3-150 ACLA 1949)

Board of Examiners In Optometry

TITLE 12. PROFESSIONAL AND VOCATIONAL REGULATIONS

CHAPTER 48. BOARD OF EXAMINERS IN OPTOMETRY

12 AAC 48.010. BOARD MEMBERSHIP. The secretary shall notify the office of the governor of Alaska whenever a vacancy occurs. The secretary shall supply the governor with a list of all Alaska registered optometrists who have resided in Alaska for a period of three years or more, and are qualified as the statute provides, AS 08.72.040. (in effect before 7-28-59; am 5-19-62 and 10-20-62; am 9-10-65, Register 21; am 4-25-71, Register 37)

Authority: AS 08.72.030
AS 08.72.050(1)

12 AAC 48.020. BIENNIAL LICENSE RENEWALS AND REINSTATEMENT. (a) The post graduate education may be obtained any time within the two-year renewal period, but may not be carried over from one renewal period to the other.

(b) Courses that will be accepted are: educational courses given at the American Optometric Association Annual Convention or any AOA affiliate state optometric convention; seminars held by committees of the American Optometric Association or organized regional Optometric Extention Program Foundation seminars for educational purposes; post graduate courses offered by recognized schools or colleges of optometry. Other post graduate courses may be approved by the board if course titles, instructors' names, and a brief description of the course material is submitted to the board 30 days before the commencement of the educational program. Licensees who submit satisfactory proof that they were prevented from attending an educational program because of illness or other reasons may be exempted from this requirement. A form shall be provided with the biennial renewal application that must be validated by the instructor teaching the course. Correspondence courses will not be accepted as fulfilling the requirements of AS 08.72.101. (Eff. 4-25-71, Register 37)

Authority: AS 08.72.101

BOARD OF EXAMINERS IN OPTOMTRY

12 AAC 48.030. BRANCH OFFICE CERTIFICATES. (a) A branch office certificate may be issued for the purpose of serving some community in the state, which cannot support an optometrist and which can be shown to the satisfaction of the board to need the service of a licensed optometrist on a part-time basis may be issued a semi-annual branch office certificate of registration. The name of an associate practicing in a branch office shall appear on the entrance door to the office used and upon all stationery; no commercial name or designation may be used in connection with any branch office nor may such a practice have any commercial lay connections, nor may there be anything in the nature of "chain exploitation" of licenses. Nothing in this section requires an active licensee to obtain a branch office certificate for the purpose of rendering necessary optometric services for his patients confined to their homes.

(b) No branch office certificate will be issued in a community where a full time optometric practice is available and any certificate in force when a full-time practice is established will not be renewed.

(c) No branch office certificate will be required for a licensee to participate in bonafide vision and eye screening projects outside of his regular or branch office. Vision and eye screening projects must be organized under the auspices of an established service organization not composed primarily of optometrists.

(d) Optometrists who participate in vision and eye screening projects may not receive remuneration for their services other than for travel and living expenses and for emergency care as required. (in effect before 7-28-59; am 5-19-62 and 10-20-62; am 9-10-65, Register 21; am 4-25-71, Register 37)

Authority: AS 08.72.125(c)

12 AAC 48.040. DISPLAY OF CERTIFICATE. A licensee's registration certificate and renewal certificate shall be displayed in the office in which the holder practices oprometry, but not in such a manner that the certificate may be seen from the street. Every licensee, whenever requested, shall exhibit the certificate to a member of the board or person authorized to represent the board and shall notify the department or board of his address and changes of his address. (in effect before 7-28-59; am 5-19-62 and 10-20-62; am 9-10-65, Register 21, am 4-25-71, Register 37)

Authority: AS 08.72.050(4)

12 AAC 48.050. WHEN A PRACTICE IS CONVEYED TO ANOTHER. When an optometrist disposes of his established practice to a successor, the successor shall, within a reasonable time, remove from all signs, cards, stationery, and directories connected with the practice he has acquired or is acquiring, all words or phrases such as "successor to", "associate of", or words of like import.

Under no circumstates may the use of these signs, cards, stationery or advertising continue for more than two years. (in effect before 7-28-59; am 5-19-62 and 10-20-62; am 9-10-65, Register 21, am 4-25-71, Register 37)

Authority: AS 08.72.050(4)

12 AAC 48.060. VISUAL ANALYSES RECORDS. Every optometrist shall keep a record of examinations and visual analyses made and prescriptions issued and for whom the prescriptions were prepared. The record shall be preserved for a period of at least five years from the date services were rendered, except in the case of death of the patient. (in effect before 7-28-59; am 5-19-62 and 10-20-62; am 9-10-65, Register 21, am 4-25-71, register 37)

Authority: AS 08.72.050(4)

12 AAC 48.070. UNPROFESSIONAL CONDUCT. (a) "Unprofessional conduct", referred to in AS 08.72.240(3), includes:

(1) Soliciting patients by advertising of any nature or description regardless of means or media employed; however, upon the opening, reopening or removal of any office for the practice of optometry, an optometrist may publish, in local newspapers an announcement, which announcement shall be limited to a statement of his name, title, profession, degrees, address, telephone number and office hours; such an announcement may not be published for more than 90 days after the opening, reopening, or removal of the office; such an announcement may not exceed eight square inches in area.

(2) Displaying any spectacle, eyeglasses or eyeglass or spectacle frames or mountings, gogles, lenses, prisms, spectacle or eyeglass cases, opthalmic material of any kind, optometric instruments or optical tools or machinery, or any merchandise, material or displays of a commercial nature in office windows or reception rooms or display cases outside the office, where the display of the merchandise, material or display would make it visable from outside the office.

(3) Using display or bold face type or type that is in any way dissimilar in size, shape or color to that used for others of the healing arts in the same directory. Announcements in directories may not contain more than one specialty for each optometrist listed.

(4) Advertising regardless of means or media employed, the price or any type or style of opthalmic prosthetic device, or any of the materials entering into the assembling thereof, or the price of optometric professional services, when the service of prosthetic devices, of necessity must vary in quality and cost.

(5) Using "bait" advertising such as "low prices", "moderate prices", "discounts", "liberal credit terms", "glasses on credit", "guaranteed glasses", "satisfaction guaranteed", or words or phrases of similar import which are not in keeping with ethical practice of a learned profession.

(6) Using signs, whether painted, neon, decalcomania, colored or otherwise, and whether constructed in the form of eyes or structures resembling them, or frames or mountings for any type of opthalic prosthetic devices displayed in any manner or place connected with the practice of optometry.

(7) Using publicly, a sign, card, stationery or other publicity medium which fails to clearly identify the individual optometrist or optometrists engaged in practice in an office or practice location, or using a name other than the name under which the optometrist is licensed, including such designations as "optical company", "optical laboratory", or words or phrases of like import which are out of keeping with the use of the title "Doctor of Optometry" and the practice of optometry as a profession.

(8) Soliciting, personally or through agents, from house to house for the rendering of optometric services or advertising for sale prosthetic devices or materials including contact lenses or opthoptic aids or devices.

(9) Advertising self-styled superiority or the performance of services in a manner presumed to be superior, or the making of untruthful, improbable or impossible claims regarding treatments cures or values.

(10) Advertising by any means or media in a manner contrary to the professional standards, lending, leasing, renting or in any other manner placing his certificate of registration at the disposal of or in the service of any person not licensed to practice optometry in this state.

(b) A registered and licensed optometrist may not associate himself with a corporation or voluntary association for the practice of optometry, or in any manner practice the profession, on a salary or commission basis, or a corporation or voluntary association. However, this subsection does not prohibit professional incorporation under the Professional Corporation Act 10.45. The fact that an officer, trustee, director, agent, or employee or a corporation or voluntary association is a registered and licensed optometrist does not permit the corporation or voluntary association to do the acts prohibited in this section, nor is that fact a defense to the board action against any of the persons mentioned in this subsection for a violation of this section; however, this subsection does not apply to a partnership of two or more registered and licensed optometrists who practice under their own names.

(c) It is unlawful for a registered optometrist to practice his profession as an employee, lessee, or sublessee of a commercial or mercantile establishment or to practice his profession in connection with one, or to advertise either in person or through a commercial or mercantile establishment that he is a registered practitioner and is practicing or will practice optometry as an employee, lessee, or sublessee of a commercial or mercantile establishment or in connection with one. Nothing in this subsection prohibits the rendering of professional services to the officer and employees of a person, firm, or corporation by an optometrist, whether or not the compensation for the services is paid by the officers and employees or by the employer or jointly by all or any of them.

(d) No optometrist may practice in or on premises where any materials other than those necessary to render his professional services are dispensed to the public.

(e) No optometrist may display a sign containing other than his name, profession, one specialty, and office hours, which sign may be used only on office windows or at an entrance to his office. Letters may not be luminous or illuminated. (in effect before 7-28-59; am 5-19-62 and 10-20-62; am 9-10-65, Register 21, am 4-25-71, Register 37)

Authority: AS 08.72.050(4)

12 AAC 48.080. DEFINITIONS. Unless the content in this chapter otherwise states,

(1) "Act", "law" or "statute", refers to AS 08.72.;

(2) "regulations", referred to are those made by the board in keeping with AS 08.72.;

(3) "registration", means registration under AS 08.72.;

(4) "chain exploitation", means establishments that provide vision care in various locations either in one community or throughout a geographic area, where the service is provided by one or more than one optometrist in each or more than one location, and who is under the employ or have an agreement based on a lease, rental agreement partnership, stockholder, or other binding agreement; where control over these establishments are exercised by an individual or group of individuals.

(5) "established service organizations" means an organization who holds a charter from a parent organization whose primary established goal is public service without profit.

(6) "vision and eye screening projects" means a project organized with the intent of identification and referral of vision and eye disorders.

(7) "prescription" means a written formula prepared by a person licensed under AS 08.72 and which contains the following essential elements when applicable to eyeglasses, contact lenses or other visual therapy, dioptric power of spheres, cylinders and prisms, axis of cylinders and position of prism base; designation of inter-pupilary distances; size, base curve, power, color and type, when a contact lense; and the name of the patient, date of prescription and name and office location of prescriber. (in effect before 7-28-59; am 5-19-62 and 10-20-62; am 9-10-65, Register 21, am 4-25-71, Register 37)

Authority: AS 08.72.050

12 AAC 1100 - 12 AAC 1121 are repealed. (Eff. 4-25-71, Register 37)

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C. Classed

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IN THE UNITED STATES DISTRICT COURT

DISTRICT OF ALASKA

RODGER LEE FERDINAND, et al.,

Plaintiffs,

vs.

THE ALASKA BOARD OF DISPENSING OPTICIANS, et al.,

Defendants.

Civil Action No. F 76-35 CIV

CONSENT DECREE

All parties to the above entitled and numbered cause, through their undersigned counsel of record, do hereby consent to a final judgment being entered by the court herein upon the parties' agreement by consent as follows:

I

The defendant Board of Examiners in Optometry shall

not initiate administrative, civil or criminal enforcement or disciplinary action against any licensee who engages in the truthful advertisement of prices, terms of payment, discounts, comparative costs, credit terms, the availability and type of credit, and the valuation of ophthalmic prosthetic products and ophthalmic services unless such advertisements violate the relevant statutes or regulations of the Board restricting time, place or manner of such advertisements.

II

The defendant Board of Dispensing Opticians shall not initiate disciplinary action or revoke, suspend or deny the license of a person who engages in the truthful advertisement of prices, terms of payment, discounts, comparative costs, credit terms, the availability and type of credit, and the valuation of ophthalmic prosthetic products and opthalmic services unless such advertisements violate the relevant statutes or regulations of the Board restricting the time, place or manner of such advertisements.

III

Nothing contained in this Decree shall restrict or prohibit the authority of either the Board of Examiners in Optometry or the Board of Dispensing Opticians from establishing minimum standards for professional advertising and/or for initial routine vision examinations. Consistent with this Decree, nothing herein shall restrict or prohibit the authority of either of the aforesaid Boards from promulgating and enforcing regulations or enforcing statutes which otherwise impose restrictions upon their respective licensees who engage in deceptive or misleading advertising of ophthalmic prosthetic products and/or opthalmic services or which impose reasonable restrictions upon the time, place or manner of such advertisements.

ATTORNEY GENERAL, STATE OF ALASKA
STATE CAPITOL
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IV

The Board of Examiners in Optometry within a reasonable period shall promulgate standards for professional advertising applicable to licensed optometrists practicing in the State of Alaska.

V

For purposes of this Consent Decree and until standards for professional advertising have been promulgated by the Board of Examiners in Optometry an advertisement for "routine vision examination" as it relates to licensed optometrists means that the licensed optometrist shall at a minimum adhere to the following standard:

A.

In the initial examination of the patient, the licensed optometrist shall make and record the following findings of the condition of the patient:

a. Complete Case History (ocular, physical, occupational, medical and other pertinent information);

b. Chief ocular complaint;

c. Aided and unaided visual acuity, at both near and far;

d. External Examination (lids, cornea, sclera, etc.);

e. Internal Opthalmoscopic Examination (media, fundus, etc.);

f. Ocular motility;

g. Neurological integrity;

h. Far Point Subjective Examination, Static retinoscopy and subjective refraction;

i. Near Point Subjective Examination; Dynamic retinoscopy and subjective refraction;

j. Test of accomodation and convergence and binocular coordination at far and near; test preferably made with phoropter;

k. Confrontation Fields.

1. Tonometry test.

B.

The Minimum Standards for Examination and Fitting of Contact Lenses which are necessary in order to insure an adequate examination of patient for whom a licensed optometrist signs or causes to be signed a prescription for a contact lens:

a. All items contained in the Minimum Standards for an Optometric Examination,

b. Slit Lamp Evaluation;

c. Fluorisine Examination;

d. Diagnostic Evaluation (for soft lenses);

e. Reexamination and reevaluation within the following periods of time:
Firm lenses - 3 months
Flexible lenses - 6 months.

VI

With the exception of the limitations contained in Paragraph I of this Decree, the Board of Examiners in Optometry shall continue to have and exercise all of the statutory authority conferred upon it by AS 08.72 and persons licensed under that chapter shall continue to enjoy all the rights and benefits inherent in their status as a licensee.

With the exception of the limitations contained in Paragraph II of this Decree, the Board of Dispensing Opticians shall continue to have and exercise all of the statutory authority conferred upon it by AS 08.71 and persons licensed under that chapter shall continue to enjoy all the rights and benefits inherent in their status as a licensee.

Nothing herein shall be construed to either expand or restrict the areas of professional practice which are set forth in AS 08.72 and AS 08.71. Nothing herein shall be

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construed as requiring the two Boards to promulgate identical standards for professional advertising in those areas where their respective fields of practice should overlap.

VII

For purposes of the interpretation and the implementation of this Decree, the following definitions shall control:

A. "Opthalmic prosthetic products" shall consist of eyeglasses, lenses, contact lenses, frames or any component thereof or any other device used for or incident to the correction of any visual anomaly.

B. "Ophthalmic services" consist of the measuring, fitting and adjusting of ophthalmic prosthetic products to the face and eyes.

C. "Routine vision examination" is the process of determining the refractive condition of a person's eyes or the presence of any visual anomaly by the use of objective and subjective tests.

CONCLUSION

A. Jurisdiction

The jurisdiction of this cause is to be retained by the court for the purpose of making such other and further orders as may become necessary. However, with respect to defendants Board of Examiners in Optometry and members thereof this decree shall be terminated and rendered null and void upon the expiration of 30 days following the subsequent promulgation of regulations by the said Board relating to the area of professional advertising practices. Furthermore, with respect to defendants Board of Dispensing Opticians and members thereof, this decree shall be terminated and rendered null and void upon the expiration of 30 days following the subsequent promulgation of regulations by the said Board or immediately upon the effective date of any amendments to the relevant provisions of AS 08.71 which may be enacted by the

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Alaska State Legislature.

B. Costs and Attorneys' Fees.

Defendants have agreed to pay reasonable attorneys' fees to plaintiffs counsel and the parties agree that all other costs and attorneys' fees incurred in the prosecution or defense of this action as of the date this Decree is entered shall be borne by each party respectively.

C. Notice Requirement.

Defendants further agree to notify all optometrists licensed under AS 08.72 and all dispensing opticians licensed under AS 08.71 of the terms of this Decree by mailing to each licensee a copy thereof within 60 days of the entry of this Decree.

WHEREAS, the parties having presented to the Court the instant Consent Decree and having consented to it serving as the final judgment of the Court in this cause;

IT IS ORDERED, ADJUDGED AND DECREED that judgment be and hereby is granted pursuant to Consent Decree as the final judgment of this Court with regard to this cause.

DATED at Anchorage, Alaska, this 13 day of December, 1977.

JUDGE OF THE UNITED STATES DISTRICT COURT

ATTORNEY GENERAL STATE OF ALASKA
STATE CAPITOL
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OREGON STATE
ATTORNEY GENERAL OPINION
5807

Use of an electronic tonometer by an optometrist does not violate the provisions of the Medical Practice Act under ORS chapter 677.

No. 5807 May 12, 1964

Mr. Howard I. Bobbitt
Executive Secretary
State Board of Medical Examiners

You have requested an opinion as to whether the use by an optometrist of an instrument known as an electronic tonometer is a violation of the Medical Practice Act, ORS chapter 677.

You state that the facts indicate that an optometrist has been advertising that he uses an electronic tonometer which is a device that measures intraocular pressure by electronic means to detect certain pathological conditions but does not require use of any anesthetic or drug. The facts also indicate that other instruments have been in use by the optometric profession for many years, such as the Wolf scleral tonometer and Schiotz type tonometer.

It appears that intraocular pressure may be an indication of various pathological or abnormal conditions of the human eye and may affect "the scope of its functions."

Under the medical practice provisions of the Oregon law ORS 677.020 provides:

"*Except as provided in ORS 677.060* no person shall practice medicine or surgery in this state without being licensed so to do by the State Board of Medical Examiners." (Emphasis supplied)

ORS 677.030 provides in part:

"A person is regarded as practicing medicine and surgery if he does one of the following:

* * *

"(4) Offer or undertake to diagnose, * * * in any manner, or by any means, * * * any disease, illness, pain, * * * deformity, defect or abnormal physical * * * condition of any person."

ORS 677.010 (1)(c) defines the word "diagnose" as:

"* * * examine another person in any manner to determine the source or nature of a disease or other abnormal physical or mental condition, or to hold oneself out or represent that a person is so examining another person. * * *"

ORS 677.060 provides in part:

"This chapter shall not be construed to affect or prevent the following:

* * *

"(8) The practice of * * * optometry * * * by any person legally authorized by this state * * *."

It is clear, therefore, that ORS 677.060 (8) permits a duly authorized optometrist to render all services contemplated and included within the term "practice of optometry."

The phrase "practice of optometry" is defined in part in ORS 683.010 (2) as:

"'Practice of optometry' *means the employment of any means other than the use of drugs* for the measurement * * * of the human vision or the determination of the accommodative and refractive states of the human eye or the *scope of its functions in general* * * *." (Emphasis supplied)

It is to be noted that the only limitations imposed on an optometrist with respect to determining the "accommodative and refractive" state of the human eye or the "scope of its functions" is with respect to the use of drugs. Aside from drugs, an optometrist may use "any means" to make these determinations. Obviously an electronic tonometer is not a drug.

The crucial question implicit in your request is, what activities with respect to pathology of the eye are encompassed by the term "practice of optometry."

The Supreme Court of Oregon in State ex rel. Sisemore v. Standard Optical Company, (1947) 182 Or. 452, 460-461, 186 P. (2d) 309, 312-313, has unequivocally answered that question. The court stated at page 460:

"The practice of optometry is undoubtedly one of the subdivisions of the practice of medicine * * *."

The court went on to say at page 461:

"While it is true that an optometrist is not permitted by law to treat diseases of the eye, nevertheless his training enables him to diagnose pathological conditions, and *his duty requires him to refer the patient to a practitioner who is qualified to treat such conditions*. The fact that he is trained to diagnose pathological conditions in itself indicates that the optometrist is not a mere skilled craftsman or mechanic. His failure to diagnose a pathological condition, with resultant delay or neglect in proper treatment thereof, might result in serious impairment of the patient's eyesight, or even in blindness." (Emphasis supplied)

It thus appears that the term "practice of optometry" as construed by our Supreme Court contemplates that an optometrist, as a part of the services he renders his patient, has a duty to use his professional training, skill and knowledge while he is performing his primary function, to determine whether his patient is afflicted with an abnormal or pathological condition of the eye which may require treatment by a person legally qualified to render such service. He is also required to advise such patient if he finds what appears to be a pathological condition so that the patient may seek treatment from a legally qualified person. This does not mean that an optometrist has a duty to subject his patient in every possible type of examination for all manner of conditions, whether apparent or hidden. Nor does the "practice of optometry" allow an optometrist to so advertise that he indicates directly or indirectly that he examines and treats diseases of the eye. It is our understanding that the questioned advertising has been withdrawn and the optometrist reprimanded by the Oregon State Board of Examiners in Optometry. Within that area, defined as the "practice of optometry," the optometrist has the right to use any instruments or aids which in his professional judgment assist him in performing his functions, provided he is not administering "drugs."

It is, therefore, our opinion that the use of the electronic tonometer by an optometrist in the circumstances described herein is encompassed within the phrase "practice of optometry" and hence not prohibited by the provisions of the Medical Practice Act.

ROBERT Y. THORNTON,
Attorney General.
By Louis S. Bonney, Assistant

ALASKA CONSENT DECREE

Routine Visual Examination

ALASKA DRUG TERMINOLOGY RELATING TO USAGE OF

"DIAGNOSTIC AGENTS"

BY OPTOMETRISTS

The following reviews an accepted dictionary definition and the Alaska Statutes' definition regarding "drug" terminology.

Dorlands Medical Dictionary defines:

> DRUG: Any chemical compound or any non-infectious biological substance, not used for its mechanical properties, which may be administered to or used on or for patients, either human or animal, as an aid in the diagnosis, treatment, or prevention of disease or other abnormal condition, for the relief of pain or suffering, or to control or improve any physiological or pathological condition.

From this definition one could conclude that an accepted aspect of the usage of a "drug" is in "diagnosis". However, pertinent terminology regarding drugs does not make any reference to "diagnostic drugs, or agents."

OPTOMETRISTS Section 08.72.300 (3)

> (2) "Practice of optometry means the diagnosis, by means or methods other than the use of drugs . . ."

MEDICINE Section 08.64.380 Definitions:

> (No specific def or drug is given but intent can be recognized under the definition of practice of medicine)
>
> (2) Practice of medicine or practice of osteopathy means:
>
> (D) for a fee prescribing, directing or recommending for the use of a person, a drug or medicine for the treatment, cure or relief of a disease, infirmity, bodily injury or defect; . . .

To clarify Medicine's definition, Dorlands Medical Dictionary defines:

CURE: 1. The course of treatment of any disease, or of a special case. 2. The successful treatment of a disease or wound. 3. A system of treating diseases. 4. A medicine effective in treating disease.

PRESCRIBING: Giving instructions concerning the use of a remedy.

TREATMENT: The means employed in effecting the cure of disease.

RELIEF: The removal of anything distressing; the alleviation of pain or discomfort.

INFIRMITY: Weakness; a disease producing feebleness.

The point here is that the term "diagnostic agent" does not come within the boundaries of the definition of "drug" within the Alaska Statutes for medicine. From this, three conclusions can be drawn:

1. At present time, the current usage of diagnostic agents by optometrists does not infringe on the Alaska Medicine Statutes.

2. If positive "diagnostic agents" wording is added to the Alaska Optometrists Statutes, no infringement will exist upon the Alaska Medicine Statutes.

3. Positive "diagnostic agents" wording should be added to the Alaska Optometrists Statutes because while § 08.72.300, "Practice of Optometry means the employment of any means other than the use of drugs . . ." does not conflict with § 08.64.380 on Medicine, it does, however, conflict with an accepted dictionary definition: "Drug is any chemical . . . used . . . as an aid in the diagnosis . . ."

which are tempered or case hardened. Glass lenses shall have a minimum thickness of two millimeters.

(b) No person may fabricate, distribute, sell, exchange, deliver or have in his possession with intent to distribute, sell, exchange or deliver eyeglasses or sunglasses having frames manufactured from cellulose nitrate or other highly flammable materials.

(c) A person who violates this section is punishable by a fine of not less than $50 nor more than $100. (1 ch 220 SLA 1968)

Revisor's note.-Section 2, ch 220, SLA 1968, provides; "The provisions of this bill take effect one year after date of passage." Legislative action on SCSHB 68 am (ch. 220, SLA 1968), was completed on April 14, 1968 and the bill was signed by the governor on May 6, 1968.

Sec. 08.72.280. Violations. No person may falsely personate a registered optometrist, nor buy, sell or fraudulently obtain a certificate of registration issued to another or advertise the practice of optometry in violation of rules of the board. Practicing or offering to practice optometry is sufficient evidence of a violation of this chapter. (sec 35-3-144 ACLA 1949)

Sec. 08.72.290. Penalty. A person who violates this chapter is guilty of a misdemeanor and is punishable by a fine of not less than $50 nor more than $500, or by imprisonment for a term of not less than 10 days nor more than 90 days, or by both. (sec 35-3-145 ACLA 1949)

C.J.S. reference.-53 C.J.S. Licenses secs 62 to 65.

Article 4. General Provisions.

Sec. 08.72.300. Definitions. As used in this chapter
(1) "board" means the Board of Examiners in Optometry;
(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 diagnois, 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;
(4) "lenses" means conventional or contact lenses. (sec 35-3-131 ACLA 1949; am sec 2 ch 95 SLA 1966)

(5) "recognized school or college of optometry" is one which is approved by the American Optometric Association or one of its committees;
(6) "department" means the Department of Commerce. (sec 35-3-131 ACLA 1949;am sec 2 ch 95 SLA 1966;am by adding (5) & (6) sec 13 SLA 1969)

Effect of amendment.-The 1966 amendment added paragraph (4).

This chapter is a valid exercise of the legislative power. Edmunds v. Board of Examiners in Optometry, 9 Alaska 462, aff'd, 9 Alaska 627, 106 F.2d 904 (1939).

Sec. 08.72.310. Short Title. This chapter may be cited as the Optometry Law. (sec 35-3-150 ACLA 1949)

Effect of amendment. — The 1974 amendment repealed paragraph (4).

Legislative committee report. — For report on ch. 127, SLA 1974 (SCSHB 817 am S), see 1974 House Journal, p. 657.

Sec. 08.64.380. Definitions. As used in this chapter

(1) "board" means the State Medical Board;

(2) "practice of medicine" or "practice of osteopathy" means

(A) maintaining an office or place of business for the purpose of treating the sick or injured for pay; or

(B) the public display of one's name and the letters "M.D.", "M.B." or "D.O." or the words "physician" or "osteopath" or "osteopathic physician", or "osteopathic surgeon", or "osteopathic physician and surgeon", or a specialist designation such as "surgeon" or "dermatologist", "psychiatrist", or the like; or

(C) the assumption or promulgation of a title which tends to show that the person is willing or qualified to diagnose or treat the sick or injured; or

(D) for a fee prescribing, directing or recommending for the use of a person, a drug or medicine for the treatment, cure or relief of a disease, infirmity, bodily injury or defect; or

(E) for a fee performing a surgical operation for the cure, relief or reduction of disease, bodily injury, deformity, or defect; or

(F) Repealed by § 1 ch 117 SLA 1971.

(3) "unprofessional or dishonorable conduct" means

(A) a violation of the provisions of AS 11.15.060 or regulations lawfully adopted by the State Medical Board concerning abortion procedures and practice;

(B) habitual overuse of alcoholic beverages or depressant, hallucinogenic or stimulant drugs, as defined in AS 17.12.150(3), or addiction to the use of narcotic drugs as defined in AS 17.10.230(13);

(C) conviction of an offense involving moral turpitude,

(D) advertising professional services to the public except for notice of opening, closing, or removing practice, and except for directories listing physicians in a community on a uniform and nondiscriminatory basis, containing only factual, truthful descriptions of physicians and their services;

(E) making untruthful or fraudulent statements in the application for examination, or deceiving or cheating during the examination for license, or procuring a license by deceit or fraud;

(F) violating the Controlled Substances Act (P.L. 91-513; 84 Stat. 1242) or any other federal law pertaining to medical practice and drugs;

(G) violating the principles of medical ethics of the American Medical Association and of the Alaska State Medical Association;

(4) Repealed by § 27 ch 148 SLA 1970.

(5) "department" means the Department of Commerce.

this title and that covered by this chapter. Speas v. State, Sup. Ct. Op. No. 889 (File No. 1555), 511 P.2d 130 (1973).

Quoted in Fresneda v. State, Sup. Ct. Op. No. 573 (File No. 1045), 458 P.2d 134 (1969); John Doe v. State, Sup. Ct. Op. No. 701 (File No. 1240), 487 P.2d 47 (1971); Egner v. State, Sup. Ct. Op. No. 784 (File No. 1443), 495 P.2d 1272 (1972); Gray v. State, Sup. Ct. Op. No. 1068 (File No. 2043), 525 P.2d 524 (1974).

Chapter 15. Drugs.

Article
1. Sale or Other Transfer of Certain Drugs (§§ 17.15.010—17.15.050)
2. Seizure of Conveyances Used in Narcotics Violations (§§ 17.15.060—17.15.110)

Article 1. Sale or Other Transfer of Certain Drugs.

Sec. 17.15.010. Written order or prescription required for dispensing of certain drugs. It is unlawful for a person to sell, give away, barter, exchange or distribute

(1) amytal, luminal, veronal, barbital, acid diethylbarbituric, or any of their salts, derivatives, or compounds, or a preparation or compound containing any of these substances, or their salts, derivatives or compounds, or a registered, trademarked or copyrighted preparation or compound registered in the United States Patent Office containing more than one grain to the avoirdupois or fluid ounce of the substances, except upon the written order or prescription of a physician, surgeon, dentist or veterinary surgeon licensed to practice in the state;

(2) chloralhydrate and para-aminobenzene, sulfonamide, sulfanilamid, sulfamidyl, prontylin, prontosil, neo prontosil, neo protylin, edimalin, sulfonamide or a salt, derivative or compound of any of them or a registered, trademarked or copyrighted preparation or compound registered in the United States Patent Office containing these substances, except upon authority, order or prescription of a physician, surgeon, dentist or veterinary surgeon duly licensed to practice in the state. (§ 40-3-31 ACLA 1949; am § 1 ch 85 SLA 1949)

Sec. 17.15.020. Authority of prescriber required for refill. Prescriptions composed of the substances enumerated in § 10 of this chapter shall not be refilled without the authority of the prescriber. (§ 40-3-31 ACLA 1949; am § 1 ch 85 SLA 1949)

Sec. 17.15.030. Exceptions. Sections 10 and 20 of this chapter do not apply to the sale at wholesale by drug jobbers, drug wholesalers and drug manufacturers to pharmacies, hospitals, physicians, dentists or veterinary surgeons, nor to each other, nor to the sale at retail in pharmacies by pharmacists to each other or to physicians, surgeons, dentists or veterinary surgeons licensed to practice in the state. (§ 40-3-31 ACLA 1949; am § 1 ch 85 SLA 1949)

P.2d 47 (1971); Op. No. 784 (File (1972); Gray v. 1068 (File No.

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Sec. 17.15.040. Penalty for violations. A person violating §§ 10 and 20 of this chapter is punishable by a fine of not less than $100 nor more than $500, or by imprisonment for not more than 180 days, or by both. (§ 40-3-32 ACLA 1949)

Am. Jur. reference. — 17A Am. Jur., Drugs and Druggists, §§ 31 to 35.

Sec. 17.15.050. Selling poison without label. A person who sells or delivers arsenic, corrosive sublimate, prussic acid, or other poison, without having the word "poison" and the true name of it in English written or printed upon a label attached to the vial, box, or parcel containing it, upon conviction, is punishable by a fine of not less than $20 nor more than $100. (§ 40-3-33 ACLA 1949)

Am. Jur. and ALR references. — 17A Am. Jur., Drugs and Druggists, § 41.

Liability for injury or death in swallowing poison in article not intended to be eaten or tasted, 50 ALR 1462.

Validity of statutes regulating sale of poisons, 54 ALR 730.

Article 2. Seizure of Conveyances Used in Narcotics Violations.

Sec. 17.15.060. Seizure and forfeiture of conveyance. A vessel, vehicle, aircraft or other conveyance used in the transportation of an illegally possessed narcotic drug shall be seized and forfeited to the state. (§ 1 ch 104 SLA 1961)

Am. Jur. reference. — 17A Am. Jur., Drugs and Druggists, § 1 et seq.

Sec. 17.15.070. Order for seizure and forfeiture. The conveyance shall be seized and forfeited in a proceeding in rem by order of the court which issues the process under which the conveyance is seized, or the court before which the person or the conveyance is taken by the officer making the seizure. (§ 1 ch 104 SLA 1961)

Sec. 17.15.080. Hearing, forfeiture and sale. The court shall order an immediate hearing on the question of whether or not the conveyance was used in the transportation of an illegally possessed narcotic drug. The court shall hear evidence and determine the question as in civil cases. If the court finds from a preponderance of the testimony that the conveyance seized was being used for the transportation of an illegally possessed narcotic drug, it shall give judgment accordingly and declare the conveyance forfeited to the state. The conveyance shall be delivered to the Department of Public Safety under the court order, and sold at public auction. (§ 2 ch 104 SLA 1961)

Sec. 17.15.090. Limitations on seizure and forfeiture. (a) No conveyance used as a common carrier in the transaction of business as

a common carrier may be forfeited under §§ 60—110 of this chapter unless the owner or other person legally in charge of the conveyance was at the time of the illegal act a consenting party or privy to it.

(b) No conveyance may be forfeited because of an act or omission established by the owner of the conveyance to have been committed or omitted by another person while the conveyance was unlawfully in the possession of a person who acquired possession of it in violation of the criminal laws of the United States or this state.

(c) No conveyance may be forfeited under §§ 60—110 of this chapter, unless the owner of the conveyance was, at the time of the illegal act, a consenting party to the illegal act or privy to it. (§ 3 ch 104 SLA 1961)

Sec. 17.15.100. Person having interest in conveyance may appear in proceeding. A person holding a lien, mortgage or conditional sales contract on a conveyance seized under §§ 60—110 of this chapter may appear before the court in the proceeding for forfeiture to petition for remittance or mitigation of the forfeiture. The court shall remit or mitigate the forfeiture if it finds that the petitioner has an interest in the conveyance which he acquired in good faith and without knowledge or reason to believe that the conveyance was being or would be used in the transportation of an illegally possessed narcotic drug. (§ 3 ch 104 SLA 1961)

Sec. 17.15.110. Definition of illegally possessed narcotic drug. In §§ 60—110 of this chapter

(1) "conveyance" means a vessel, vehicle, trailer, aircraft or other conveyance used in the transportation of an illegally possessed narcotic drug;

(2) "illegally possessed narcotic drug" is a narcotic drug (A) possessed with intent to sell or offer for sale in violation of any law or regulation of the United States or this state, or (B) acquired, possessed, sold, transferred, or offered for sale in violation of any law of the United States or this state, or (C) acquired by theft, robbery or burglary;

(3) "narcotic drug" means a narcotic drug defined by the federal internal revenue laws and the regulation issued under them. (§§ 1, 4 ch 104 SLA 1961; am § 4 ch 225 SLA 1968)

Chapter 20. Alaska Food, Drug and Cosmetic Act.

Article

Section

Sec. 17.20
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could not say that the sentencing court was clearly mistaken in imposing a five-year sentence for selling amphetamines in violation of AS 17.12.010. Thurlkill v. State, Sup. Ct. Op. No. 1279 (File No. 2735), 551 P.2d 541 (1976).

Where defendant was convicted, upon his plea of guilty, of four counts of sale and one count of distribution of marijuana, the superior court was not clearly mistaken in imposing a sentence of five years, with two suspended, on each count, to be served concurrently, the court also having fined defendant $5000, suspending payment of $3000. Wolfe v. State, Sup. Ct. Op. No. 1301 (File No. 2766), 553 P.2d 472 (1976).

Sentence of three years imprisonment for selling LSD was not excessive. Aceveda v. State, Sup. Ct. Op. No. 1534 (File No. 2900), 571 P.2d 1013 (1977).

Where defendant was convicted of possession of an hallucinogenic drug with intent to sell or distribute and was sentenced to seven years, with execution of the sentence suspended for five years, defendant being placed on probation for 30 months on condition that he: (1) complete school; (2) be employed while not in school or incarcerated; and (3) report to a correctional institution in September 1976 to serve six months, subject to school release and credit for the 45 days he had already served, and this sentence was to run concurrently with the sentence for his conviction on an earlier offense, with probation in that case to be revoked by the judgment in the instant case, such sentence was not too lenient under the facts of the case. Clark v. State, Sup. Ct. Op. No. 1570 (File Nos. 2943, 2964), 574 P.2d 1261 (1978).

Sentence held excessive. — Imposition of two consecutive five-year terms for the sale of small quantities of marijuana was excessive. Salazar v. State, Sup. Ct. Op. No. 1404 (File No. 2567), 562 P.2d 694 (1977).

Case remanded for resentencing. — The supreme court remanded for resentencing where the trial court had improperly considered the goal of community condemnation of the offender in sentencing defendant to five years' imprisonment for possession of marijuana for the purpose of sale or distribution. Snyder v. State, Sup. Ct. Op. No. 1744 (File No. 3321), 585 P.2d 229 (1978).

Applied in Barrett v. State, Sup. Ct. Op. No. 1225 (File No. 2299), 546 P.2d 161 (1976); State v. Buckalew, Sup. Ct. Op. No. 1391 (File No. 3143), 561 P.2d 289 (1977).

Cited in State v. Erickson, Sup. Ct. Op. No. 1547 (File No. 3250), 574 P.2d 1 (1978).

Sec. 17.12.130. Forfeiture.

Difference between AS 11.45.040 and this section and AS 16.05.195. — Both this section and the fish and game forfeiture statute, AS 16.05.195, define broadly the property subject to forfeiture to include "accessories" and "paraphernalia," respectively, used to violate the law. Furthermore, both of them provide optional dispositions for forfeited property, unlike the gambling forfeiture statute, AS 11.45.040 which mandates destruction of property seized. One Cocktail Glass v. State, Sup. Ct. Op. No. 1437 (File No. 2729), 565 P.2d 1265 (1977).

Sec. 17.12.150. Definitions.

Cocaine does not appear specifically in paragraph (3). State v. Erickson, Sup. Ct. Op. No. 1547 (File No. 3250), 574 P.2d 1 (1978).

Quoted in State v. Buckalew, Sup. Ct. Op. No. 1391 (File No. 3143), 561 P.2d 289 (1977).

Cited in Belgarde v. State, Sup. Ct. Op. No. 1206 (File No. 2447), 543 P.2d 206 (1975).

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."

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HOW THE DIAGNOSTIC AGENTS BI L IN ALASKA RELATES TO:

1. Other States:

Thirty-one states al ow optometrists to use diagnostic agents. Other states such as Alaska are currently making legislative efforts to broaden this.

2. Other Countries:

a. The large english speaking countries of Canada, Australia, and England all certify optometrists to use diagnostic drugs.

b. England's joint declaration (February, 1970) by the ophthalmologists and optometrists of England confirm the many beneficial years as well as pronounce the future continuation for the usage of diagnostic agents by optometrists.

3. The United States Armed Forces:

All branches of the military either allow or specifically state in the regulations that optometrists shall be permitted the usage of diagnostic agents or drugs.

HOW THE DIAGNOSTIC AGENT BILL IN ALASKA

RELATES TO OTHER STATES

1. Recent positive state law changes: (23 state law changes)

   a. Rhode Island enacted optometry redefinition law in 1971:

      Optometrists "shall be permitted to apply drugs topically to the eye for the purpose of detecting any disease or pathological condition of the eye."

   b. Pennsylvania enacted optometry redefinition law in 1974:

      Optometry shall include the use of "diagnostic pharmaceutical agents, known generically as cycloplegics, mydriatics, topical anesthetics and miotics."

   c. Iowa enacted optometry redefinition law most recently in June, 1979:

      Certified licensed optometrists may employ cycloplegics, mydriatics and topical anesthetics as diagnostic agents topically applied . . .

   d. Louisiana

   e. Oregon

   f. Delaware

   g. Maine.

2. States which have no prohibitive laws on diagnostic agent usage by optometrists:

   a. Florida

   b. Idaho

   c. Indiana

   d. Minnesota

   e. Nevada

   f. New Jersey

Total of (31) states allow the use of diagnostic agents by optometrists. Map showing dates--geographic locations.

3. Experience of states where diagnostic agents are used:

Letter enclosed from E.C. Nurock, Secretary-Treasurer, Department for Law and Public Safety, Board of Optometrists, State of New Jersey.

New Jersey optometrists have had the right to use these diagnostic agents since 1919. "In the state there have been no cases reported regarding any problems caused by optometrists using any of the diagnostic drugs. The use of diagnostic drugs by optometrists is definitely in the public interest."

RHODE ISLAND DEFINITION

(Enacted at 1971 Session)

Optometry is defined as the profession whose practitioners are engaged in the art and science of the evaluation of vision and the examination of vision and the examination and refraction of the human eye which includes:

The employment of any objective or subjective means for the examination of the human eye or its appendages;

The Measurement of the powers or range of human vision or the determination of the accommodative and refractive powers of the human eye or the scope of its functions in general and the adaptation of lenses, prisms, and/or frames for the aid thereof;

The prescribing, directing the use of or administering ocular exercises, visual training, vision training, or orthoptics, and the use of any optical device in connection therewith;

The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to the human eye;

The examination or diagnosis of the human eye to ascertain the presence of abnormal conditions or functions; and

The topical application of drugs to the eye, to wit, mydriatics, miotics, and the use of topical anesthetics, provided, however, that no optometrist licensed in this state shall treat by the use of these drugs or attempt to perform any surgery and shall be used only for the purpose of detecting any diseased or pathological condition of the eye, or the effects of any disease or pathological condition of the eye, further provided however, that with respect to presently licensed optometrists, only presently licensed optometrists who

1. have satisfactorily completed a course in pharmacology, as it applies to optometry, at an institution accredited by a regional or professional accreditation organization which is recognized by the national commission on accreditation, with particular emphasis on the topical application of drugs to the eye for the purpose of detecting any diseased or pathological condition of the eye; or the effects of any disease or pathological condition of the eye, approved by the board of examiners in optometry and the chief of pharmacy of the department of health, and

2. have successfully completed an examination given by the board of examiners in optometry in conjunction with the chief of pharmacy of the department of health, shall be permitted to apply drugs topically to the eye for the purpose of detecting any diseased or pathological condition of the eye, or the effects of any disease or pathological condition of the eye. Said chief of pharmacy shall consult and advise the board of examiners in optometry with respect to that portion of the examination dealing with pharmacology.

PENNSYLVANIA REDEFINITION

(Enacted in early 1974)

Section 1. That the practice of optometry is hereby defined to be the employment of any means or methods, other than the use of surgery, or drugs, except diagnostic pharmaceutical agents, known generically as cycloplegics, mydriatics, topical anesthetics and miotics, which are administered topically for

The examination of the human eye and the analysis of ocular functions, or

The prescribing, providing, furnishing, adapting or employing any or all kinds and types of lenses and prisms, visual training, orthoptics, ocular exercises, and any and all preventive and corrective methods for the aid, correction or relief of the human eye, its associated structures, appendages and functions, other than the use of drugs or surgery:

The Secretary of Health shall designate the specific agents to be used under the above generic classification. Provided, however, that with respect to optometrists licensed at the time of the effective date of this amendatory act, only such licensed optometrists who

1. have satisfactorily completed a course in pharmacology, as it applies to optometry, by an institution accredited by a regional or professional accreditation organization which is recognized or approved by the National Commission on Accrediting or the United States Commissioner of Education, with particular emphasis on the topical application of diagnostic pharmaceutical agents to the eye for the purpose of examination of the human eye and analysis of ocular functions, approved by the State Board of Optometrical Examiners, and

2. who upon successful completion of such course shall be permitted by the State Board of Optometrical Examiners in Optometry to use diagnostic pharmaceutical agents topically in the practice of optometry.

Whenever an optometrist during the course of his examination shall determine the possibility of the existence of a pathological condition he shall advise the person of such opinion, and refer such person to physician for further evaluation.

XTRAS

American Optometric Association

BULLETIN
from
OFFICE OF COUNSEL

VOL. XXXVII, BULLETIN NO. 70 June 11, 1979

TO: O, T, DEC-C, Statutory Definition Advisory Committee, EMS, E, State Association Presidents, Executives, Legislative Chairmen, Attorneys, Legislative Counsel, Statutory Definition Chairmen, Optometric Legislators, IAB-EC, State Board Presidents, Secretaries, Attorneys, Administrative Heads of Schools and Colleges, Mr. Adams, Mr. Andrew, Mrs. Martin, GC, NE

SUBJECT: Iowa Legislation

FROM: Thomas E. Eichhorst, Counsel

On June 8, 1979, Iowa Governor Robert D. Ray, a Republican, signed into law Senate File 93. This law, entitled, "AN ACT RELATING TO THE USE OF DIAGNOSTIC PHARMACEUTICAL AGENTS BY OPTOMETRISTS" is enclosed.

The bill passed the Senate on March 7, 1979 by a vote of 29 to 17. It passed the House, as amended, on April 19, 1979, by a vote of 67 to 25. It was concurred in by the Senate on May 1, 1979 by a vote of 29 to 20.

Iowa is the twenty-third (23rd) state to enact legislation specifically authorizing optometrists to utilize pharmaceutical agents. Twenty-one (21) states authorize optometrists to utilize diagnostic pharmaceutical agents; two states authorize optometrists to utilize pharmaceutical agents for diagnostic and therapeutic purposes. The list (and dates of enactment) of these states is as follows:

American Optometric Association
243 North Lindbergh Blvd.
Saint Louis, Missouri 63141
314 991 4100

Executive Offices in St. Louis and Washington, D.C.

PD F-5685

SENATE FILE 93

AN ACT

RELATING TO THE USE OF DIAGNOSTIC PHARMACEUTICAL AGENTS BY OPTOMETRISTS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. Section one hundred fifty-four point one (154.1), Code 1979, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. Certified licensed optometrists may employ cycloplegics, mydriatics and topical anesthetics as diagnostic agents topically applied to determine the condition of the human eye for proper optometric practice or referral for treatment to a person licensed under chapter one hundred forty-eight (148) or one hundred fifty A (150A) of the Code. A certified licensed optometrist is an optometrist who is licensed to practice optometry in this state and who is certified by the board of optometry examiners to use diagnostic agents. A certified licensed optometrist shall be provided with a distinctive certificate by the board which shall be displayed for viewing by the patients of the optometrist.

Sec. 2. Section one hundred fifty-four point three (154.3), Code 1979, is amended by adding the following new subsections:

NEW SUBSECTION. A person applying to be licensed as an optometrist after January 1, 1980, shall also apply to be a certified licensed optometrist and shall, in addition to satisfactorily completing all requirements for a license to practice optometry, satisfactorily complete a course consisting of at least one hundred contact hours in pharmacology and receive clinical training as it applies to optometry with particular emphasis on the topical application of diagnostic agents to the human eye for the purpose of examination of

the human eye, and the diagnosis of conditions of the human eye, at an institution accredited by a regional or professional accreditation organization which is recognized or approved by the council on postsecondary accreditation or the United States office of education.

NEW SUBSECTION. A person licensed as an optometrist prior to the effective date of this Act who applies to be a certified licensed optometrist shall first satisfactorily complete a course consisting of at least one hundred contact hours in pharmacology as it applies to optometry including clinical training as it applies to optometry with particular emphasis on the topical application of diagnostic agents to the human eye and possible adverse reactions thereto, for the purpose of examination of the human eye and the diagnosis of conditions of the human eye, provided by an institution accredited by a regional or professional accreditation organization which is recognized or approved by the council on postsecondary accreditation or the United States office of education, and approved by the board of optometry examiners.

NEW SUBSECTION. In addition to the examination required by section one hundred fifty-four point three (154.3), subsection three (3) of the Code, a person applying to be a certified licensed optometrist shall also pass an examination prescribed by the optometry examiners in the subjects of physiology and pathology appropriate to the use of diagnostic pharmaceutical agents and diagnosis of conditions of the human eye, and pharmacology including systemic effects of ophthalmic diagnostic pharmaceutical agents and the possible adverse reactions thereto, authorized for use by optometrists by section one hundred fifty-four point one (154.1) of the Code.

Sec. 3. Chapter one hundred fifty-four (154), Code 1979, is amended by adding the following new section:

NEW SECTION. A certified licensed optometrist employing diagnostic pharmaceutical agents as authorized by this Act shall be held to the same standard of care in the use of such agents and in diagnosis as is common to persons licensed under chapter one hundred forty-eight (148) or one hundred fifty A (150A) of the Code in this state.

Sec. 4. Section one hundred fifty-five point twenty-two (155.22), Code 1979, is amended to read as follows:

155.22 EXCEPTIONS. Sections 155.20 and 155.21 do not apply to sales by wholesalers of drugs and medicines to licensed physicians, dentists, podiatrists or veterinarians

or to sales by wholesalers to certified licensed optometrists of those diagnostic pharmaceutical agents which are authorized for use by certified licensed optometrists pursuant to this Act.

Sec. 5. Section one hundred fifty-five point twenty-six (155.26), Code 1979, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. This section shall not apply to the possession by a certified licensed optometrist of those diagnostic agents which are authorized for use by certified licensed optometrists pursuant to this Act. The dispensing by pharmacists to certified licensed optometrists of those diagnostic agents which are authorized for use by certified licensed optometrists pursuant to this Act shall be permitted.

Sec. 6. This Act is effective January 1, 1980.

Terry E. Branstad

TERRY E. BRANSTAD
President of the Senate

FLOYD H. MILLEN
Speaker of the House

I hereby certify that this bill originated in the Senate and is known as Senate File 93, Sixty-eighth General Assembly.

Frank J. Stork

FRANK J. STORK
Secretary of the Senate

Approved June 8, 1979

Robert D. Ray

ROBERT D. RAY
Governor

Regular Session, 1975

HOUSE BILL NO. 107

BY MESSRS. BREAUX AND J. JACKSON

ACT 123

LOUISIANA

AN ACT

To amend and reenact Paragraph (3) of Section 1041, Section 1051, and Paragraph (15) of Section 1061 of Title 37 of the Louisiana Revised Statutes of 1950 and to amend Section 1041 of Title 37 by adding thereto a new Paragraph to be designated as Paragraph (4) thereof, and to add a new Section to be designated as Section 1067 of Title 37 of the Louisiana Revised Statutes of 1950, relative to defining the practice of optometry; to provide for a definition of diagnostic pharmaceutical agent; to provide regulations for the examination required by applicants for a license as an optometrist; to provide for procedures regulating the employment of topical ocular diagnostic pharmaceutical agents by a licensed optometrist; and to provide with respect to the causes for refusal, suspension, or revocation of a certificate of license, and otherwise to provide with respect thereto.

ORIGINATED

IN THE

Rec'd by the Governor
June 26, 1975 at 2:15 PM
Doris C. Davenport

House of Representatives

Received by Secretary of State
this 7th day of July, 1975
Wade O. Martin, Jr.
Secretary of State

David R. Poynter
Clerk of the House of Representatives

Regular Session, 1975

ACT 123

HOUSE BILL NO. 107

BY MESSRS. BREAUX AND J. JACKSON

AN ACT

To amend and reenact Paragraph (3) of Section 1041, Section 1051, and Paragraph (15) of Section 1061 of Title 37 of the Louisiana Revised Statutes of 1950 and to amend Section 1041 of Title 37 by adding thereto a new Paragraph to be designated as Paragraph (4) thereof, and to add a new Section to be designated as Section 1067 of Title 37 of the Louisiana Revised Statutes of 1950, relative to defining the practice of optometry; to provide for a definition of diagnostic pharmaceutical agent; to provide regulations for the examination required by applicants for a license as an optometrist; to provide for procedures regulating the employment of topical ocular diagnostic pharmaceutical agents by a licensed optometrist; and to provide with respect to the causes for refusal, suspension, or revocation of a certificate of license, and otherwise to provide with respect thereto.

Be it enacted by the Legislature of Louisiana:

Section 1. Paragraph (3) of Section 1041 and Section 1051 of Title 37 of the Louisiana Revised Statutes of 1950 are hereby amended and reenacted to read as follows:

§1041. Definitions

* * *

(3) "Optometry" means that practice in which a person employs or applies any means other than surgery, for the measurement of the powers and testing the range of vision of the human eye, and determines its accommodative and refractive state, general scope of function,

and the adaptation of frames and lenses, including contact lenses in all their phases, to overcome errors of refraction and restore as near as possible, normal human vision. The practice of optometry does not include the use of drugs or medication, except the use of topical ocular diagnostic pharmaceutical agents and then only by a licensed optometrist and in accordance with the provisions of this Chapter. The practice of optometry does not include the use of pharmaceutical agents, in the treatment of disease.

* * *

§1051. Examinations and educational requirements

Examinations given by the board shall be based upon subjects taught in approved schools and colleges of optometry, such as general anatomy, physics, chemistry, biology, physiology, anatomy and physiology of the eye, general physiology, general pathology, ocular pathology, ocular neurology, ocular myology, psychology, physiological optics, optometrical mechanics, vision therapy, visual field charting, orthoptics, clinical optometry, contact lenses, general pharmacology and ocular pharmacology as it applies to optometry with emphasis on the topical use of diagnostic pharmaceutical agents to the eye, and the applications of the general law of optics and refraction and such other materials and subjects as are essential in the practice of optometry. Examinations shall be conducted at least once annually on dates fixed by the board.

All written examinations held by the board and the answers of applicants shall be kept as records by the board for at least one year.

Section 2. Paragraph (4) of Section 1041 and Section 1067 of Title 37 of the Louisiana Revised Statutes of 1950 are hereby enacted to read as follows:

§1041. Definitions

* * *

(4) "Diagnostic pharmaceutical agent" means any chemical in solution, suspension, emulsion, or ointment base other than a narcotic which when applied topically to the eye, results in physiological

changes which permit more efficient, or otherwise facilitate, examination of the external eye or its adnexa or the evaluation of vision, or which is necessary to determine normal physiological function as part of an examination regimen.

* * *

§1067. Chemical agents used in examination, board authorization required

Prior to the employment of topical ocular diagnostic pharmaceutical agents by a licensed optometrist, that licensed optometrist must submit to the Louisiana State Board of Optometry Examiners, satisfactory evidence that the optometrist has successfully completed courses approved by the board, in pharmacology as they apply to optometry, with particular emphasis on topical application of diagnostic pharmaceutical agents to the eye.

Section 3. Paragraph 15 of Section 1061 of Title 37 of the Louisiana Revised Statutes of 1950 is hereby amended and reenacted to read as follows:

§1061. Causes for refusal, suspension, or revocation of certificate

* * *

(15) Using, prescribing, giving away, selling or offering for sale, or having in his possession any eye remedy, lotion, salve, or medicine of any kind or description, or practicing medicine or surgery for the use of carrying on the practice of optometry; provided, however, that this Paragraph shall not prevent the possession or use of topical ocular diagnostic pharmaceutical agents by a licensed optometrist in accordance with the provisions of this Chapter.

* * *

Section 4. If any provision or item of this Act or the application thereof is held invalid, such invalidity shall not affect other provisions, items or applications of this Act which can be given effect without the invalid provisions, items or applications, and to this end the provisions of this Act are hereby declared severable.

Section 5. Nothing in this bill shall in any way apply to a licensed physician or to any nurse, technician, or allied health personnel acting

under a physician's prescription, supervision, or direction nor to any screening, testing or teaching program conducted by the state of Louisiana or in any parish or city eye program.

Section 6. All laws or parts of laws in conflict herewith are hereby repealed, with the exception noted in Section 5.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

LIEUTENANT GOVERNOR AND PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: July 6, 1975

Enrolled

House Bill 2740

Sponsored by Representatives OTTO, GRANNELL, GWINN, WALDEN, Senators HOWARD, JERNSTEDT

CHAPTER_____

AN ACT

Relating to the practice of optometry; amending ORS 683.010, 683.040, 683.060 and 683.270.

Be It Enacted by the People of the State of Oregon:

Section 1. ORS 683.010 is amended to read:

683.010. As used in this chapter, unless the context requires otherwise:

(1) "Board" means the Oregon Board of Optometry.

(2) "Practice of optometry" means the employment of any means other than the use of drugs, except diagnostic agents, topically applied, known generically as cycloplegics, mydriatics, topical anesthetics, dyes such as fluorescein, and, for emergency use only, miotics, for the measurement or assistance of the powers or range of human vision or the determination of the accommodative and refractive states of the human eye or the scope of its functions in general or the adaptation of lenses or frames for the aid thereof, subject to the limitations of ORS 683.040.

(3) "Trial frames" or "test lenses" means any frame or lens used in testing the eye which is not sold and not for sale.

Section 2. ORS 683.040 is amended to read:

683.040. (1) Every person desiring to commence the practice of optometry in this state must show by satisfactory evidence that he is of good moral character and has graduated from a school of optometry which is recognized and approved by the board and which maintains a standard of four school years of at least nine months each.

(2) Every person desiring to commence the practice of optometry after January 1, 1976, or employ the use of diagnostic agents shall in addition to the requirements of subsection (1) of this section have satisfactorily completed a course in pharmacology, as it applies to optometry, by an institution accredited by a regional or professional accreditation organization which is recognized or approved by the National Commission on Accrediting or the United States Commissioner of Education, with particular emphasis on the topical application of diagnostic agents to the eye for the purpose of examination of the human eye and the analysis of ocular functions, approved by the Oregon Board of Optometry.

Section 3. ORS 683.060 is amended to read:

683.060. (1) Any person who has signified to the board his desire to be examined by it and who has filed proof that he is qualified under this chapter and the rules of the board to take such examination shall appear before the board at such time and place as the board may designate, and before beginning the examination the applicant shall pay $50 to the secretary of the board. At the examinations the board shall examine applicants in the anatomy of the eye, in the use of diagnostic agents as used topically, in normal and abnormal refractive and accommodative and muscular conditions and coordination of the eye, in subjective and objective

optometry, including the fitting of glasses, the principles of lens grinding and frame adjusting, and in such other subjects as pertain to the science and practice of optometry, such subjects to be enumerated in a publication by the board.

(2) The board may, in its discretion, accept the certificate of successful examination of the National Board of Examiners in Optometry in one or more areas of the examination in lieu of its written examination in such areas.

(3) If an applicant shall fail to pass a second examination, the board may permit additional examinations upon compliance by the applicant with the law and the rules of the board.

Section 4. ORS 683.270 is amended to read:

683.270. The powers and duties of the board are as follows:

(1) To organize and elect from its membership a president and secretary of the board, each of whom shall hold office for one year, or until the election and qualification of a successor.

(2) To adopt and use a common seal.

(3) To employ agents, attorneys and inspectors to secure evidence of, report on, and prosecute all violations of this chapter and to employ other necessary assistance in the carrying out of the provisions of this chapter, and to pay the same from the funds provided in this chapter.

(4) To hold regular meetings at least once a year at which an examination of applicants for certificates of registration shall be held at such places as the board shall from time to time designate, and special meetings upon request of a majority of the members of the board or upon the call of the president.

(5) To keep an accurate record of all proceedings of the board and of all of its meetings, of all prosecutions for violations of this chapter, and of all examinations held for applicants for certificates of registration, with the names and addresses of all persons taking examinations and their success or failure to pass such examinations. All the records of the board shall be public and shall be kept in the office of the board.

(6) To keep an accurate inventory of all property of the board and of the state in the possession of the board and to obtain a receipt therefor from its successor.

(7) To keep a register of optometrists which shall contain the names and addresses of all persons to whom certificates of registration have been issued in the State of Oregon, together with the date of the issuance of such certificate and the place or places of business in which each optometrist is engaged, and all renewals, revocations and suspensions thereof.

(8) To grant or refuse to grant certificates of registration as provided in this chapter and to revoke the certificate of registration of any optometrists for any of the causes specified in ORS 683.140.

(9) To designate diagnostic pharmaceutical agents for topical use in the practice of optometry from among the generic categories enumerated within subsection (2) of ORS 683.010. Said designation shall take place not later than January 1, 1976, and shall be with the advice and guidance of the Board of Medical Examiners for the State of Oregon.

[*(9)*] **(10)** To administer oaths and take testimony upon granting and revoking or suspending any certificate of registration.

[*(10)*] **(11)** To make rules not inconsistent with the laws of this state as are deemed necessary or proper to carry out the lawful powers and duties of the board, as may be necessary or proper to determine the qualifications of applicants for a certificate to practice optometry in this state, and to establish educational, moral and professional standards for such applicants, subject to the laws of this state. If an applicant fails to pass a second examination the board may adopt rules which may provide the required courses of study before further examination.

Chapter , Oregon Laws 1975

ENROLLED

House Bill

Passed by House

Repassed by House

Chief Clerk of House

Philip D. Lang

Speaker of House

Passed by Senate

Repassed by Senate

Jason Boe

President of Senate

Received by Executive Department:

3:15 p.m., May 14, 1975.

Approved: 12:07 p.m. May 20, 1975.

Governor

Filed in Office of Secretary of State:

M., 1975.

Secretary of State

HOUSE OF REPRESENTATIVES

128TH GENERAL ASSEMBLY

FIRST SESSION - 1975

HOUSE BILL NO. 63

AS AMENDED BY

HOUSE AMENDMENT NO. 1

AN ACT TO AMEND CHAPTER 21 OF TITLE 24, DELAWARE CODE, RELATING TO THE USE OF DRUGS OR SURGERY IN EXAMINATIONS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend §2116 of Chapter 21, Title 24, Delaware Code, by striking said section in its entirety and substitute a new section to read as follows:

"§2116. Use of Drugs or Surgery in Examinations

Nothing in this Chapter shall be construed as conferring on the holder of any certificate of registration for license, issued by the Board the right to make use of drugs or surgery in the treatment of eye diseases. He may employ topical ophthalmic drugs for diagnostic purposes only, the drugs that he may use for such diagnosis will be limited to the following four classes of drugs: Topical Anesthetics, Mydriatics, Cycloplegics and Myotics; provided however, that the Delaware State Board of Examiners in Optometry will include an examination on the subject of pharmacology as it relates to optometry and

the use of topically applied diagnostic drugs for all new applicants for licensure; further provided that no presently licensed optometrist shall be permitted to make use of topically applied diagnostic drugs until he shall have completed a refresher course in pharmacology as it relates to optometry and the use of topically applied diagnostic drugs given by an institution accredited by a regional or professional accrediting organization which is recognized by the National Commission on Accreditation, and is approved by the Delaware State Board of Examiners in Optometry."

APPROVED

JUN 24'75

BY GOVERNOR

CHAPTER

563

PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-FIVE

S. P. 169 — L. D. 556

AN ACT to Further the Conservation of Vision.

Be it enacted by the People of the State of Maine, as follows:

Sec. 1. 32 MRSA § 2411, as enacted by PL 1973, c. 788, § 156, is repealed and the following enacted in place thereof:

§ 2411. Definitions

1. Practice of optometry. The practice of optometry is defined as any one or any combination of the following practices:

A. Eye examination. The examination of the eye and related structures to ascertain defects or abnormalities and to detect the presence of eye diseases.

B. Functional examination. The determination of the accommodative or refractive states of the human eye and evaluation of visual functions.

C. Correctional treatment. The correction of vision problems without the use of drugs, medicine or surgery by prescribing or adapting ophthalmic lenses, including contact lenses and other optical aids, and by using other corrective procedures to preserve, restore or improve vision.

D. Fitting of eyeglasses. The fitting, bending and adjusting of eyeglasses with ophthalmic lenses, except that this subsection shall not be considered as the practice of optometry providing the fitting, bending and adjusting is by order of and under the responsibility of an optometrist or ophthalmologist.

E. Replacement of lens. The replacement or duplication of an ophthalmic lens without a written prescription from a person licensed under the laws of this State to practice either optometry or medicine. . .

Nothing in this section shall be construed to prevent an optical mechanic from doing the merely mechanical work associated with adapting, fitting, bending, adjusting, replacing or duplicating of eyeglasses with ophthalmic lenses.

An ophthalmic lens within the means of this section shall be any spectacle lens or contact lens which has a spherical, cylindrical or prismatic power or value or any lens ground pursuant to a written prescription.

2. Optometrist. "Optometrist" means a person who has obtained a certificate of registration from the Maine State Board of Optometry and a license to practice optometry in the State of Maine.

3. Diagnostic drug. "Diagnostic drug" means a diagnostic pharmaceutical agent known generically as topical anesthetic and mydriatic which is

administered topically. The Commissioner of Health and Welfare shall designate the specific agents to be used under the generic classifications.

Sec. 2. 32 MRSA § 2419 is enacted to read:

§ 2419. Use of drugs

1. Diagnostic drugs. The use of diagnostic drugs is permitted only by an optometrist who has obtained a diagnostic drug license under section 2427 or who has passed the examination under section 2422.

2. Standards for use of diagnostic drugs. The following shall constitute the minimum standards for use of diagnostic drugs:

A. The optometrist shall complete or have completed a course in general and ocular pharmacology as it applies to optometry approved by the board.

B. The diagnostic drug shall be used solely for the purpose of detecting any pathological condition or functional abnormality of the eye.

C. Each use of a diagnostic drug shall be noted in writing and shall be made part of the permanent record of each examination and placed on file in accordance with section 2417, subsection 3.

Sec. 3. 32 MRSA § 2422, as enacted by PL 1973, c. 788, § 156, is amended by adding after the 2nd sentence 2 new sentences to read:

The board shall include an examination on the subject of general and ocular pharmacology as it relates to optometry and the use of topically applied diagnostic drugs for all new applicants for a certificate of registration and license. Presently licensed optometrists shall be permitted to use diagnostic drugs only if they obtained a diagnostic drug license under section 2427.

Sec. 4. 32 MRSA § 2427 is enacted to read:

§ 2427. Diagnostic drug license

Every presently licensed optometrist desiring to use diagnostic drugs shall:

1. Have satisfactorily completed a course and examination in general and ocular pharmacology as it applies to optometry approved by the board.

2. Upon satisfying the foregoing requirements, an optometrist shall be granted a diagnostic drug license.

Sec. 5. 32 MRSA § 2432, sub-§§ 13 and 14 are enacted to read:

13. If such person uses diagnostic drugs without first obtaining either a diagnostic drug license or passing the examination under section 2424 after the effective date of this Act;

14. If such person fails to display his diagnostic drug license issued under section 2427.

Sec. 6. 32 MRSA § 2446 is enacted to read:

§ 2446. Drugs

Any optometrist who uses diagnostic drugs, without first having obtained a license under section 2427 or being duly registered as provided in section 2421 and 2424 after the effective date of this Act shall be deemed guilty of a misdemeanor and shall be punished by a fine of not less than $50 nor more than $200.

UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

NAME	DATE OF ENACTMENT
Rhode Island	July 16, 1971
Pennsylvania	March 1, 1974
Tennessee	May 8, 1975
Oregon	May 20, 1975
Maine	June 24, 1975
Louisiana	July 6, 1975
Delaware	July 10, 1975
*West Virginia	March 4, 1976
California	July 9, 1976
Wyoming	February 17, 1977
New Mexico	March 4, 1977
Montana	April 12, 1977 (at 10:10 a.m.)
Kansas	April 12, 1977 (at 2:00 p.m.)
*North Carolina	June 3, 1977
Kentucky	March 29, 1978
Wisconsin	April 29, 1978
Nebraska	February 13, 1979
South Dakota	March 15, 1979
Utah	March 21, 1979
North Dakota	March 22, 1979
Arkansas	April 2, 1979
Nevada	May 25, 1979
Iowa	June 8, 1979

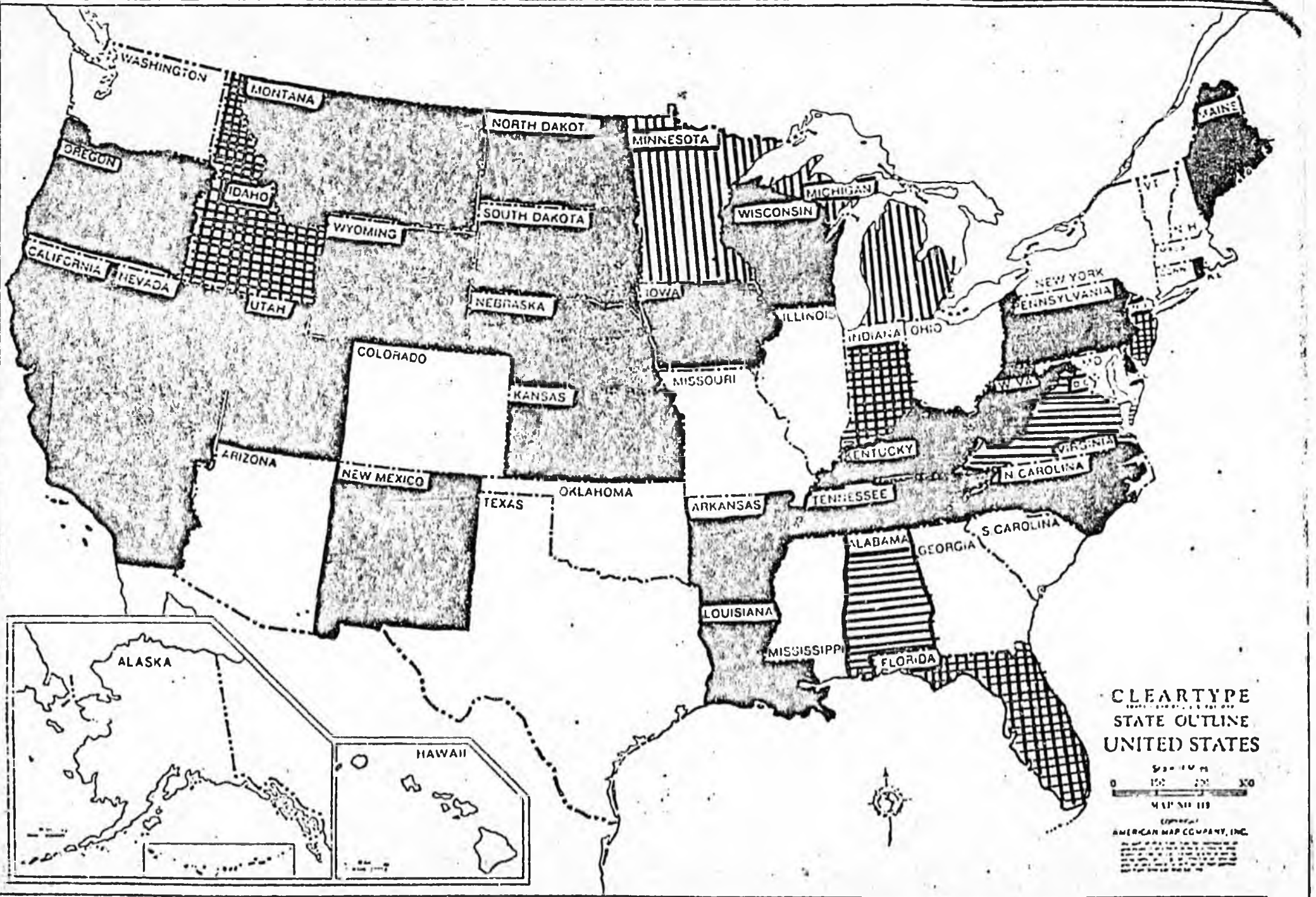
*both diagnostic and therapeutic

[In addition, there are eight (8) other states that do not statutorily prohibit the use of DPAs by optometrists; several of these states have attorney general opinions (+favorable) (-unfavorable) on this point: Alabama (AG-), Florida (AG+) Idaho (State Board Statement +), Indiana (AG+), Michigan, Minnesota, New Jersey (AG+), Virginia (AG-).]

For your information we are including an updated map showing geographically the utilization of pharmaceutical agents by optometrists as of June 8, 1979.

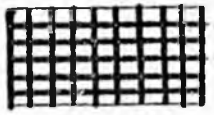
UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

JUNE 8, 1979



UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

Authorized by Optometrists by Statute



Permitted by Opinion of Attorney General or State Board Statement

No Statutory Prohibition

No Statutory Prohibition but Negative A.G. Opinion

ENGLAND, FEBRUARY 1970

JOINT DECLARATION ON BEHALF OF

OPHTHALMOLOGISTS AND OPHTHALMIC OPTICIANS (OPTOMETRISTS)

Following discussions between the General Optical Council, the Faculty of Ophthalmologists and the Joint Committee of Ophthalmic Opticians, the following declaration on matters relating to Hospital and the practice of orthoptics has been agreed on behalf of ophthalmologists and ophthalmic opticians.

1. Hospital Experience for Ophthalmic Opticians

It is desirable in the public interest that ophthalmic opticians should, in their pre-registration year and subsequently, have the opportunity of hospital experience to enable them, in the course of eye examinations, to widen their clinical experience in the recognition of deviations from the normal.

2. Contact Lenses - The Faculty accepts the policy of the General Optical Council in respect to the fitting of contact lenses.

3. Drugs

It is proper for an ophthalmic optician, if necessary, to use appropriate drugs for eye-examination or for first-aid treatment in emergencies.

(The following are examples of appropriate drugs for particular purposes:

a. Atropine - 1% or an alternative cycloplegic for refraction in children up to school-learning age.

b. An appropriate mydriatic and cycloplegic e.g. homatropine 1% for examination of the eye in older children and adults up to the age of 45.

c. A weaker mydriatic such as cyclopentolate hydrochloride 0.5% for patients over 45 years of age.

d. A miotic such as eserine 0.25% or pilocarpine 2% for use when required to overcome the effect of a mydriatic or cycloplegic.

e. In contact lens fitting a suitable local anesthetic such as amethocaine 0.5%).

On pages 8 and 9 of this issue, AOA Trustees Albert A. Bucar, O.D., of Antioch, IL, and Gerald J. Easton, O.D., of Coronado, CA, give some frank, honest and personal answers to questions posed during a recently-conducted AOA *News* interview session concerning their first year in office.

An interprofessional "Older Americans Health Fair Day" screening program is being offered May 5 in more than 200 communities throughout the nation. Doctors of optometry and members of the Auxiliary to the AOA will have the opportunity to participate since vision screening has been suggested as an important part of the program, which is being sponsored by the U.S. Administration on Aging, state and local Agencies on Aging, the Red Cross and the National Health Screening Council for Volunteer Organizations (NHSCVO). The event is one of several public service suggestions the AOA has offered in observance in next month's celebration of Older Americans Month. All suggestions are contained in a planning guide which has been distributed to state and auxiliary public information chairmen and state leaders. O.D.s and auxiliary members interested in participating in Older Americans Month and/or the May 5 event should contact their state association office, which has been furnished with a list of screening sites and local sponsors by the AOA through the NHSCVO.

The next issue of the AOA *News* will be an expanded one featuring several items of interest to doctors of optometry. Included in the May 1st issue will be the "Continuing Education Quarterly" supplement. Prepared by the Education & Manpower Division, this supplement will list about 150 continuing education courses which will be offered throughout the United States from July through September. The next issue of the *News* will be devoted partially to the upcoming AOA Congress. Numerous photos and articles, including highlights of the June 17-23 event, will be published. The May 1st issue also will contain several stories on membership services for association members, including results of the recent readership survey on the AOA *News*.

AOA News Apr. 15, 1979.

determined by the doctor involved, the FDA said, and it is recommending leaving the contact lenses in place for 30 days at a time under normal circumstances.

Europeans, Australians and Canadians have been able to buy prolonged-wear contact lenses for three to six years, with mixed results reported. A handful of people have gone blind in one eye or required corneal transplants because of serious infections caused by the lenses. A more significant proportion of wearers — half or more in some instances — stopped using the lenses. And, the lenses can be dropped and lost as easily as conventional ones, although manufacturers expect replacement of the lenses won't cost as much as the first pair.

Major companies and firms expected to be vying for a share of the anticipated market for the new lenses include Danker & Wohlk, Inc.; American Hospital Supply's subsidiary, Heyer-Schulte Corp.; Continuous Curve Contact Lenses, Inc.; Rynco Scientific Corp.; Dow Corning; Syntex Ophthalmics, and Cooper Laboratories, Inc.

Arkansas okays DPA legislation

LITTLE ROCK, AR — Gov. Bill Clinton has signed into law H.B. 843, making Arkansas the [illegible] state in the nation to specifically authorize optometrists to utilize pharmaceutical agents.

The April 2nd signature by Gov. Clinton makes Arkansas the fifth state this year to enact such legislation. An additional six states do not prohibit, either statutorily or administratively, such utilization.

According to Virgil I. Rhodes, O.D., of Manchester, TN, chairman of the AOA Statutory Definition Advisory Committee, the Arkansas law has special significance because a diagnostic pharmaceutical agent (DPA) bill was vetoed in 1977 by the previous governor.

The Arkansas bill was passed, in final form, by the state Senate by a 20 to 10 vote and in the state House of Representatives by a 77 to two vote.

NEWS

American Optometric Association

Vol. 18, No. 7
April 1, 1979

DPA laws

(See map, page 4)

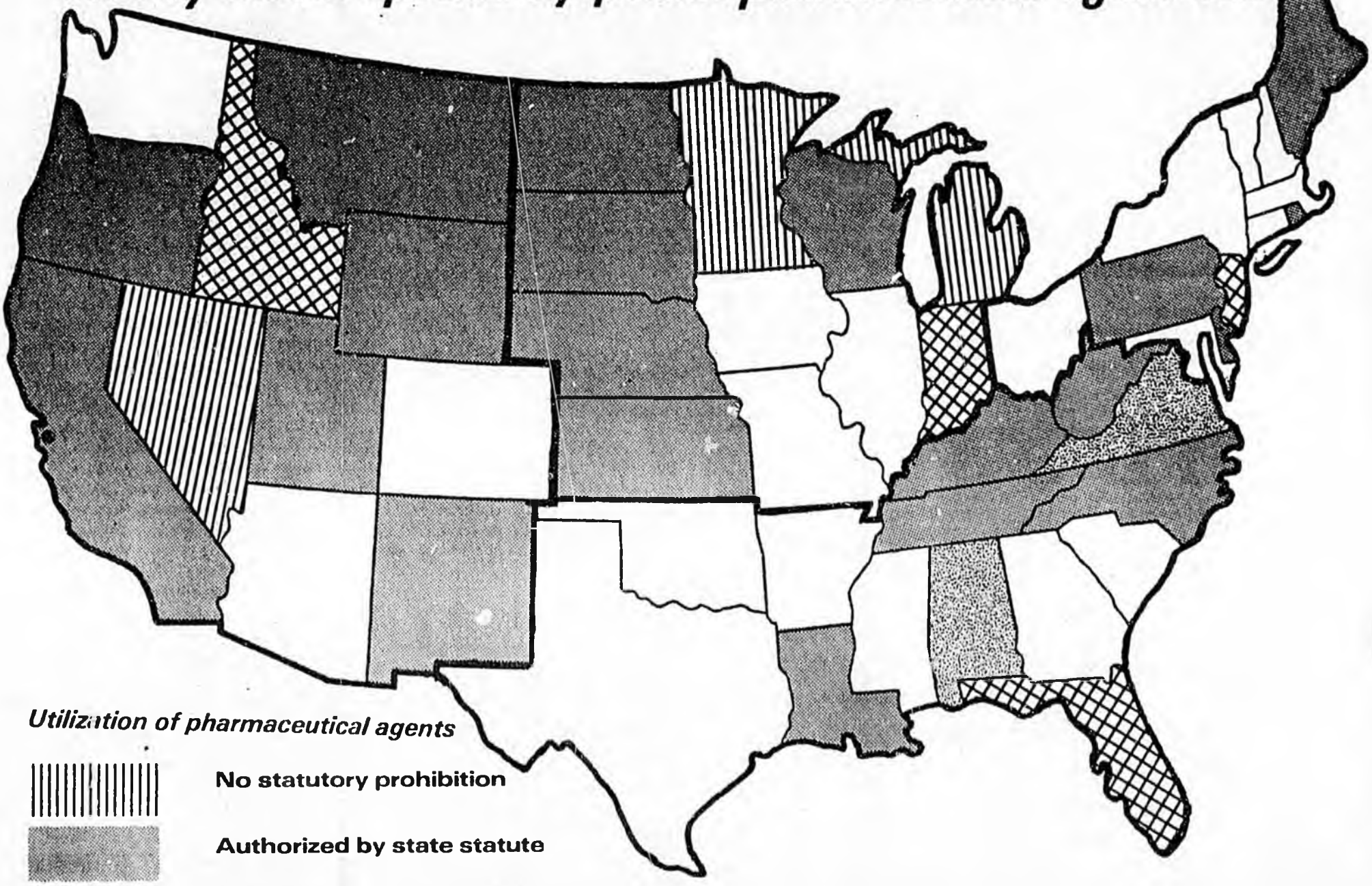
Diagnostic pharmaceutical agent (DPA) bills in North Dakota, South Dakota and Utah have become law, creating 20 states which specifically authorize the use of pharmaceutical agents by O.D.s. An additional six states do not prohibit, either statutorily or administratively, such utilization.

South Dakota became the 18th state when Gov. William J. Janklow signed into law S.B. 85, a measure which had passed the State Senate by a 22:11 vote and, in the House, by a 64:2 vote.

Utah's H.B. 98 became the 19th law on March 21, when the governor did not sign or veto the measure. The legislation had passed the State House by a 50:12 vote and by a 20:4 in the Senate.

North Dakota Gov. Arthur Link signed S.B. 2356 the following day, making the 20th such enactment. The bill passed the Senate earlier by a 41:7 vote and, in the House by an 85:10 vote.

Twenty states specifically permit pharmaceutical agent use



Utilization of pharmaceutical agents

- No statutory prohibition
- Authorized by state statute
- No statutory prohibition but negative attorney general opinion
- Permitted by opinion of attorney general or state board statement

Four successful enactments this year of legislation permitting the use of pharmaceutical agents by optometrists bring to 20 the number of states with laws specifically authorizing such usage. An additional six states do not prohibit such utilization, either statutorily or administratively. According to Virgil L. Rhodes, O.D., of Manchester, TN, chairman of the AOA Statutory Definition Advisory Committee, similar legislation is pending in 12 other states, with several pieces reported near passage. Bills in Arizona and Arkansas have been approved by their respective House of Representatives, while bills in Iowa and Oklahoma have been passed by their respective state Senates, Dr. Rhodes said.

In a related development, the Virginia Senate has decided not to vote on overriding Gov. John Dalton's recent veto of a bill which would have allowed O.D.s in the state to use diagnostic pharmaceutical agents. According to the Virginia Optometric Association, the State Democratic Caucus made the decision in a recent closed session, basing the action on the grounds the legislation was a health issue and not a political partisan one. The legislation, which was supported by more than 30 sponsors from the Virginia House of Delegates, had passed both legislatures by large majorities — by a 74 to 19 vote in the House and a 25 to 15 vote in the Senate. The bill was identical to legislation the Republican governor vetoed last year.

Don Hostak, Director
Div. of Occupational Licensing

02 13 79

Byron Perkins BP
Licensing Examiner

I spoke with Eldon Ulmer, President of the Board of Pharmacy, and he asked me to convey the following to you in response to your teletype to him last week.

RE House Bill 79 regarding optometrists and particularly their ability to prescribe legend drugs and pharmaceuticals, the Alaska Board of Pharmacy has not changed its position on this issue. The board is not primarily concerned with whether or not an optometrist should be given this priviledge, but rather, that the proposed bill in no way addresses the legal question of how they are to obtain legend drugs. Current Federal and State statutes do not permit pharmacists to fill prescriptions for legend drugs by any one but Medical Doctors, Veterinarians, and Dentists.

Re House Bill 101 and Senate Bill 65, the Uniform Controlled Substances Act, this is the number one legislative priority for the Board of Pharmacy, and the board supports it conceptually. However, the current bill is primarily a police bill, and needs to be ammended substantially to make it palatable to the industry. There is not enough language addressing the rights and responsibilities of professionals authorized to handle controlled substances. The Board of Pharmacy is pushing for a Uniform Controlled Substances Act that parallels the federal guidelines.

cc: Eldon Ulmer, R.Ph.
Chairman, Board of Pharmacy

Rep. Buchholdt

Alaska State Legislature

POUCH V
JUNEAU, ALASKA 99811

P.O. BOX 9
KENAI, ALASKA 99611

REPRESENTATIVE HUGH MALONE

24 January 1979

Peter E. Cannava, M.D.
Box 1629
Soldotna, AK 99669

Dear Peter:

I received your letter and court brief regarding the optometric drug bill and have forwarded a copy to Rep. Thelma Buchholdt. She is the new chairperson of the Health, Education and Social Services Committee. As yet, no legislation has been introduced regarding this issue, however, I expect it will be soon.

Thank you for the information.

Sincerely,

Hugh Malone

jk

Peninsula Eye Clinic
PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669

TELEPHONE 262-4462

Hugh Malone
State Capitol Building
Pouch V
Juneau, Alaska 99811

Dear Hugh:

I gave the enclosed talk to the legislators present at our political meeting and I thought it would be helpful to you to receive a copy of it considering your vote of last session.

The case illustrates the fact that the optometric drug bill represents more than a political "power play" but in fact has and will mean loss of eyes of our fellow Alaskans. We have at least two other cases documented where vision was lost because of inadequate medical knowledge on the part of optometrists.

The judges decision clearly states that there is no reason why optometrists can be permitted to make medical diagnosis on a legal basis. In addition the testimony by the "professor of optometry" clear illustrates the lack of medical knowledge on the part of optometrist educators.

Sincerely,

Peter

Peter E. Cannava, M..D.

PEC/bc

Hugh,
Please have one of your staff save the court brief as it will have to be used for the "HESS" committee hearings & also for future discussions I will have w you.
Good Luck this yr & I wish you a short 90 day session. P.

13Dec78.

American medicine has estabilished a tradition which dates back well over 200 years! Despite the ups and downs of certain aspects of American medicine the very basic integrity of the system has never and will never be challanged. This is fact because the system rests upon a foundation of sound scientific principle. American people may not like what type of treatment is offered them but they at least can rest assured that any prescription promulagated by our traditional medical system is based upon a scientific method, and those practitioner licensed with-in the system have completed a satisfactory curriculum approved by both private and governmental bodies who attest to the fact that medical practitioners are qualified to practice with the use of drugs and other modalities. In addition to the traditional modality of medical care there are two other broad categories of health care which our people choose to utilize. One is not based upon scientific methodology, cannot be supported by established objective data. Examples of these would be naturopathic healing and chiropractic.
The second category of non-medical health care sought by Americans is based upon scientific principles but is not traditionally associated w[illegible] medical education. Examples of those are psychology and optometry. In past years no major conflict has arisen between traditional medicine and other forms of health care. However, of late there is a movement on by non medical people to seek enactment of legislation which would grant them privileges which traditionally have been the provence of medical practitioners. Examples would include attempts by chiropractors to utilize medical facilities for laboratory testing and more germane to our state the attempt by optometry to seek legislation approved for their use of drugs within their practice.

Legislators must be aware of the short and long term implications of such legislation! Granting non-medical practitioners medical priveleges obscures the traditionally clear cut lines between the dicipline of medicine and the non-medical practices. Such obscuration of lines of deliniation serves to thoroughly confuse the public as to what type of health care is to be expected from each type of practitioner! In such confusion the public will have no clear concept of what type of "product" to expect of each health care practitioner. I wish now to focus upon a problem which confronted last years legislators and may surface again! Optometrists as you may be aware are non-medical practitioners by virture of their ancestory, training, current definition and as of several months ago defined by U.S. District judge for Alaska. They are requesting the legislature to grant them privilege of using drugs in their practice! Such a priviliege would have two fold effect and firstly it would set a precident with-in our state and open the door to all non-medical health personell to seek similar privilege. Secondly it would further endanger the people of Alaska to the risk of loss of sight because of the injudicious use of drugs and false sense of security the use of drugs imparts upon the recipients of such treatment. Indeed as time goes on I will supply you with case histories of Alaska residents who have lost eyes because they were lured into feeling they had been examined by eye physicians or ophthalmologists. I will also supply you with a legal suit prompted by such a loss of eye and additional pertinent information. I urge you not to grant non-medical health practitioners by legislation what they should rightfully earn by education that is the right to join the ranks of traditional medicine thru time honored institutions, estabilished testing procedures and time tested licensing procedures.

P E Carnava, M.D.

Rep. Buchholdt

5 February 1979

Peter E. Cannava, M.D.
Peninsula Eye Clinic
Box 1629
Soldotna, AK 99669

Dear Pete:

Yes, I did receive your packet of information and I apologize for the length of time it took me to respond.

I will forward the new information to Rep. Buchholdt as I did earlier for her files.

Again, thank you.

Sincerely,

Hugh Malone

jk

Peninsula Eye Clinic
PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669

TELEPHONE 262-4462

February 1, 1979

Representative Hugh Malone
Pouch V
Juneau, Alaska 99811

Dear Hugh:

I hope you received my last packet of information on HB79 (optometric drug bill) As you will recall it included a copy of Judge Fitzgeralds decision regarding the loss of a childs eye because of optometric mis-managment! Since I have not heard from you I presume you are quite busy and I wish you luck in your difficult task.

Enclosed please find two items: 1. the copy of"P E N" describing optometric education, 2. Veto message of Gov. Rhodes, Ohio.

Sincerely,

Peter E. Cannava M.D.

Peter E. Cannava, M.D.

PEC/bc

Governor's Veto Message

(Unofficial Copy)

December 15, 1978

Pursuant to Article 2 Section 16 of the Constitution of Ohio, I return herewith to the Clerk of the Senate for presentation to the Senate Amended Substitute Senate Bill 163 which I disapprove and have not signed. Amended Substitute Senate Bill No. 163 would expand the definition of the practice of optometry to allow the use by optometrists of specific diagnostic drugs to the eye in the form of eyedrops. If the specified drugs are used solely for the purpose of detecting disease and are of a specific level of potency the matter of health care is of vital concern they must insure to all Ohio citizens that they receive the highest quality health care possible. Health care is an area in which we can take no risks because any mistakes can bring tragic and irreversible results. We must be committed to our citizens to provide practitioners that are highly skilled individuals and who will at the same time provide the best health care at the lowest cost.

Optometrists have been doing an excellent job in working with the medical profession to bring quality eye care to Ohio citizens. The tools that the optometrists are presently using are not dangerous and are effective in screening for eye disease. However, Amended Substitute Senate Bill No. 163 would allow optometrists to use drugs in order to make a full diagnosis of the medical condition of the eye. If the individuals involved were properly trained this procedure would be in the best interest of Ohio citizens, however without proper training the bill would allow unwarranted risks without corresponding benefits. The drugs involved are dangerous and have a potential of causing a great deal of pain including blindness. The adverse reactions associated with these drugs are not common but they do occur and medical and emergency treatment must be administered in those instances. While this bill does provide for mandatory training of 180 clock hours this amounts to little more than a month of isolated training in a clinical use of the drugs involved. The goal of this legislation should be to build a working relation between optometrists and the medical community. The issue of using drugs should be an issue decided by the professions rather than by the legislature. Both professions have taken an oath to provide quality health care, they should work together toward that end. I pledge the aid of my office for that purpose. For the foregoing reasons I have vetoed Amended Substitute Senate Bill No. 163 and urge the General Assembly to sustain my veto.

James A. Rhodes
Governor

Official Business

House ,

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

February 7, 1979

Peter E. Cannava, M.D.
Peninsula Eye Clinic
Ophthalmology
Box 1629
Soldotna, Alaska 99503

Dear Dr. Cannava:

Thank you very much for your letter and back up material regarding HB-79. I do appreciate your taking the time to send this information to the committee.

We have, to date, received this same information from Rep. Hugh Malone, and I am sure it will be of help to members of this committee.

At this time, I have not yet scheduled the bill for hearing, but I will keep you informed as to when the bill will be up for a hearing.

Again, thank you for your interest.

Sincerely yours,

THELMA BUCHHOLDT
Chairman
House HESS Committee

TB/ch

Peninsula Eye Clinic
PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669
TELEPHONE 262-4462

February 1, 1979

Thelma Bucholt, Representative
Pouch V
Juneau, Alaska 99811

Dear Mrs. Buckhodt:

HB 79 (optometric drug bill) has been sent to your committee for review. It is essential that you review the enclosed court decision concerning the loss of a young Alaskans eye due to optometric irresponsibility. As you will recall the issue last year was whether ot not optometrists were qualified to use dangerous drugs on the eyes of Alaskana. Judge Fitzgerald's decision should settle that question in the minds of Alaskans.

In addition you will find enclosed the Ohio Governors veto message of such a dangerous bill.

I would appreciate your response to the material.

Sincerely,

Peter E. Cannava, M.D.

PEC/bc

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

Reclaimed

Deputy

(-70)

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ALASKA

RECEIVED

OCT 24 1978

Parrish Law Office

ROBERT K. STEELE, as the Natural father and next friend of TIMOTHY R. STEELE, and ROBERT K. STEELE, individually,

Plaintiffs,

v.

UNITED STATES OF AMERICA,

Defendant.

NO. F 75-27 Civil

OPINION

Timothy Steele is an eight year old boy whose father is a soldier in the United States Army. Timothy received medical care as a medical dependent at the Eye Clinic, Bassett Army Hospital, Fort Wainwright, Alaska, in 1973 and 1974. This litigation stems from a claim brought on Timothy's behalf by his father against the United States for loss of Timothy's right eye. The Federal Tort Claims Act [1] furnishes the required jurisdiction.

In October and November of 1973, Timothy's mother noticed Timothy's eyes crossing. On December 19, 1973, she took Timothy to the Eye Clinic, Bassett Army Hospital. There Timothy saw Dr. John Shank, an optometrist in charge of the clinic.

1/ 28 U.S.C. 1346(b). Plaintiffs' original complaint founded jurisdiction on the Federal Tort Claims Act but mistakenly cited the section as 1366(b).

Dr. Shank made an extended examination and diagnosed Timothy's eye condition as an accomodative esotropia correctable by eyeglasses. Following his examination of Timothy, Dr. Shank wrote Mrs. Steele a prescription for eyeglasses and made an appointment for her to return Timothy to the clinic January 29, 1974, for a checkup.

During the January visit to the clinic Timothy's mother reported to Dr. Shank that she thought the eyeglasses were helping since Timothy's right eye was not crossing as frequently. However, Dr. Shank's clinical record noted "no good reflex" in Timothy's right eye. The optometrist wrote a different prescription for eyeglasses and instructed Mrs. Steel to make a follow-up appointment for Timothy four months after Timothy would begin wearing the new eyeglasses.

By early May, Mrs. Steele noticed that Timothy frequently removed his eyeglasses. When questioned Timothy told her that sometimes he wasn't able to see well. An appointment at the eye clinic was scheduled for Timothy on June 10. When Dr. Shank examined Timothy on that date he found vision in Timothy's right eye limited to light perception. At this point Dr. Shank made an appointment for Timothy with ophthalmologist, Dr. Bruce Wolf, [illegible] in Fai

When Dr. Wolf examined Timothy on June 17th he found Timothy's visual acuity in the right eye limited to hand motion although capable of perceiving light. Essentially Timothy's right eye was blind. The doctor diagnosed Leucocoria, right eye, with right esotropia. In his medical opinion the inflammatory cause was a vitreous hemorrhage with possible involvement of toxocara canis or retinoblastoma. Since either disease was extremely serious, Dr. Wolf ordered a complete workup by a pediatrician hoping to rule out one or both. The pediatric workup proved negative and Dr. Wolf then arranged for ophthalmologist, Dr. William Kim, as consultan

Dr. Kinn, a highly qualified ophthalmologist, before opening a prac in ophthalmology at Fairbanks spent ten years as a military medical officer. His last three years of military service were spent at Fort Wainwright where he was chief of ophthalmology and supervised the optometrists assigned to Bassett Army Hospital.

On examination of Timothy July 9th, Dr. Wolf and Dr. Kinn observed a retinal detachment of the right eye with a sub-retinal tumor. "Tumor" in this context was defined as a mass rather than a malignancy. Their diagnosis was possible retinoblastoma, but toxocara canis was also to be considered. The doctors concluded specific tests were necessary so that the precise identity of the disease might be known.

Arrangements were made to airvac Timothy from Fairbanks to Letterman Army Medical Center at the Presidio in San Francisco. At Letterman, Timothy was examined July 12 by a team of medical doctors, including Dr. Michael Hogan who was internationally recogn in the field of ophthalmologic pathology.

On examination the medical team observed a retinal detachment involving a grayish yellow tumor. The doctors diagnosed the cause of the tumor as possibly retinoblastoma or toxocara canis. Eye condition at that point in time made it impossible to differentiate between either disease. Because of the danger of retinoblastoma, a particularly fast-spreading and life-threatening malignancy, the doctors recommended to Timothy's parents that his right eye be removed. Timothy's parents immediately consented to the operation and Major Bradley C. Black, a resident assigned to the ophthalmology unit at Letterman, performed the surgery.

After the eye was enucleated it was sent to the ophthalmolo pathology laboratory at the University of California, Berkeley, California, for examination. The laboratory report revealed total retinal detachment of the eye with giant reaction and massive disorganization of the retina. The pathological examination ruled out a

retinoblastoma but concluded the cause of the disease to be granulomatous retinitis,[2/] etiology unknown. Unlike as in most eye removals, an implant was not inserted into the socket of Timothy's right eye immediately following surgery as there was a substantial possibility that the pathology report might confirm retinoblastoma. The malignancy would necessarily require radiation treatment and a follow-up examination not possible with an implant. When the pathological report ruled out retinoblastoma Timothy was returned to surgery and an implant was placed in the socket.

Dr. Black continued to treat Timothy following the second operation until Timothy returned to Fairbanks. After Timothy returned to Fairbanks he was treated by Dr. Wolf who noted that Timothy's recovery was excellent with the exception of periodic socket inflammation.

Timothy returned in September to Letterman where a prosthesis was inserted into the eye socket with good cosmetic result. Probably the prosthesis will never appear similar to a natural eye since it could not be inserted immediately following the operation.

It is claimed in this litigation that the optometrist, Dr. Shank, failed to provide adequate care required of an optometrist when he treated Timothy in December of 1973 and January of 1974.

OPTOMETRIC RESPONSIBILITY

Dr. Shank graduated with a degree in optometry from Pacific University at Forest Grove, Oregon, in 1971. He was commissioned in the United States Army as a Captain in the medical services and during the summer of 1973 was assigned to Fort Wainwright, Alaska. In November of 1974 he left the Army and now is in the practice of optometry at Kodiak, Alaska.

2/. Retinitis is an inflammation which chiefly involves the retina. "Granulomatous" is a type of inflammation. Thus, the pathology conclusion was that of a general retinal inflammation of unknown origin.

When Dr. Shank made his first examination of Timothy's eyes on December 17, 1973, he recorded a brief history:

History: Past 6 weeks mother thinks pat. is crosseyed. Father amblyopic. Age 4 Was med. Rubs eyes after playing up close. Notices nasal [illegible] depth. No allergies

In addition he also tested Timothy's unaided vision using a standard AO chart (pictures) for children. The best possible visual acuity when measured with an AO chart is 20/30. Dr. Shank recorded Timothy's visual acuity 20/30 OD and OS (both eyes). After dilating Timothy's eyes he made an internal examination a[nd] noted:

Internal Exam Media - [illegible] Shows opacity OD. Dilated c 1% Also at 11:30 OD [illegible] Imp. [illegible]

Upon completing the examination, Dr. Shank concluded that Timothy's eye problem was caused by an accomodative esotropia[3] correctable by a prescription for eyeglasses. He did not think it necessary to refer Timothy to an ophthalmologist.

Dr. Willard Bleything, Dean of the College of Optometry, Pacific University, Forest Grove, Oregon, who was called as a government witness at trial, agrees with Dr. Shank. According to Dr. Bleything, the findings of Dr. Shank's December examination are entirely consistent with an accomodative esotropia, hence, there was no need to send Timothy to a medical doctor.

3/ Estropia, meaning pointing inward.

In his testimony Dr. Bleything touched on the scope of training provided in a school of optometry. A significant part of optometric training is given over to recognition of diseases in the eye. In this case no one questions the principle requiring optometrists to refer their patients to medical doctors once disease is detected in the eye. In Timothy's case, however, Dr. Bleything would distinguish between an active vitreous hemorrhage and an inactive vitreous hemerrhage. He classifies an inactive vitreous hemorrhage as a scar and suggests referral to a medical doctor is indicated only in the event that an active vitreous hemorrhage were detected. It is implicit by this reasoning that to Dr. Bleything a scar is not an indication of existing disease. Scar tissue, according to Dr. Bleything's opinion, when old or inactive, is typically black. This is consistent with Dr. Shank's testimony that the vitreous hemorrhage detected in his December examination was old because it appeared black or dark.

ODs only need refer active hemorrhages ??

wrong Professor!

Actually a black or dark color in a vitreous hemorrhage has nothing at all to do with its age, but rather is a result of its magnitude or extent. The black or dark color indicates a lack of reflected light from the retina behind the hemorrhage. Blood in a vitreous hemorrhage is not black; it is only the shadow that appears black. Indeed, as Dr. Black states in his deposition, an old vitreous hemorrhage would appear as white strands in the vitreous and settle to the lower part of the vitreous. And Dr. Kinn testified that he had personally observed hemorrhages in the vitreous more than a year old which were red in color. He explained that a hemorrhage would appear to be black because it was sufficiently thick with blood to absorb all the light reflecting off the retina during an examination, not because of an innate darkness of color.

The interrelationship between optometric and medical responsibility is discussed in considerable depth in the scientific text referred to at trial, "The Optometric Profession," by Hirsch

& Wick. The text notes that responsibility for recognizing eye disease has not always been a part of optometry, nor indeed is it now a part of optometric services in parts of the world outside of the United States and English speaking countries. In some European countries an optometrist is expressly forbidden to examine the eye to determine whether it is healthy or not.[4/]

Some of the diseases which may be discovered by examination of the eye are brain tumors, diabetes, kidney disorders, hypertension, as well as some diseases caused by microorganisms such as tuberculosis. Optometrists study about these and other diseases in order to recognize eye manifestations of diseases. An optometrist should not attempt to complete a definitive diagnosis but recognize this responsibility is part of the practice of medicine. This principle is clearly stated in "The Optometric Profession."

> The difference between optometric and medical responsibility to the patient may be clarified by example. If an optometrist observes a hemorrhage in the fundus, he recognizes that it may be due to any of the diseases already enumerated. It also may have resulted from a vascular accident or from undue capillary fragility. The important consideration for the optometrist, however, is that he see and identify the hemorrhage. It is his responsibility to refer the patient to the appropriate medical practitioner for diagnosis and treatment of the disorder. The optometrist's understanding about disease is sufficient to recognize the various diseases that can cause hemorrhage. He does not attempt to differentiate between them. Medical technology has advanced so greatly in the past few decades that there are now many laboratory tests the physician can use in making the correct diagnosis. Disease is diagnosed by many procedures. The appearance of the eyeground is only one of them. The Optometric Profession

I am not persuaded with Dr. Bleything's reasoning that referral to a medical doctor ought to depend on whether the optometrist

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4/ The Optometric Profession by Monroe J. Hirsch and Raiph E. Wick, (1968 edition) Chilton Book Co. at page 17.

has diagnosed a vitreous hemorrhage as active or inactive. The authors, Hirsch & Wick, suggest in their text that the important consideration is that the optometrist be able to see and identify the hemorrhage. It then becomes his responsibility to refer the patient to a medical doctor for diagnosis and treatment. Since Dr. Shank detected the vitreous hemorrhage of the right eye during his December examination, it was his immediate responsibility to promptly refer Timothy to a medical doctor. In point of fact, ophthalmological services were then readily available to military personnel at Fort Wainwright and to their dependents under a federal contract with Dr. Wolf.

Dr. Shank was aware of symptoms other than vitreous hemorrhage which are of significance to an optometrist. Esotropia in a child of four, Timothy's age in 1973, is a serious matter. Dr. Black states that esotropia in a four year old child is very rare. Most cases of congenital esotropia caused by muscle imbalance develop before age two. This condition is correctable by an operation on the muscles of the eyes. Accomodative esotropia, such as diagnosed by Dr. Shank in December, 1973, develops in most cases at age two to two and a half, although it occasionally develops as late as age four or five. This condition is correctable by eyeglasses and the esotropia usually corrects itself after eyeglasses are worn. An esotropia may also indicate some type of retinal or vitreous pathology in the visual axis. This will often involve a disease in the macula, the central part of the retina. This condition reduces visual acuity in the eye and as a result the eye turns inward. In Dr. Black's opinion the most important thing to rule out when a child does present an esotropia is retinal or vitreous pathology. But even more, when a vitreous hemorrhage is observed in a child, it is very important that retinoblastoma be immediately considered until that disease can be completely ruled out.

Dr. Wolf, who treated Timothy at Fairbanks before and after his hospitalization at Letterman, agrees with Dr. Black that Dr. Shank should have referred Timothy to an ophthalmologist in December. Dr. Wolf believes that referral to a medical doctor ought to have been made immediately when Dr. Shank learned of the esotropia from Timothy's mother. Dr. Kinn, who consulted with Dr. Wolf, also agrees that referral was indicated in December. Indeed, Dr. Zimmerman, an eminent ophthalmic pathologist, who testified for the government at trial, concurs that further investigation should have been undertaken at the time the lesion was observed in Timothy's right eye.

I am persuaded from credible, convincing medical opinion, as well as the scientific publication referred to, that Dr. Shank failed to meet the standards required of his profession when he examined Timothy in December of 1973. He knew that Timothy presented an esotropia and in the course of his examination he observed a vitreous hemorrhage in the right eye. An optometrist's responsibility is to observe during his eye examinations any manifestation of disease visible in the eye. Upon detecting disease in the eye, it is then his obligation and duty to the patient to make known what the optometrist has observed. In such cases he may not undertake to diagnose the disease, but should inform his patient that the matter is beyond his competence and advise the patient to see a qualified medical doctor. Certainly in January when Dr. Shank detected the poor reflex in Timothy's right eye, he should have sent Timothy to a medical doctor. Instead, he delayed making a referral to an ophthalmologist until after his last examination in June, 1974. By that time Timothy was essentially blind in his right eye and by then the retina had pulled away from the rear of Timothy's right eye. As it was to turn out, nothing thereafter could be done to restore the vision or to save the eye. Time had run out.

Several questions arise at this juncture. Was the disease which ultimately caused the eye to be removed present when Dr. Shank made his examination in December, 1973? What was the nature of the malady and could it have been diagnosed? Could the disease have been treated had it been timely discovered?

There is general agreement in the testimony of the physicians that the disease which brought about the removal of Timothy's right eye was present when Dr. Shank made his initial examination.

When Dr. Wolf examined Timothy in June, 1974, he diagnosed a vitreous hemorrhage with the possibility of either retinoblastoma or toxocara canis. The team of medical doctors who examined Timothy at Letterman Hospital in July considered four possibilities. The first was persistent hyperplastic primary vitreous, a congenital defect of the eye present at birth and generally noticed shortly after birth. With such a condition as persistent hyperplastic primary vitreous, the eye is usually a bit smaller. The front part of the eye is ordinarily not normal so there are distinguishing factors for that disease. The medical doctors at Letterman were able to rule out this possibility. They were also able to rule out a vitreous hemorrhage as a cause since the vitreous of the eye was fairly clear when the doctors made their examination. The two remaining considerations related to some type of inflammatory response, most probably either toxocara canis or retinoblastoma.

Retinoblastoma is an extremely dangerous malignancy, sometimes found in the eyes of young children. When diagnosed, retinoblastoma requires removal of the diseased eye to prevent the malignancy from escaping outside the eye, possibly through the optic nerve into the brain.

Retinoblastoma was ruled out in the University of California pathological report following examination of the eye after the operation. A negative finding of retinoblastoma eliminated any

need for radiation treatment. In Dr. Black's medical opinion the cause of the inflammation of Timothy's eye was probably toxocara canis. Dr. Black observed that although the larva was never found in the few sectionings of the eye, it is known that the larva may disintegrate or completely disappear in the eye.

Toxocara canis is a parasitic round worm frequently found in dogs. The eggs of the parasite may be ingested by children playing in dirt and the eggs hatch in the intestines of the child into a larva. The larva bores through the intestinal wall and enters the blood stream and is disseminated to different parts of the body. In every instance, with possible rare exception, the parasite is not able to complete its life cycle in a human host and the larva dies without developing into an adult worm. The most common locations where it has been found are in the liver or the lungs. Inflammation of the eye by toxocara is fairly rare. But when it does appear it tends to result in a massive inflammation which usually involves the retina and sometimes may intrude into other structures inside the eye. The presence of toxocara in the body often leads to visceral larva migrans syndrome. The child can have a fever and may have some type of lung disorder, his liver may be enlarged and tender and there may be some abnormalities in certain blood tests. However, an ocular toxocara inflammation frequently occurs without a visceral larva migrans syndrome occurring at the same time. Some studies suggest that in only three or four percent of ocular toxocara inflammation is the syndrome present. With ocular toxocara, so long as the larva remains alive, there is usually not much effect on the eye. There may be a local inflammation in the retina or a small whitish elevated lesion in the retina at the site of the larva or where it penetrated the retina, but the stage at which the parasite usually becomes very damaging is when the larva dies and decomposes. This leads to an extensive lesion in the eye eventually.

resulting in a massive scar. If the larva is able to work itself into the vitreous cavity of the eye , it brings about an even more severe inflammatory process.

Dr. Iris Krupp of Tulane University in New Orleans, Louisiana, is a widely renowned expert in the field of parasitology. She began her work on toxocara as a graduate student in 1954. Since then, she, in association with several opthalmologists, has done extensive work in the detection and treatment of toxocara. She developed a reliable serologic test for the detection of toxocara which was announced in an article[5/] published in the "American Journal of Tropical Medicine" in May, 1974.[6/] After examining the medical records, including the pathology report, in Dr. Krupp's opinion the probability was 90 percent that the disease in Timothy's right eye was toxocara.

Ophthalmic pathologist Dr. Lawrence Zimmerman was a principal government witness at trial. He agreed that the University of California pathological report required that retinoblastoma be ruled out as a cause. However, he noted Dr. Helenor Foerster, a widely known ophthalmic pathologist also performed a pathological examination on Timothy's eye. Dr. Foerster has published a number of important scientific papers, one of which presented the initial description of toxocara infection of the eye. Dr. Foerster prepared a pathological report in connection with a paper which she presented to the Western Ophthalmic Club. In her report Dr. Foerster observed many pigment-

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5/ Hemoglutination Test for the Detection of Antibodies Specific for Ascaris and Toxocara Antigens in Patients with Suspected Visceral Larva Migrans.

6/ Since the article did not appear until May, 1974, the physicians who treated or examined Timothy were probably not aware of Dr. Krupp's serological test.

laden macrophages and giant cells in the retina. Dr. Zimmerman believed this was significant since it implied substantial bleeding into the eye, or alternatively, that a foreign body containing iron might have been introduced into the eye. He postulated that bleeding may have been brought about by several causes, including persistent hyperplastic primary vitreous. In addition, Dr. Zimmerman suggested another possibility of the cause of the inflammation might be a low grade bacterial infection. He did not, however, conclusively rule out toxocara as a possible cause but noted that the larva was not found in either pathological examination. Also, in Dr. Zimmerman's opinion the iron pigment described by Dr. Foerster in her pathological report would not be characteristic of toxocara infection. For these reasons he discounted toxocara as the cause.

Dr. Zimmerman concluded that in this instance it is unlikely that the cause of Timothy's eye inflammation can ever be reliably known, hence the doctor's final diagnosis was chronic sclerosing endophthalmitis, cause undetermined.

It is true that the larva was not found during pathological examination. But as Dr. Fleck explained, the larva may decompose and disintegrate. The University of California pathological report following examination of the eye was prepared by Dr. Joseph Eliason, an ophthalmologist. In his deposition testimony Dr. Eliason stated the pathological diagnosis was granulomatous retinitis, etiology unknown. As stated above, this is a general inflammation involving the retina. Toxocara canis characteristically causes this type of inflammation although other causes are possible.

In the course of the pathological examination,

a technician prepared 30 to 40 sections from the eye. A section is less than a tenth of a millimeter and unless the entire eye is sectioned it is possible to miss the larva. In Dr. Krupp's opinion insufficient sections of the eye were examined to exclude the possibility that the larva was in the eye. Other possibilities suggested by Dr. Zimmerman that bleeding into the vitreous was caused by persistent hyperplastic primary vitreous were ruled out during the medical examination in July at Letterman, nor is there anything to suggest the possibility of a foreign metallic object as the cause of the inflammation.

I find on the basis of the testimony of the treating physicians, including Dr. Wolf, Dr. Kinn and Dr. Black, that toxocara canis was the probable cause of the inflammation in Timothy's right eye. The opinions of the treating doctors are substantially similar to the opinion of Dr. Krupp whose qualifications in this field are outstanding. I find in all probability the larva entered the eye through the retina prior to the time Dr. Shank made his examination in December of 1973. Probably the vitreous hemorrhage observed by Dr. Shank was caused by underlying lesion in the retina of the eye.

While it cannot be known with absolute certainty what an ophthalmologist would have done or been able to do if Timothy had been seen in December, 1973, Dr. Kinn testified that the ophthalmologist would have been immediately concerned with making a diagnosis. At that time the physician might have had some indication of a retinal lesion which would cause him to suspect either a granulomatous reaction or a retinoblastoma. The ophthalmologist would have been able to examine the

inflammatory cells were observed, the doctor could have concluded that an inflammatory reaction was present. In such circumstances a diagnosis of toxocara would be likely. Dr. Kinn explained that since the eye was functioning in December it would not have been prudent to remove the eye even if retinoblastoma was suspected. Rather, Dr. Kinn would recommend a therapeutic trial of steroids be undertaken and if the response would be favorable, then the eye not be removed. But if the mass continued to grow despite the treatment and if retinoblastoma could not be ruled out, it would be necessary to enucleate the eye.

Although in Dr. Zimmerman's opinion there is no recognized treatment for toxocara canis, in fact according to Dr. Krupp, the use of steroids in treating toxocara appeared in the medical literature as long ago as 1961. And since that time, Dr. Krupp maintains there have been numerous reports in the literature on the use of steroids. In her own right, Dr. Krupp has participated in treating approximately 20 cases involving ophthalmic toxocara. Her treatment for toxocara includes thiabendozole and steroids, generally used in combination. Thiabendozole is an anthelmintic medicine which kills the larva. The steroid is an anti-inflammatory agent which reduces the [illegible] of inflammation generally associated with toxocara. In each of the cases in which Dr. Krupp participated treatment was able to arrest the loss of vision at the stage it was when the patient was first seen. Results of treatment can usually be observed within three to four weeks. In the event a patient does not respond to treatment, retinoblastoma may be indicated.

7/ By Schneider at the Oxnard Clinic.

Dr. Black was also aware of several cases where inflammation of the eye was treated with steroids, and in isolated cases steroid treatment has decreased the inflammation, resulting in minimal scarring. But in Dr. Black's opinion in most instances toxocara is not seen by the ophthalmologist until it has been quite destructive. However, assuming that visual acuity in Timothy's right eye was 20/30 in December of 1973 and treatment with steroids was instituted, some vision might have been salvaged.

In Dr. Wolf's opinion if Timothy had been seen by an ophthalmologist in 1973, very possibly the eye could have been saved. Since a granulomatous inflammation is a cellular reaction to a foreign object, treatment would be taken to block the reaction. Steroids are a recognized form of treatment for granulomatous inflammation.

I find it probable that an ophthalmologist examining Timothy's right eye in December, 1973, would have diagnosed possible granulomatous reaction, toxocara canis or retinoblastoma. Although there was a lesion in the eye that to some extent impaired Timothy's vision, his visual acuity in the eye was 20/30, the best that could be measured on Dr. Shank's eye chart. The ophthalmologist under such circumstances would almost certainly institute a course of treatment involving steroids in order to reduce the inflammation. The treatment would have prevented further loss of vision and toxocara inflammation would have caused minimal scarring. The eye would have been saved.

Since the jurisdiction of the court is found under the Torts Claims Act, Alaska tort law controls. Richards v. U.S., 369 U.S. 1; U.S. v. English, 521 F.2d 63 (9th Cir. 1975).

The concept of liability arising out of negligence has been recently stated by the Alaska Supreme Court to be:[8/]

> It is elemental that in order for liability to be imposed in a negligence action, the plaintiff must establish a duty of due care owed him by the would-be defendant, a breach of that duty, and finally, that the injury was proximately caused by the breach of duty. Generally speaking, the duty of due care or ordinary care is the duty to act with that amount of care which a reasonably prudent person would use under the same or similar circumstances.
>
> Leigh v. Lindquist, 540 P.2d 492, 494 (1975).

Dr. Shank's failure to promtly inform Mr. and Mrs. Steele of the vitreous hemorrhage in their child's eye and his accompanying failure to refer Timothy to an ophthalmologist was a breach of the standard of care owed to Timothy Steele and his parents. I find Dr. Kinn's testimony as the duty owed to be especially persuasive. Not only is he a board certified ophthalmologist who continually deals with optometric referrals, but Dr. Kinn was previously chief of the eye clinic at Bassett Army Hospital for three years. During those years, he was in charge of the optometrists at the eye clinic and had overall responsibility for all medical and optometric care at the clinic. Additional evidence of the breach of the standard of care is found in the established text "The Optometric Profession." That authoritative work explicitly

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8/ The standard of care required of medical doctors, osteopaths, and dentists is found at AS 09.55.540. Optometrists were not included. In 1976 the statute was broadened to include all health care providers. 34 Ch. 102 SLA 1976. The amendment was limited, however, to actions filed after the effective date, May 29, 1976. Since Steele v. U. S. was filed August 20, 1976, the amendment is not applicable.

states that an optometrist is bound not to try to differentiate between pathologies such as hemorrhages. Instead, an optometrist must refer the patient to a medical practitioner for prompt examination.

I conclude that competent optometric practice required that Timothy's parents be notified and that the child be referred. The failure to inform and refer was not a "judgment call" but a violation of the governing principles of professional standards.

Optometrist are trained to recognize symptoms of many diseases which may be discovered by eye examination. They are not permitted under recognized optometric standards to undertake a definite diagnosis but recognize this as the responsibility of a medical doctor. 9/ Obviously, it is foreseeable that failure to refer to a qualified medical practitioner, when required to do so, will result in delay of diagnosis and the institution of treatment; so it proved to be in Timothy's case. At the time the referral was finally made to an ophthalmologist, it was too late. Time had run out, and the only thing that could be done was to remove the eye.

I conclude that the plaintiff is entitled to recover in this action from the United States for the loss of Timothy's right eye.

DATED at Anchorage, Alaska, this 20th day of October, 1978.

JAMES M. FITZGERALD
United States District Judge

9/ The Optometric Profession, pp 6, 17.

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

February 26, 1979

Respresentative Thelma Buchholdt, Chairman
House of Representatives
Health, Education, and Social Services Committee
Pouch V, Mail Stop #3100
Juneau, Alaska 99811

Dear Ms. Bushholdt:

The Alaska State Medical Association Legislative Committee has reviewed House Bill 79, an act relating to the practice of optometry.

Enclosed is a copy of correspondence relating to the issue during the 1978 Legislative Session. The position of the Association remains essentially the same, namely:

(1) We are unable to determine how this legislation will improve eye care or specifically benefit the public.

(2) Specifically, we know of no <u>diagnostic use</u> for the drug class, miotics, requested; in converse, their use would be appropriate for <u>treatment</u> of narrow angle glacoma, precipitated by a mydriatic/ cycloplegic use. This condition, we understand, is more prevalent amongst the Alaska natives than the general population, such that bush use of these drugs could carry increased risk.

(3) We approve the educational requirements added in the 1979 legislation. It follows that should the Legislature believe the proposed legislation is in the broad public rather than for special interest, no grandfather type clause should be allowed.

Sincerely,

W Fish

Winthrop Fish, M.D.
Chairman, Legislative Committee
Alaska State Medical Association

WF:mlm

Enclosure

February 14, 1978

Representative Charlie Parr
Chairman, House HFSS 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,

WFish

Winthrop Fish, M.D.
Chairman, Legislative Committee

WF:mlm
cc. ASMA Council
ASMA Legislative Committee

why drops?

"WHY DROPS?"

Patients sometimes ask their eye physician, "Why do you use 'drops' when you examine my eyes?"

A clear answer to this question will help one understand the fundamentals of medical eye care and the relationship of his eyes to the health of his body.

"Drops" are of several kinds and they serve several important medical purposes.

One of the commonest uses of drops is to **enlarge the pupils**, so that the physician may examine more thoroughly the interior of the eye—to "look through the open door instead of through the keyhole." There, for the trained medical man to see, may be the first sign of disease elsewhere in the body. Drops make it possible for him to study not only the lens through which the light must pass, but also the retina where the image is formed, and the optic nerve which transmits the picture to the brain.

Such drops are particularly important in examining older people, who are prone to eye diseases, and often have a small pupil that becomes even smaller under the light of the examining instrument. Dilation of the pupil is necessary in examining the eye for suspected cataract, diabetes, hardening of the arteries, high blood pressure—to name a few examples. The effect of drops used merely to dilate the pupils lasts only a matter of hours, and frequently causes little or no blurring of vision.

A second common use of drops is to **relax the focusing muscles** in the eye. This is often necessary to determine the true degree of refractive error that has to be corrected by glasses. Because the focusing muscles in the eye are relaxed by these drops, the eye cannot focus and the vision is blurred until the effect of the drops wears off. These drops also cause the pupil to dilate; however, it is not the dilated pupil but the relaxed focusing muscle that causes blurring of vision. The use of these drops is especially important when examining children. When a physician examines a young child with strabismus (crossed eyes), it is essential to use drops that relax the focusing muscles in order to determine what corrective glasses are required.

A third use of drops is to **anesthetize the eye**, to permit the physician to perform certain diagnostic tests without discomfort to the patient. These drops cause little or no blurring of vision. They are required for the all-important testing for glaucoma. Anesthetic drops are also necessary for the relief of pain resulting from injury.

Finally, there are several ways in which drops are used in the **treatment of the eye.** Some drops are used to destroy bacteria, some to relieve inflammation within the eye, others to relieve a bloodshot condition, and still others to make the pupil small in order to lower the pressure within the eye. Drops to dilate the pupil are used in certain diseases to keep the muscles resting while the eye recovers, or to prevent complications which might develop if the muscles controlling the focus and the pupil were not kept at rest.

Of course, all drops are medicine and they can be prescribed only by a physician, who is licensed to practice medicine and surgery, and administered only by him or someone acting on his order. You should never let anyone else put anything in your eye. Sometimes drops are prescribed by your family doctor, to whom you can always turn for advice about your eyes. He or any other Doctor of Medicine can also tell you of a Doctor of Medicine who specializes in the eye—an ophthalmologist.

Whether or not drops of any kind are to be used is a decision for the attending physician. Only the Doctor of Medicine who examines your eyes can say whether drops are needed.

* * *

Why drops? Because they are useful medicines in the modern scientific care of the eyes—as useful in their place as any other drug or instrument that physicians have at hand for the relief of pain and the restoration of health. They are often the key to the prevention of blindness and even the saving of the eye itself.

American Association of Ophthalmology
1100 17TH STREET, N.W. • WASHINGTON, D. C. 20036

Joyce -

Dave Walker has added a sec. to this (Sec. 4) on the last pg. You might want to take a look @ it.

Sloan

Work Order #5987
(for Walker)

Original sponsors: Martin, McKinnon,
Meekins, et al

IN THE HOUSE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

CS FOR HOUSE BILL NO. 79

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - FIRST 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, including proper responses to reactions which may result from topical applications

of drugs to the eye.

(b) No person practicing optometry may administer drugs except for recognition of pathology and diagnosis of a vision anomaly.

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

* Sec. 3. AS 17.15 is amended by adding a new section to Article 1 to read:

Sec. 17.15.055. SALES TO OPTOMETRISTS. A person licensed to practice optometry under AS 08.72 who has been authorized by the Board of Examiners in Optometry to use topically applied drugs under AS 08.72.305 may purchase topical anesthetics, mydriatics, miotics and cycloplegics.

* Sec. 4. AS 08.80.260(7) is amended to read:

(7) conviction of selling federal legend drugs without prescription of a licensed physician, surgeon, dentist, optometrist, or veterinarian;

REPORT TO THE CONGRESS: REIMBURSEMENT UNDER PART B OF MEDICARE FOR CERTAIN SERVICES PROVIDED BY OPTOMETRISTS

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE • Public Health Service • Health Resources Administration

The Bureau of Health Manpower projects the overall number of active ophthalmologists in the United States to rise to 13,300 in 1980 and to 18,400 by 1990; this compares with projected levels of 22,000 and 28,200 for optometrists in the same time intervals. The proportion of ophthalmologists as a percent of total professional vision care manpower is projected to grow from 35 percent in 1973 to 38 percent in 1980 and 39 percent in 1990. These estimates should be interpreted cautiously, and should be undertaken in the context of written documentation available from the Bureau of Health Manpower. Available data preclude such projections on a detailed geographic basis.

More specific data indicates that in recent years many areas of the country, particularly non-metropolitan areas, are served only by optometrists. Approximately 40 percent of counties have an optometrist but no ophthalmol gist. Another 27 percent have neither.

Optometric Practice

The Institute of Medicine of the National Academy of Sciences, in describing primary health professions who are direct providers of patient care, defined optometry as follows: "The Doctor of Optometry (O.D.) is a health professional who performs eye examinations to determine the presence of visual, muscular, or neurological abnormalities, and prescribes lenses, other optical aids, or therapy, such as eye exercises to enable maximum vision. Optometrists are trained to recognize disease conditions of the eye and ocular manifestations of other diseases, and to refer patients with these conditions to the appropriate health professional."

This definition, as well as available documentation on the utilization of optometric services, points to the optometrist's role as a provider of primary health care services. In this role, the optometrist functions as a principal point of contact within the health care system for persons having visual complaints, including certain numbers who have symptoms or conditions that require referral to other health practitioners.

The scope of practice for optometry, similar to that for other health care providers, is difficult to define precisely. However, information is available from a number of sources to develop valid concepts of a profession's role and function. Such sources include State laws, judgments of courts concerning the responsibilities of practitioners, the usual and customary practices of the profession, and the objectives, content, and standards of education and training for the profession.

An examination of a variety of such sources suggests that optometry is a profession qualified to provide a broad range of services which are effective in patient management, including the management of aphakic and cataract patients. (See discussion in Part II of this report for detail on sources cited and information examined.) It is reasonable to infer that such services correspond to many specific

HB79

ATTACHMENT B

BASIC ELEMENTS OF THE CURRICULUM OF SCHOOLS OF OPTOMETRY

1. Biological science knowledge base.

   a. Gross human anatomy and microscopic anatomy, with emphasis on head, neck, and thorax.

   b. Embryology, gross and microscopic anatomy of the human nervous system - concentrating on the central nervous system.

   c. General human physiology, including the study of the fundamental organ systems and the mechanisms which regulate body function. Emphasis is on the sensory, motor and cardiovascular systems.

   d. Basic concepts of general and cellular biochemistry, with study of nomenclature, structure and reactions of organic molecules. Emphasis is on the visual system - tears, intraocular fluids, lens, retinal photochemistry, and actions of drugs upon these.

   e. Concepts of human genetics and genetic disorders, including the frequency and distribution of genetic disease, inheritance patterns, polygenic inheritance, chromosomal abberration syndromes, multifactorial genetics, and principles of genetic counseling.

   f. Gross and microscopic anatomy of the lids, orbit, orbital content, globe, muscles, nerves, and vessels, and embryology of the eye.

   g. Vegetative physiology of the eye, extraocular and intraocular fluids, corneal and lens metabolism, ocular circulation, retina and optic nerve metabolism.

   h. General pharmacological principles, methods of administration, various systemic drugs and their pharmacological action and side effects with emphasis on those that affect the visual system, such as cataractogenic and glaucoma-producing drugs.

   i. Pharmacology; uses, doses, contraindications, and adverse effect of drugs producing miosis, mydriasis, cycloplegia, accommodation, and ocular anesthesia. The pharmacology, use contraindications, and adverse effect of drugs commonly used in treating visual and ocular problems.

HB79

As is evident from the discussion above, the Department endorses the first recommendation. For reasons cited, however, Department endorsement of the second recommendation is viewed as inappropriate and premature at this time.

During the course of the study effort, a number of additional issues and concerns were identified by the expert consultants which, although important considerations, represent matters not directly responsive to the specific legislative charge as interpreted by the Department. These recommendations and comments, made unanimously by the consultants, are presented here to provide an opportunity to bring these matters to the attention of Department Agencies and the Congress. Because the following items go beyond the requirement of this report, the Department has not fully examined them and makes no recommendation at this time.

1. Refractive services for aphakic patients

Aphakic patients, specifically, should be considered as having special needs given their disabled condition. Refractive services for such patients represent non-routine and necessary services in the provision of prosthetic devices, i.e., lenses.

Study advisors recommend that consideration be given to extending coverage under Part B of Medicare to include refractive services for aphakic patients when provided by either ophthalmologists or optometrists.

2. Low vision services and aids

For those patients who have inoperable cataracts or have less than optimal results from cataract surgery, that is, those who have reduced visual acuity, low vision services and aids represent essential components of reasonable and necessary health care services for these patients.

Study advisors recommend that coverage under Part B of Medicare be extended to include the provision of appropriate low vision services and optical aids for the above-referenced patients, when provided by either ophthalmologists or optometrists.

3. Prevention, health maintenance, and health education

In the interests of health care cost advantages, effects on productivity, and the overall improvement of benefits that can be afforded our population, the expert consultants recommend that a more effective effort be made to improve preventive, health maintenance, and health education measures. While this is needed in all areas of health services, the vision/eye care field offers a particularly promising area for such approaches.

4. Other service provided by optometrists

Vision/eye care services currently covered by Part B of Medicare, when provided by ophthalmologists or other physicians, include eye conditions other than cataract and aphakia. Optometrists can provide appropriate services for some of these conditions. It is recommended that extension of reimbursement to include the services of optometrists for such appropriate conditions is a desirable subject for further consideration.

5. Administrative considerations

Also during the course of the study effort, expert advisors raised several concerns pertinent to the administration of the Medicare program. These issues, also applicable to other Medicare services, include the following: (a) inconsistent application of coverage and reimbursement policies by individual carriers, (b) the problem of payment duplication for services and reimbursement for similar diagnostic procedures when performed for specific individuals by more than one provider, and (c) need of improvement in coding and billing procedures for vision/eye care services.

6. Cooperative working relationships between vision/eye care professionals

It became clear during the course of this study that more effective working relationships between optometry and ophthalmology and other providers in the vision/eye care field would enhance patient care and result in improved services to individual patients. While improved interdisciplinary coordination applies to all the health disciplines and specialties, it is a problem of particular concern in the vision/eye care field. Such working relationships could be significantly strengthened by

a. Development of joint educational programs at the undergraduate and graduate levels, including rounds, clinics, conference, and meetings and publications.

b. Establishment of interdisciplinary clinics with optometrists and ophthalmologists working together.

c. Facilitation of referral of patients between the optometrist and the ophthalmologist when in the best interest of the patient.

d. Joint development of quality standards for service and materials by peer review mechanisms. By materials, particular reference should be assigned to varying quality of lenses and frames and the need for furnishing laboratory invoices of material costs for reimbursement.

e. Joint development of appropriate revision to State [illegible] laws to permit use of diagnostic drugs, [illegible] and local anesthetics by optometrists

While such [illegible] are evident in various areas of the country, they need to be broadened and reinforced.

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

March 13, 1979

Ms. Maureen Roche
3311 Eureka Street #3
Anchorage, Alaska 99503

Dear Ms. Roche:

Thank you for your recent letter regarding HB-79, "An Act relating to the practice of optometry."

This bill did pass the House last year as HB-664 but was held up in Senate Rules. This year, the House Health, Education and Social Services Committee has held three hearings on the bill so far. We've heard testimony from both Optometrists and Optomologists and have had work sessions on the bill. We do plan to hold at least one more hearing on HB-79, which will probably be another work session to mark up the bill.

So, at this time, we are still giving consideration to HB-79, hence, your letter of suggestions will help.

I do appreciate your taking the time to write to me to express your feelings on this bill. I will keep your suggestions in mind when I make my vote.

Sincerely yours,

THELMA BUCHHOLDT
Chairman
house HESS Committee

TB/ch

3311 EUREKA St.#3
Anchorage, Ak.99503
March 3,1979

Dear Ms. Bucholdt,

It is my understanding that House Bill 79 is under view by your committee in the eleventh legislature-first session. If at all possible I would appreciate being informed as to the status of this "act relating to the practice of optometry".

My interest in this matter takes on a fervent stance due to the fact that I have been directly involved in the delivery of eye care services to to those recipients in the Bering Straits Region. In light of this Ifeel obligated as well as deeply concerned with this notion of introducing Sec.08.72.305 to the enactment of the legislature.

I need not inform you that we both share a vested interest in this matter since we are potential candidates of optometric services; let alone the populus that this bill will effect if passed.

This missive serves you in a genuine tone of concern since Alaska now is beseiged by the "drug bill", SEC. 08.72.305. Pursuant to this is the idea that health care, specifically, the medical health eye care aspect should be viewed under a microscope for what is to be understood as a redefinition of the scope of the optometrist. Or, if you would , a broadening of the defined scope of the optometrist. To wit... allowing the utilization of pharmaceutical agents (drugs). I beseechingly ask that you read the following paragraphs for the sole purpose of another outlook from a concern citizen, not to mention for the sake of the public whom you represent in this permissive matter of eye care.

The decision that confronts the legislative body is a precarious one. Due to the fact that a question mustbe brought forth & posed , what constitutes the optometrists in this state to utilize drugs in their non-medical profession.

An apparent exigency is prevalent to bring to attention the delination between the non-medical profession (optometrists-O.D.) & the medical profession, (ophthalmologists-M.D.). Both are distinguished in their own right & certainly are awarded the recognition & respect from our society. However the oohthalmologist has gone through an intense array of medical education & training for his endavour of the total encompassing diagnosis, treatment, & care of the eye. The optometrist need only attend a few years of schooling for gainful knowledge of a cognizance of an optical deficiency correctable as he sees it by administering & prescribing lenses &/or prisms. Hencefore, the medical profession is more adequately & better prepared for the entire entity of tending to the eye than the optometrist, merely by training & education. Be it stated here that the above mentionned was not meant in a derogatory fashion nor a demeaning one towards the optometric profession.

In conjunction with this is the question posed , why would a non-medical profession such as optometry effaciously invade the medical profession in medicine. Both are sciences,but, both are concerned with different concentrations intrinsically related to their science. Optometry was established with the initial purpose as a profession to aid in "vision improvement" acting as a liason for the ophthalmologists.

At this propitious time of concern with rising health care at an annual rate of 12% & an approaching make-up of 10% of the GNP the non-medical profession of optometry has sought an entrance into & engagement in being a medical provider of health care delivery by the pursuit of practicing ophthalmology .I can only surmise this from reflecting observations of the events & recent developments between these two professions & what is taking place in the state house / senate in Alaska.

This issue becomes sensitive not only for the reason that the eye as an organ is one of mans' most cherished & most relied upon senses but primarily how Alaska will handle, cope, & decide upon what constitutes the profession of optometry to utilize drugs in their profession. Advertently, how health care will be delivered to its constituents. All legislative powers are in throes of controlling this predicament. However, I fail to see how amending this bill will alleviate & eliminate the cost of medical care, let alone upgrade & enhance the quality of medical health eye care.

As with any service rendered in our society one seeks the quality of service for the least amount of cost to them. The same holds true in medicine. I believe as you might concur that a patient seeks a physician eye doctor for his knowledge, skill, ability,talent in his area of medicine with a degree of trust for all intents & purposes of effaciously being relieved of whatever objective &/or subjective sign &/or sympton that the individual had to seek the M.D. in the first place. For you to fully understand the topic in deliberation, this missive necessiates that you be privy to the condition of glaucoma. The example to be cited is stated in order to stress the full impact & seriousness of Sec. 08.72.305

Pertinent to this is the prevailing factor that Alaska is different than the other states that have considered the "drug bill" in regards to its recipients of eye care health services. For the Alaskan Natives are predisposed to the condition of glaucoma, particularly of the four types, narrow angle glaucoma This is due to their anatomical trait of a shallow anterior chamber.

I ask that you bear with me in a basic description of the eye & vocabulary related to it.

Affecting 1 out of every 100 people over 40 & being the second leading cause of blindness in the U.S.:glaucoma is an afflicting disorder. There exists within the eye an intricate drainage system, so established that the aqueous humor (fluid which aids in maintaining the shape of the eye & its nourishment for it) continuously leaves the eye through the drainage network. In the case of an individual afflicted with glaucoma the exit route is complicated.Basically, a squelching effect of that which is a composite of the angle of drainage in the anterior chamber of the eye becomes narrow,or more fluid is produced than what is considered the normal. Hence, the subsequent build-up of pressure within the eye. IT IS THIS intraocular pressure that jeopardizes the sight of an individual. For glaucoma is that injurious increase of pressure within the eye pressing on the optic nerve. The optic nerve being the running umbilical cord to the brain for the interpretation of vision. If you will, it is the M.D.'s insight & his ability to detect this disorder that is quite significant , whether or not the individual will maintain good vision. For this is an eye condition that is not curable, solely controllable with medication &/or surgery.

Narrow angle glaucoma may be precipitated when the pupil (black portion of the eye) dilates (enlarges) as it encounters darkness or after the administration of mydriatics (dilating drugs).

The latter precipitory factor arises when a doctor utilizes one of many mydriatic drugs during the course of an eye exam , fundus exam (viewing the posterior portion within the eye) & for evaluating refractive errors. (Sec. 08.72.305 2,c) Mydriatics facilitate examinations of that already mentionned.

A patient with an underlying condition of narrow angle glaucoma may be subjected to medication by the attending physician whether it be for any one of the mentionned eye examinations. In view of this, induced is the incidence of an attack of acute narrow angle glaucoma.. WHY? The iris, (colored portion of the eye) had been induced to dilate by the administered drug. Consequently, this inhibits the muscle to constrict therefore closing off the escape route for the aqueous fluid. What now ocurrs is excruciating & intense pain due to the escalating intraocular pressure upon the optic nerve. If not quickly tended to with the attention of rectifying the precarious situation by a counter effect of medication whether this be administered orally, or intravenously irreversible damage will ensue.

Obviously, at this point & time the reflexive resposes of the attending eye examiner is weighted with responsibilities of anothers vision AS you & your committee are weighted with the responsibility of answering what constitutes the optometrists in this state to utilize drugs in their non-medical profession. My faith lies herein with your time & consideration of Sec. 08.72.305.

Sincerely,

Maureen Rock

Peter E. Cannava, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669
TELEPHONE 262-4462

March 15, 1979

Representative Thelma Bucholdt
Pouch V.
Juneau, Alaska 99811

RE: HB79

Dear Mrs. Bucholdt;

Many legislators have asked about the harm which can come to Alaskans as a result of HB 79 (optometric drug bill). In addition to the Fairbanks case which you are well aware, please see the enclosed list of patients across the country whom have suffered as a result of optometrists attempting to practice medicine. A study of the individual cases is educational and provocative.

Sincerely,

Peter E. Cannava, M.D.

ENC;PEN

PEC/bc

PUBLIC DANGER DOCUMENTED

SPECIAL SUPPLEMENT

ANNUAL REVIEW OF SELECTED CASE HISTORIES

As published in THE PEN...— during 1977-78

TUMOR OVERLOOKED

Mrs. Lois McWalters

•

Massachusetts Widow

Vol. 1, No. 1, July 15, 1977

The first issue of THE PEN featured a tragic testimonial headlined "Massachusetts Widow: 'It Seems Bizarre.'" Excerpts follow:

Five years ago my husband began complaining about his eyesight. He decided to see an optometrist and he continued to do so for 2½ months. As his vision deteriorated at this time, he experienced headaches so violent they would awaken him from a sound sleep. I pleaded with him to see an ophthalmologist or some person with a medical background. He became increasingly irritated at my suggestions and I was forced to bow to his decision or submit to an unhappy home life.

As each day passed, before my eyes his personality changed; this sweet gentle man became verbally abusive and the general tenor of our home was unbearable. At that time our four children were 6, 7, 8, and 9 years old. They watched their father hold a cup of coffee, his hand tremors so pronounced he would spill it and leave the table in a terrible rage.

I pleaded again, to no avail. How does a wife forcibly take a grown man to a doctor? He *trusted*

SPECIAL ANNUAL PERSONAL EXPERIENCE REVIEW ISSUE

During its first year, THE PEN has published numerous carefully documented cases of eye damage resulting from attempts by non-medical practitioners to practice medicine. These four pages are a collection of selected excerpts of those cases which have prompted expressions of maximum interest from readers.

While there has been no official response or challenge from organized optometry, individual optometric lobbyists have advised legislators that these cases are "isolated instances." The steady flow of similar testimony pouring into PEN headquarters prompts us to suggest that the cases are not "isolated," but rather "the tip of an iceberg."

The Editors

OPTOM-PSYCHIATRY

Barbara Cosgrove

•

"Lack of Love"

Vol. 2, No. 3, Feb. 1, 1978

A Connecticut woman, interviewed by Jeffrey Gold, M.D. of New Haven, told how an optometrist

DANGER AND WASTE IN THE VA

Robert B. Nolan

•

Disabled Veteran

Vol. 2, No. 8, April 15, 1978
Vol. 2, No. 11, June 1, 1978

In these issues, a totally and permanently disabled veteran told how he got less than the deserved in-depth investigation into the problem of allowing VA optometrists medical functions. Mr. Nolan again found more evidence of danger and waste in the VA. Excerpts from the first story follows:

". . . The VA would not permit me to receive outpatient treatment from a private physician unless I lived 30 to 50 miles from a VA treatment center. I didn't, so I decided to pay for my own doctor and then go to the VA and see their M.D. for medication only.

"My wife called the VA in the federal building in downtown St. Petersburg for an appointment early in August of 1977. She told the girl on the phone that I needed an eye doctor because I had glaucoma.

"My first visit to the VA eye 'doctor' was August 22, 1977. I presumed that the doctor I saw was an M.D. ophthalmologist. His name was on the door and it said 'doctor.' . . .

"The 'doctor' finally tested my tension with a hand tonometer after the [illegible]

the optometrist. The optometrist changed his glasses three times - each prescription being for stronger lenses - during those 2½ months. Each time his eyesight and the pain was not even slightly improved by the change of glasses. He was told it would take time to get used to them. The optometrist never suggested he see a medical person.

His suffering increased to such a point he could not work or concentrate. I suggested a vacation and he agreed. . . . He now had a black patch over one eye "to rest it" prescribed by the optometrist.

I was frightened; I felt he was dying and I was helpless. After a few days of rest I gently broached the subject again and very unlike me, burst into tears. . . .

Our vacation was cut short because he was so ill. He insisted upon going to work when we got home, but surprised me by phoning from the hospital. He had seen an ophthalmologist who immediately spotted the problem and within minutes called in a neurosurgeon. The neurosurgeon admitted him to the hospital at once. I discovered later that when the ophthalmologist's *secretary* heard the symptoms over the telephone, she had insisted Dick come to the office immediately.

The neurosurgeon told me frankly he felt that Dick had a brain tumor. At our community hospital, tests were done in the next few days; the consensus was a brain tumor.

Surgery was at nine. . . .

Bad news it was, a malignant brain tumor called an astrocytoma. "I would give him about eighteen months," the doctor said, "but be prepared for some horrible times ahead." Twelve days later God mercifully took his beautiful soul and left his tired, worn body. . . .

In retrospect, it seems bizarre to me that when one (in this case the optometrist) realizes a situation is out of his control, that he wouldn't immediately make a referral, especially when seeing a patient suffer so much. ●

claimed her child's blurred vision could be cured with "more love and understanding at home" in a story headlined "O.D. Calls Diabetes A 'Lack of L. c'." Passages of that interview follow:

Dr. Gold: "Mrs. Cosgrove, why did you bring Barbara to me?"

Mrs. Cosgrove: "We were referred here by our family doctor who just found diabetes in Barbara. She is 11 years old. I told him I had just had her eyes checked by an optometrist."

Dr. Gold: "Do you mean Barbara was examined by an optometrist lately?"

Mrs. Cosgrove: "Yes, she failed the school vision test in November and they said to have an examination. He (the optometrist) has a great big sign out in front, that says 'Doctor,' and I thought he was one."

Dr. Gold: "What did he find?"

Mrs. Cosgrove: "He said there was nothing wrong with her eyes and when I asked him why she kept getting blurred vision, he told me that she was a nervous child and when she gets up-tight, her eyes get blurry. My reaction was to take her to a social worker, but he (the optometrist) told me she just needs more love and understanding at home and that there was no reason to do any more than see him again next year."

Dr. Gold: "Then what happened?"

Mrs. Cosgrove: "I thought I was some kind of a rotten mother with such a nervous child, and I cried that night."

Dr. Gold: "Did you pursue the blurred vision at that time?"

Mrs. Cosgrove: "During December, Barbara seemed to have the flu, but it didn't go away and by Christmas Eve, I real-

Continued on page 6

a hand tonometer after the eye test for glasses and said the pressure was 19 in each eye. I showed him the prescription I had received from Kenneth Safko, M.D., my own ophthalmologist, and he said, 'Wait until I xerox this as it is no good here. I will have to write my own prescription.'

"After copying Dr. Safko's prescription and putting it in my file, he wrote his own prescription and took it next door to get it co-signed. . . .

"On my way to the pharmacy with my wife, she looked at the prescription and said it didn't look right. We took it back and the 'doctor' changed it from pilocarpine to 3/4% carbachol with six refills. Another doctor (probably an M.D.) co-signed the new prescription. . . .

"On our next trip to the VA center, my wife asked the woman at the front desk if the doctor we saw was an M.D. and an ophthalmologist. The woman at the desk replied, 'Yes, he is a full-fledged doctor and an ophthalmologist fully qualified to treat eyes.' . . .

"When I finally got the glasses, sometime in late November or early December of 1977, I discovered I could see much better without them.

"On my next trip to the VA on December 19, 1977, I returned the glasses. The 'doctor' told me the reason the glasses had been so long coming was because he rejected them two or three times, since they were not to his prescription. When he took the glasses to the next office to check them, my wife and I looked at his diploma on the wall. It said 'Doctor of Optometry.' When I told him we thought he was an ophthalmologist, he became very angry and said, 'Do you question my qualifications?' I told him I certainly did question his qualifications to treat glaucoma or any other eye disease. He told me that the people at the front desk didn't know the difference between an ophthalmologist and an optometrist. I said, 'If this is true, what if my eyes need surgery?' He said if that were the case, I would have to go to the Tampa VA Hospital or the Bay Pines VA Hospital and some other doctor would operate. . . .

"Talking to people in the waiting room, we

Continued on page 6

Tragic Case Histories Dramatize The Need To

NETWORK TV WARNING

Totie Fields

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Comedienne

Vol. 1, No. 8, Nov. 1, 1977

The following is a portion of an interview between TV-talk show host Merv Griffin and comedienne Totie Fields, during which she warned all diabetics to seek eye care only from ophthalmologists:

MERV: It was kept very quiet; but all of a sudden, about two months ago we all heard rumors that, now you were losing your eyesight from the diabetes.

TOTIE: It's true, it's true! — and you know why I want to talk about it?

MERV: Blue Cross must hate you!

TOTIE: They have lost so much money on me.

MERV: Have they?

TOTIE: Yeah, but you want to know? I didn't know it, Merv, I swear to you I saw 20/20! . . . this is what I want to make a point of, I went to an optometrist all the time and he said, "Totie you're doing wonderfully, everything is fine," . . . I've been a diabetic since I was nineteen years old, and you know how I watch myself; I weighed 200 pounds; all I ever thought about was eating. I swear to God they told me I couldn't eat and that was the end of it!!! I mean, I just ate myself into oblivion! I used to do a show and in the I did "Fight for Sight" — the benefit "Fight for Sight" for about five, six years in a row and that's the money that helped this whole thing! (applause) To get this discovery! Isn't that incredible? (applause) And you won't believe how I can see every wrinkle in your face, Merv, every wrinkle in your face, I never could see them before . . . ●

GLAUCOMA UNDETECTED

Mrs. Agnes Karrman

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Connecticut Housewife

Vol. 1, No. 5, Sept. 15, 1977

Appearing in this issue of THE PEN under the headline "Conn. O.D. Tells Housewife: 'You Don't Have Glaucoma'," a Conn. woman told of an optometrist who failed to recognize her glaucoma. Excerpts follow:

"I was a nervous wreck before I visited the ophthalmologist that day in October, 1975, and then the bottom had just dropped out of everything. My fears had been justified because the ophthalmologist had just told me that I was suffering from far-advanced glaucoma. For some time I had experienced increasing difficulty with my vision. I couldn't read the paper without a magnifying glass. My eyes were constantly watering and sometimes I awakened at night with a headache. I could no longer see well enough to play the piano or organ.

"...Yet, despite these complaints, my optometrist had assured me for over a year there was nothing seriously wrong with my eyes.

meantime, my vision had continued to get worse and I could no longer enjoy any activities that required good eyesight.

"As I said earlier, my first visit to the ophthalmologist was a shocker. It was such a different examination! Not only did the ophthalmologist find that my pressure was higher than normal, he also found that my optic nerves had been severely damaged by this long-standing pressure and that my side vision had been destroyed. I could only see as though I were looking down a gun barrel . . . He discovered that I did have cataracts, but they were only a small part of my eye health care difficulties.

"The ophthalmologist's diagnoses and explanation of the extent of my problems not only added to my nervousness but made me very angry. I was angry with myself for not having listened to my sister's advice months ago to see an ophthalmologist and not an optometrist, and I was plenty angry with the optometrist! The doctor told me that an optometrist is not trained in medicine nor to diagnose or treat eye diseases. How can an optometrist act like an 'eye specialist' and flatly assure people that he is capable of this type of decision making? How can he keep peddling new glasses and sell eyewash types of eyedrops with implied assurance that they can cure? How can he stand by and literally watch one of his long-time customers go blind?" ●

EXTENSIVE EYE DAMAGE

Denton Livensparger

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Double Jeopardy

middle I used to think where could I get a pizza around here; you know I thought of nothing but food, Mallomars if I could only eat a Mallomar! Oreos, you know I was an Oreo freak . . . Oh, I talk about them and my mouth gets filled with saliva!!! I saw a little thing floating in my eye like a little hair, you know, that you couldn't get rid of and so I went to an ophthalmologist. Diabetics should never go to an optometrist, they must go to ophthalmologists because they see behind the eye. He said, "Totie, you've got to go . . . the best man in the country is in San Francisco and you must get to him right away." The next morning I was there and this man was telling me I was going blind, and I said, "You're crazy! Why didn't anybody else . . ." Well, they were so busy worrying about everything else, no one thought of my eyes, and I've never (incidentally, no one's ever heard this story before) — Well, to make a long story longer . . . yeah! I want, because I really want diabetics to be so aware because this operation is only two years old, Merv, and ironically enough, my dad died blind, my brother died blind, and I would have. . . .

One day you get to that age where all the print is gone and the paper comes and you say why did they send me a white paper (laughter) — you know, and you'd go to the toilet and drop it on the floor and read it there (laughter) . . . you know what I mean. But, I can read proof! I mean, to open a menu and be able to see it without looking for my glasses is the most exciting thing, but I want you to know, everybody out there that is a diabetic, please, please go to an ophthalmologist . . . because you can be saved! You know the ironic part of this entire story,

"I had been going to an optometrist regularly for about seventeen years — ever since he had opened his office. He was always pleasant and the glasses he fitted for me were generally satisfactory. In 1974 I went to him complaining of blurred vision. He gave me new glasses but they didn't help. I went back to him and he told me that they were the right glasses and that I just hadn't allowed enough time to get used to them. I told him that I was worried about glaucoma because my brother had had surgery for glaucoma and is almost blind, and my sister was being treated for glaucoma by an ophthalmologist. She is doing well because her problem was discovered early. The optometrist assured me that he had checked for glaucoma and that I didn't have it.

"Several months later, because of increasing trouble with my vision, I returned to the optometrist . . . He again changed my glasses. At that visit I again voiced my fear of glaucoma and once again he assured me that my eye pressure was normal and that I didn't have glaucoma. He said my eyes were just tired. Well, the new glasses didn't help at all. They seemed to be no different than the previous pair he sold me . . .

". . . After another month and a half had passed I returned to the optometrist because my eyes pained at times and I often awoke at night with headaches. My vision was getting worse and my eyes watered constantly. This time I really pressed about my fear of glaucoma. He re-examined me and again sold me a pair of glasses — the third pair in less than a year! He told me that his $3,000 special instrument measured accurately for glaucoma and that a referral to an ophthalmologist was not necessary. In fact, he told me that I had nothing to worry about, that my eyes were perfectly clear. He said, *'You don't have glaucoma and you don't have cataracts.'* He gave me some eye drops to use three or four times a day. I used them regularly for the next four months until my sister finally persuaded me to see her ophthalmologist. In the

Vol. 2, No. 7, April 1, 1978

In a story headlined "Misuse of Drugs Plus Misdiagnosis Puts Floridian In Double Jeopardy," a Florida ophthalmologist told of how an optometrist missed signs of glaucoma and serious corneal abrasions requiring surgery in both eyes of a male patient. Excerpts follow:

"Misdiagnosis combined with the misuse of powerful drugs by untrained practitioners poses a frightening threat to public health and places our citizens in double jeopardy," says John D. Mallonee, M.D., a practicing ophthalmologist in Ft. Pierce, Florida. "The advanced years of many of our patients makes this menace even more serious and the public must be made aware of this grave danger," Dr. Mallonee said.

In support of his forthright statement, Dr. Mallonee detailed the following case history.

"On February 4, 1978, I first saw Denton Livensparger. This 65-year-old man came to my office of his own volition, and without referral. He told me he lived at 1196 Proctor Lane in Port St. Lucie, Florida, a nearby retirement community, and had been suffering severe pain in both eyes for some time. Mr. Livensparger voluntarily gave the following account of his experience to date."

"In early November 1977, I think it was the 8th," the patient said, "I went to see an optometrist about the pain I had in both eyes . . . I told them that for a long time, maybe nine or ten months, I felt as though I had something in both of my eyes, and that the pain was just getting worse all the time. After they examined me, they told me all I had was an eyelid infection and they gave me some antibiotic drops called Neodecadron. I went back again the next day and they told me I didn't have glaucoma, and all that was the matter with me was a minor eyelid infection that would clear up if I used the drops."

Continued on page 6

Protect The Public From Sub-Standard Eye Care

GLAUCOMA UNNOTICED

Mrs. Florence Hubbard

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Blinded High School Student

Vol. 1, No. 2, Aug. 1, 1977

The following excerpts are from a byline story by a Massachusetts student headlined "'They Call Themselves Doctors' - . . Blinded High School Student," in which she told how an optometrist could not recognize advanced glaucoma.

"In August 1967 I was walking home from a friend's house when I knocked over a trash can because I didn't see it. A couple of days later I noticed that things looked blurry. I couldn't read signs or make out faces and when I looked at lights, there was a rainbow around them.

"I went to an optometrist in September and told him about all of this and that I had a throbbing pain in my eyes. My left eye was worse than my right eye. The optometrist asked me to read his eye chart but I couldn't see where it was. He examined my eyes and told me not to worry, he could help me. He said I had a lazy left eye and astigmatism, and he had just the cure for me — he was going to prescribe some glasses.

"Before the glasses were ready, the pain got much worse and my eyesight got more and more blurry. However, I trusted the doctor. I figured you go to a doctor and he knows how to treat you. I had always thought optometrists were doctors. They call themselves doctor.

"When I went in to get my glasses in October, I told him that my vision was much worse and he

Similar heartbreaking circumstances have accompanied many of the cases in PEN's growing file. Here's a random sampling.

● From the Wills Eye Hospital, a division of the Thomas Jefferson Medical School in Pennsylvania, - when a female patient complained of pain in the eye, an optometrist gave her an anesthetic drop to use. Later, he refused to see her. She developed a pseudomonas ulcer (infection) and the eye had to be removed.

● Also from Wills, a female patient told an optometrist that for seven years she had episodes of blurred vision brought on by reading. They usually lasted about an hour and when severe were associated with headaches. She was followed by an internationally famous optometrist throughout the seven years and was reassured nothing was wrong. Later, an M.D. found textbook symptomatology of chronic angle-closure glaucoma and advised immediate surgery on both eyes.

GOING BLIND

Mrs. Anita Oliver

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Baltimore Cook

Vol. 1, No. 10, Dec. 1, 1977

The following passages are from an interview between a blinded Baltimore cook and ophthalmologun

LED TO BLINDNESS

Charles B. Wilson

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Arizona Steelworker

Vol. 1, No. 10, Dec. 1, 1977

The following are excerpts from the story of an Arizona man headlined "Arizona Steelworker 'Led To Blindness'," in which he told how an optometrist informed him he would eventually go blind, but gave no reason, and his misadventures with more optometrists:

"When I first thought I needed glasses 25 years ago, there was only one place to go in my home town in Ohio — and that was to an optometrist. He had the whole works — he gave examinations and sold glasses.

"He checked me one time, gave me glasses and then he said, 'In about 20 years, you're going to think you're going blind.'

"I asked him why, but he wouldn't give me a definite answer. He just said, 'Well, your eyes are going to change that much and you're going to think you're going blind.' To this day, I still don't know what he was talking about.

"I just figured it was my nearsightedness or the opposite, whatever that was. I wasn't bothered with anything until I came out here 17 years ago.

"I worked in a steel mill and once my glasses got all burned up in there, so I went to an optometrist in Mesa.

"He just checked my eyes like everyone else does. I got a new pair of glasses there.

"In the meantime, the Union got into the plan

got out the glasses and said, 'These should take care of you.'

"I went home with the glasses but they weren't helping. I was banging into desks at school, I kept banging into people, I couldn't see the blackboard. I must have called the optometrist about 10 times and he kept telling me I would be all right, that I was getting too worked up and making myself not see.

"When my mother and I went to see him the next day, my mother said he looked a little worried. He told us that I lacked something in my body, that I had a deficiency, and he would make an appointment for me with an ophthalmologist but not until after Christmas. He said I should go home and have a nice Christmas.

"When my mother and I went to the ophthalmologist on December 27, it was the first time I heard the word 'glaucoma.' He said I had all the classic signs.

"The ophthalmologist found that I had a pressure of 95 in both eyes — normal is 20, and total blindness is 100, he said.

"In April the pressure in my eyes went up again and this time the ophthalmologist thought it would be necessary to operate. By now my parents were so upset they had decided that they should be extra careful and get another opinion and I should go to Massachusetts Eye and Ear Infirmary. I did and it was decided I should have surgery on both eyes, to save what little sight I had left. I've lost 99 percent in my left eye and I have only the very center of the vision in my right eye — I can only see things that are straight ahead.

"After I got out of the hospital and began to feel better, my little eight-year-old cousin began to take me all around Gloucester by the hand so I could learn my way around. I still don't like going to new places and there are some things I can't do for myself. Once I set myself on fire trying to reach something over the gas stove and I didn't even know it. I was lucky my husband was home and saw it." ●

resident Larry Thompson, M.D. In a story headlined "Mrs. Oliver: 'I Told Him These Are My Eyes'," she told how a vision-center optometrist became annoyed when she told him the glasses he prescribed did not work:

Mrs. Oliver: "I came to University Hospital because I was getting this blindness, and I couldn't see. I was at church on the fourth Sunday in July, and I fell down those steps."

• • •

Dr. T: "You were seen for your eyes before coming here — when, back in February of 1977?"

Mrs. O: "Yes, it was February."

Dr. T: "And you were seen at - - - - Vision Center?" (an enterprise which employs optometrists, but has no medical personnel.)

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Mrs. O: "Yes, I was there for glasses. They examined me but they didn't tell me anything. I asked the doctor why I couldn't see. The doctor got angry with me when I said I could not see out of my left eye like I should. I was trying to read the board, the letters and the numbers. And when he put the glass to my eye, I couldn't see and I told him that I couldn't see. He got very, very angry. He told me that he was doing the examination, not me. *I told him that these were my eyes and I should know whether I could see or whether I couldn't.*"

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Dr. T: "OK, he prescribed new glasses for you at that time. After you got those glasses, you could not see with those glasses, is that correct?"

Mrs. O: "Yes. I went back to them again and had that left lens changed. It was supposed to have been changed."

Dr. T: "Did they ever measure the pressure in your eye, touch your eye with anything to measure the pressure?"

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Dr. T: "Did they ever measure the pressure in your eye, touch your eye with anything to measure the pressure?"

Continued on page 6

and the company had to furnish eyeglasses. So, another optometrist in Tempe gave me a cut-rate price for an eye examination, since I was an employee. It was a ridiculously low price. After that exam, I went to that optometrist all the time, about every two years. I went through this same routine for about 10 years.

"I started noticing that I was stumbling a lot out at the steel mill. I was falling and tripping over things, which I don't ordinarily do, I tried to get an appointment with the optometrist, but most of them in town were at a convention. I finally found one to examine my eyes.

"He examined me and said he saw something in one eye, but he admitted that he didn't know what it was. He recommended that I see an ophthalmologist.

(At this point, Mr. Wilson was asked whether or not the optometrist who checked him every two years for a decade ever checked anything besides his vision, such as his eye pressure.)

"No, sir, he never did anything like that. I figured I was getting a complete eye exam, like I'd had all of my life. He was called a doctor, and to me an eye doctor was an eye doctor.

"An ophthalmologist was just a long word as far as I was concerned! I'd never been around one, and where we came from there wasn't any. This last optometrist I asked point blank what was in my eye and he said he did not know and that he recommended my coming to see one of you fellas. He said you would have to 'lift the pupil up and look behind it and see what was in that eye.'...

"Well, here I am. I was legally blind. Now I've had surgery to save what vision I had left, but I'm still in bad shape. I believe this other guy that I went to should have seen something and checked it. But I didn't know he should have looked into my eyes with all those lights and stuff that he didn't do it. He never gave me a pressure check or anything like that.

"So now I'm disabled. I was led to blindness for 25 years." ●

OPTOM-PSYCHIATRY

Continued from page 3

ized that she had lost her appetite and was losing weight; also she was always thirsty and urinating excessively, so I took her to our family doctor."

Dr. Gold: "What did he find?"

Mrs. Cosgrove: "He found diabetes. Her sugar was 790!" *(Normal is around 100)*

Dr. Gold: "Did the optometrist ever mention to you the possibility that variably blurred vision could be a sign of diabetes?"

Mrs. Cosgrove: "No, never. I don't think he should be allowed to be out there, on the street, calling himself a doctor! He doesn't know anything about disease. Why is he there? What's wrong?"

Dr. Gold: "Mrs. Cosgrove, do you give us your permission to publicize the danger to people inherent in Barbara's story?"

Mrs. Cosgrove: "Yes, I do."

Dr. Gold: "Thank you very much." ●

NEW YORK SPECIAL REPORT

The following case histories of optometric failure to recognize and refer medical eye patients were collected by Karl J. Marchenese, M.D. of Rochester. All patients except one were personally interviewed by Dr. Marchenese. Except where indicated, the source of information was the patient. All cases came to the attention of Dr. Marchenese within the past 12 months through his practice as an ophthalmology resident. The patients reported in this paper as incidents of failure to recognize or refer medical eye problems, outnumber appropriate referrals to the clinic by four to one.

● A young college student called a local HMO (prepaid health insurance in which the patients have little choice of physician) with complaints of an irritated red eye. He was seen the same

GOING BLIND

Continued from page 5

Mrs. O: "No."

Dr. T: "Did they ever suggest that you see a medical doctor?"

Mrs. O: "No, never."

Dr. T: "Do you feel that poor people — people that haven't had a lot of education — are at a particular disadvantage since they probably do not understand the difference between an optometrist and a medical eye doctor?"

Mrs. O: "I sure do think so. I was getting blind."

Dr. T: "Do you realize that you would have been totally blind in another couple of months if you had not come down here?"

Mrs. O: "I sure do." ●

EXTENSIVE EYE DAMAGE

Continued from page 4

Mr. Livensparger continued, "I took the drops just like they told me, but my eyes got even worse and I went back to see them on November 14. They told me just what they said before, that I had an eyelid infection that would go away if I kept taking the drops, even though I told them my eyes felt worse, not better. I continued using the medicine they gave me but it didn't help at all and I went back again to see them (the optometrists) on January 10th of this year.

"Again, they examined my eyes. They didn't mention glaucoma or pressure — just looked into my eyes with a light. They told me the medicine I was using wasn't doing the job and gave me something called Vasocidin. I used the new drops for about eight days and my eyes only got worse, so I went back again on the 18th of January. They said just keep using the new stuff and your infection will go away.

"Since I was getting worse all the time and the medicine wasn't helping, I thought I should see somebody else," Mr. Livensparger concluded.

"When I talked to Mr. Livensparger on Feb. 4," Dr. Mallonee said, "he told me, 'I have continuous pain in both of my eyes. I can't stand the light, and keep my eyes closed most of the time.

DANGER AND WASTE

Continued from page 3

found many had gotten the wrong glasses. One man didn't get bifocals and he had used them all of his life. This whole farce left me with little faith in the VA health care system. . . .

"On February 27, 1978, I returned to the VA and asked to see the M.D. I had seen on my last visit. I was told that he had retired, so they sent me to another M.D. This doctor assured me that he was an M.D. and an ophthalmologist, and when I told him of my previous experience, he agreed that optometrists should not treat eye disease, but explained that since he was new with the VA, he couldn't change the rules, and he didn't want to 'make waves.' He told me that he also co-signed prescriptions for the optometrists even though he never sees the patients. This doesn't seem right to me . . ." ●

TREATMENT DELAYED

Mrs. Clara Jones

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Writes Iowa Legislature

Vol. 2, No. 2, Jan. 15, 1978

The following excerpts are from a story headlined "Damaged Patient Writes Lawmakers," which carried a letter that an Iowa woman wrote to the entire Iowa Legislature, reminding them that optometrists have no medical training:

"For the last 25 years my family has been going to an optometrist for our eye care needs.

"Some time after the most recent change of lenses, I began experiencing difficulty with my vision. Consequently, I reduced [illegible]

day by an "eye doctor" whom he believed was a physician but was in fact an optometrist. The optometrist diagnosed "iritis" and gave the patient a prescription for two therapeutic eye medications (homatropine and a steroid preparation) which was filled in the HMO pharmacy. The patient reports that the prescription had another physician's signature preprinted on it. The patient was examined only by the optometrist. He was subsequently examined by the optometrist four additional times over a six-month period. The optometric records were obtained and revealed that several therapeutic agents had been prescribed and no mention was made of consultation with or referral to a physician. Ocular examinations and evaluations for systemic disease were inadequate. The optometrist was unsure of the diagnosis, at times referring to "recurrent conjunctivitis" and "episcleritis" as well as iritis. Finally on the last visit the patient was referred to an ophthalmologist.

Comment: The optometrist clearly exceeded the limits of his licensure by attempting to make a medical diagnosis and prescribing therapy. It is illegal for an optometrist to fill in (and for an organization to provide) presigned prescription forms. It is inappropriate for an HMO to use an optometrist to care for patients with acute eye problems.

● A 73-year-old woman with diabetes was followed for 15 years by an optometrist who knew about her disease but referred her for a medical eye evaluation only when cataracts caused a significant deterioration in her vision. The patient had evidence of diabetic retinopathy (blood vessel disease of the back of the eye) which was more difficult to evaluate because of the presence of cataracts.

Comment: All patients with diabetes are at a significant risk of major ocular complications (including total blindness) and should have a medical eye examination at regular intervals. The examination requires special expertise which only the ophthalmologist can provide. Treatment is available for retinopathy at some stages.

because they water when I try to open them. The pain is bad, and I have it all the time.'"

Dr. Mallonee reported that his external examination revealed a very obvious problem. A condition existed whereby the patient's lower lids had turned in, causing the lashes of the lower lids in both eyes to rub against the corneas causing recurrent and chronic corneal abrasions. It was lashes rubbing on the cornea that gave the patient the feeling he had a foreign body in his eyes. He was in so much pain that he kept his eyes closed almost constantly since the abrasions were causing him severe pain.

"I found on further examination that much of the corneal tissue was gone due to the constant irritation," Mallonee said, "I also found early vertical cupping of the optic nerve head — an early sign of glaucoma.

"I recommended immediate surgery on both lower lids to eliminate the severe irritation. This has been done since and the patient is much better at this point in time. I also discontinued the medication prescribed by the optometrists, both of which cause glaucoma in susceptible patients. The eye pressure is now down, verifying that the long use of drugs had contributed to increased pressure. In addition, we performed a complete glaucoma work-up, which was clearly indicated." ●

● A 30-year-old woman was seen six weeks previously at work by an industrial nurse for complaints of a red, irritated eye. She was referred that day to a local HMO where she was seen by an "eye doctor" whom the patient thought was a physician, but was in fact an optometrist. He diagnosed an allergic problem, recommended "Sinutabs," and referred her to an internist in one to two weeks.

Comment: The patient was inappropriately evaluated by an optometrist for an acute eye problem. HMO's should not use optometrists to evaluate patients with acute eye problems without direct physician supervision.

and told him my sight in my right eye was blurred and that something was wrong. After his examination he told me my glasses were correct, the blood vessels were healthy, and further there were no signs of glaucoma or cataracts.

"I still believed that something was wrong in my right eye but believed the doctor must know, so accepted his diagnosis. However, as the difficulty continued and gradually increased, after five months I decided to consult a medical eye specialist. In his preliminary examination he immediately suspected glaucoma which was subsequently verified in both eyes and that the disease had been there for a long time. Also the cataracts are starting. I am informed that a considerable portion of my vision has been lost due to the delay of treatment and cannot be restored, all due to a false sense of security given me by my optometrist.

"My medical doctor tells me that an optometrist is not trained in medicine nor to diagnose eye diseases.

"Because of this lack of training, the optometrist, in my opinion, should be severely penalized when he tries to perform such services which could well end in blindness for his patient.

"I strongly urge you to give this matter your most rigid study and action."

Mrs. Jones later told her ophthalmologist that vision loss was not the only way she suffered due to the optometrist's bold attempts to practice medicine.

"I fell twice," she said, "broke my right arm near the shoulder and the second time my left wrist. I still can't see a step."

Her physician, Leo J. Plummer, M.D., reports that her glaucoma is currently under control, on a program of medications. The Des Moines ophthalmologist notes that dense and extensive visual defects in both eyes are permanent, and that it is necessary for her to learn to walk with her head down to avoid tripping. Dr. Plummer has noted that the drugs Iowa optometrists seek to use are not necessary for the trained physician to suspect, or in most cases, diagnose glaucoma. ●

the University of Alabama in Birmingham / UNIVERSITY STATION / BIRMINGHAM, ALABAMA 35294

the Medical Center / SCHOOL OF OPTOMETRY / February 27, 1979

Representative Thelma Buchholdt
Pouch V
Mail Stop Number 3100
Juneau, Alaska 99811

Dear Representative Buchholdt:

It is my understanding that the Legislature of the State of Alaska is considering legislation (HB 79, SB 75), sponsored by the Alaska Optometric Association, to authorize optometrists to use drugs for diagnostic purposes when qualified by the State Board of Optometry. A graduate of this School of Optometry, Dr. Aharon Sternberg of Anchorage, has written me about this matter and requested that I write you regarding the inaccurate statements contained in the letter from Dr. Sam A. McConkey to you on February 14, 1979.

First, I completely and wholeheartedly support the use of drugs for diagnostic purposes by optometrists. I believe this is in the public interest and an essential tool for the optometrist in the discharge of his moral, ethical and legal responsibilities for the early detection of ocular disease and ocular manifestations of systemic disease. This school has regularly provided, as part of its required curriculum, courses in general and ocular pharmacology for all optometry students from its beginning in 1969, as well as courses in general, systemic and ocular pathology. These courses (pharmacology and pathology) are presented by faculty of the Joint Basic Science Departments of the Medical Center, the School of Medicine and the School of Optometry include lecture, laboratory and clinical instruction.

I am enclosing a copy of our Bulletin for the year in which Dr. Sternberg graduated which is essentially the same as the previous four years. A casual look at the curriculum (pages 41-47, summarized on pages 48-49) and a look at the faculty, (pages 63-66) clearly indicates that Dr. McConkey is in error regarding the education of optometrists. Graduates of this institution have an extensive background in pharmacology and pathology taught by qualified faculty (O.D., M.D., Ph.D.).

This is not an Alaskan problem since optometrists in twenty-two states may now use drugs for diagnostic purposes and other states are seeking the privilege based on their qualifications and the needs of the public. I am sorry that the emotional response of some ophthalmologists leads them to circulating inaccurate information which tends to obscure the public interest.

I hope this information will be of assistance to you in your deliberations on this matter.

Most sincerely,

Henry B. Peters
Dean

Enclosure

cc: Dr. Sternberg

ROBERT N. PAGE, JR., M.D.
JUNEAU MEDICAL CENTER
R.R. 3, BOX 3031
JUNEAU, ALASKA 99801

PRACTICE LIMITED TO THE EYE

February 27, 1979

Honorable Thelma Buchholdt
House of Representative
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

Pending legislation in the form of House Bill No. 79 and Senate Bill No. 75 represents an attempt on the part of optometrists to gain, through legislation, the right to use drugs. This is a right heretofore granted only on the basis of educational qualifications for very sound reasons. Optometry is a measuring science and has no medical background. An optometrist is not clinically trained. They are not qualified by education to diagnose or treat disease.

However, should this legislation pass, the public will be deceived into believing that they are receiving medical evaluation by optometrists, a definite hazard to public safety. Numerous cases substantiate this. The latest case occurred in Alaska (Steele v. United States of America) and is explained by an enclosure.

I hope that you will oppose this legislation which would downgrade the quality of medical care for the people of Alaska by allowing intrusion into the field of medicine by those without medical training or expertise. It is a dangerous precedent. Absolutely no shortage of medical profession talent exists anywhere in Alaska to justify such a compromise of professional standards of care and treatment. The cost of eye examination by optometrists in many cases is higher than that of a physician (ophthalmologist).

I would be happy to discuss with you the particular risks inherent in the use of the various drugs which are indicated in this legislation, since I will be responsible for treating the various drug complications, should they occur in this area.

Also find enclosed the reports of vetoes of similar bills by the governors of Virginia and Ohio. These are well thought out conclusions by men who are only partial to public well-being. Your serious consideration and concern is appreciated.

Sincerely,

Robert N. Page, Jr., M.D.

Enclosures

"M.D. IS THE MAJOR DIFFERENCE"

THE PEN...

PRO BONO PUBLICO

Published in the Public Interest by Ophthalmology

VOL. 3, NO. 2 JANUARY 15, 1979

RHODES OF OHIO: "WE CAN TAKE NO RISKS"

Ohio Governor Vetoes Optometric Drug Law

COLUMBUS, OHIO — On December 15, 1978, Governor James A. Rhodes of Ohio vetoed amended substitute S.B. 163, which would have permitted optometrists in Ohio to use diagnostic drugs. This marks the second time this year that a state governor has rejected optometric drug legislation in order to protect the citizens of his state.

The first veto came in Virginia when Governor John N. Dalton vetoed similar legislation, noting that, "There is reason for grave concern for patients' welfare where optometrists practice in isolation from medical backup."

Governor Rhodes echoed Governor Dalton's concern when he said in his veto message, "Health care is an area in which we can take no risks because any mistakes could bring tragic and irreversible results. We must be committed to our citizens to provide practitioners that are highly skilled individuals and who will at the same time provide the best health care at the lowest cost.

"Optometrists have been doing an excellent job in working with the medical profession to bring quality eye care to Ohio citizens. The tools that the optometrists are presently using are not dangerous and are effective in screening for eye disease."

He went on to point out that S.B. 163 "would allow optometrists to use drugs in order to make a full diagnosis of the medical condition of the eye. If the individuals involved were properly trained," the Governor said, "this procedure would be in the best interest of Ohio's citizens. However, without proper training, the bill would allow unwarranted risks without corresponding benefits. The drugs involved are dangerous and have the potential of causing a great deal of pain including blindness. The adverse reactions associated with these drugs are not common, but they do occur and emergency treatment must be administered in those instances."

Noting that he vetoed the bill despite the fact that it included a provision that would require optometrists to take 180 hours of mandatory training, Gov. Rhodes said, "This amounts to little more than a month of isolated training in a clinical use of the drugs involved."

Concluding his commentary, the Governor pointed out that the issue of using drugs was one that should not be decided by the legislature.

The veto in Ohio brings to 15 the number of states that have rejected optometric drug laws this year. In only two states, Kentucky and Wisconsin, were such laws passed in 1978.

Continued on page 2

HONORABLE JAMES A. RHODES
. . . acts to protect Ohioans

Governor James A. Rhodes of Ohio has served in that capacity on two different occasions. He was first elected in 1962, serving until 1970, and was re-elected in 1974. The recently re-elected Governor, who attended Ohio State University, holds numerous honorary degrees from several institutions.

Prior to being elected governor, James A. Rhodes served as Auditor and Mayor of Columbus, Ohio and as State Auditor.

Author of three books on the Civil War, Gov. Rhodes was a delegate to the Republican National Convention in 1972, and is a member of the Professional Golfers Association Advisory Committee, and the United States Olympic Committee. ●

WHY "THE PEN?"

The files of state and national medical associations, all learned societies concerned with the public health, overflow with a preponderance of evidence that the quality of health care is threatened by the precedent of Government encouraging the lowering of professional standards by allowing medical functions to practitioners with no medical education. Medicine accepts the responsibility to respond to epidemics. Death and trauma are resulting, and Doctors of Medicine can do no less than warn potential victims through the continuous presentation of this evidence. The public press of America, given the facts, is supporting this cause, and concerned physicians throughout the nation are pooling their knowledge and resources to package and present the truth through the PHYSICIANS EDUCATION NETWORK.

Ohio Veto Is Second Of 1978; Fourth Optometric Drug Law Veto

VIRGINIA

Hon. John N. Dalton
vetoed H.B. 205
April 11, 1978

ARKANSAS

Hon. David Pryor
vetoed S.B. 48
1977

WEST VIRGINIA

Hon. Arch Moore
vetoed H.B. 1005
1976

THE PEN is a public newspaper, international in scope. Its readers include people from every walk of life. THE PEN is freestanding and independent of any national or state association, with the exception of its sponsor, Physicians Education Network, Inc. PEN, Inc. is a Florida non-profit corporation. Submissions to this newspaper are welcome and are published at the discretion of the editors. THE PEN does not accept paid advertising or paid subscriptions.

DR. ALLEN'S

DIAGNOSES

James H. Allen, M.D.; founding president, New Orleans Acad.my of Ophthalmology; professor of ophthalmology, Univ. of Iowa and Tulane Univ. for 30 years, Senior Surgeon, Tulane Univ.; awarded the prized Gold Medal of the Ophthalmology Section of AMA, 1976.

1979 — All Eyes On West Virginia

Prohibition — often referred to as "the noble experiment" — was repealed by government because it failed.

In the eyes of those West Virginia lawmakers who, in 1976, truly believed that to permit the use of drugs to optometrists would bring eye health care to more West Virginians, the optometric drug use law was a "noble experiment."

In the single remaining eye of Mrs. Dent, whose tragic deposition appears on page 3, the "noble experiment" of 1976 has failed. She is one of many human guinea pigs who have suffered and is among a vanguard of victims who will suffer as optometrists convince themselves that they are capable of diagnosing disease and providing treatment despite the total absence of medical education.

In the eyes of medical experts throughout the nation, the 1976 West Virginia optometric drug use law is a disaster. It is inconceivable that such a law can remain on the books when available evidence in 1978 has prompted lawmakers in 13 states, last year alone, to fail to pass similar, less dangerous optometric diagnostic drug use proposals.

In two more states, these proposals were lobbied through, only to be vetoed by conscientious governors. In the eyes of Governor James A. Rhodes of Ohio (see page 1), to allow Ohio optometrists the use of diagnostic agents "would allow unwarranted risk without corresponding benefits."

In the eyes of Governor John N. Dalton of Virginia, the eye health of Old Dominion residents was threatened by H.B. 205, a diagnostic drug use proposal less ominous than the extant West Virginia law. In his veto message of April 11, 1978, Governor Dalton said: "There is concern of legislative appointment of 'medical' responsibility and authority to non-medical personnel."

In the eyes of optometric leader Dean Henry B. Peters, O.D., of the School of Optometry at the University of Alabama in Birmingham, the reckless 1976 West Virginia law was the result of a "display of legislative machismo" on the part of overambitious optometrists. "The practice of medicine is an inappropriate goal for optometry" the Dean wrote, commenting on passage of the West Virginia law.

Dean Peters further stated, "Not one of our schools is prepared by either faculty resources or availability of clinical experiences to accept this challenge (treatment of eye disease at this time . . .); no such resources exist for 1,000 graduating optometrists this year nor are they in prospect."

In 1976, West Virginia lawmakers were told that modern optometric education made restrictions obsolete. In 1978, the six non-ophthalmic physicians who serve as the medical Advisory Board to the ultra-modern University of Alabama at Birmingham, where optometric education has high standards, took a close look at their curriculum. In their eyes, their own graduates, receiving the O.D. degree, are not qualified to treat disease or use drugs. Its October 18, 1978 resolution (confirming Dean Peters' conclusion about the inadequacy of optometric education) states in part:

"This education in no way prepares these graduates with the knowledge to prescribe or use drugs to treat eye disease. This training should not be viewed as a medical credential."

In 1976, optometrists argued that the new law would make eye care more available to rural residents. Rural residents know better than to take a horse to a blacksmith for colic, but unfortunately are unaware of the total absence of medical education in optometry.

In 1976, optometry promoted the conceptual myth of "primary care." We doubt that any thinking lawmaker would want his eye examined for disease by the least qualified. To place the optometrist in a position where he may overlook a fatal tumor is unfair to him as well as his patient, and to allow him to experiment with dangerous drugs will inevitably produce more unfortunate cases.

Mrs. Dent seeks repeal of the 1976 law. A growing Citizen's Committee seeks repeal. Medicine acknowledges its failure to present a coherent case in 1976, when confusion obfuscated the inherent danger to the public.

This is 1979. Since 1976, the motives of optometry to expand into medicine at the expense of the public health, by exploiting state legislatures have become apparent. Scores of legislative sessions have rejected these efforts, and West Virginia has the most dangerous law of all.

A mass of new incontrovertible evidence attesting to the danger of the 1976 law is ready for presentation. In the eyes of the presentors there is confidence that the 1979 West Virginia lawmakers will open their eyes and ears while taking a fresh look at eye health care.

M.D.s make mistakes. So do elected officials. To acknowledge them is statesmanlike.

The eyes of the nation are on West Virginia.

JHA

THE PEN....

VOLUME 3, NUMBER 2
JANUARY 15, 1979
ST. PETERSBURG, FLORIDA

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Misinformation Provided Magazine Readers

American housewives are warned that there is a dangerous paragraph of misinformation which appeared recently in national magazines. The advertisement promoted ignorance regarding the possibility of fatal malignancy in the eyes of children.

The advertisement, sponsored by the American Optometric Association, stated:

"On the other hand, if a child who is 18 months or younger momentarily turns one eye in or out, there is probably no cause for worry. At this stage of growth your child lacks what is referred to as internal organization. He just can't seem to make anything . . . hands, feet, legs . . . work together.

"In any of these cases, your family optometrist can diagnose problems or reassure you that your child is normal."

No cause to worry?

James H. Allen, M.D., former senior surgeon at Tulane University, worries about the complacency which may result from this advertisement reassurance.

"This ad is irresponsible," he said.

Dr. Allen advises, "A child begins to coordinate eye movements in the first six months of life but may occasionally turn one eye in or out up to 12 months of age. However, if there is a constant turning in or out of one eye even before one year of age or if there is intermittent turning in or out of one eye after 9 months to one year of age, the child should have a medical eye examination.

"There are several things that can interfere with the development of coordinated eye movements, the most dangerous thing being a malignant tumor of the retina of the eye — which must be diagnosed early if the child's life is to be saved.

"Other causes, although not likely to be fatal, could destroy much or all vision in one eye if not diagnosed and treated properly as early as possible.

"An optometrist is not trained adequately to diagnose diseases of the eye or disease affecting the body as a whole. Therefore, he cannot reassure parents that their child is normal. There are numerous recorded examples in which an optometrist failed to recognize or diagnose diseases or tumors of the eye with the result that vision was lost or the life of the patient lost." ●

OHIO GOVERNOR VETOES

Continued from page 1

Commenting on Governor Rhodes' veto message, Lawrence L. Young, M.D., President, Ohio Ophthalmological Society said, "All of medicine in Ohio is impressed with the thoroughness of the Governor's investigation which led to the veto of S.B. 163. He has correctly assessed the danger to the public and his message reflects his deep concern for the eye health of the citizens of our state."

To date, four state governors have carefully reviewed the pros and cons of optometric drug legislation and concluded that passage of such a law would endanger the health of their citizens. In each instance these chief executives have exercised the power of their veto to protect their constituents. ●

AN OPEN LETTER SEEKS REPEAL

W. Va. Eye Victim Deplores Optometric Care

A West Virginia supermarket cashier, who is blind in her left eye and who has a serious problem with her right eye, has made a public appeal through an open letter for repeal of West Virginia's optometric drug law.

In a signed deposition, Mrs. Laura Dent of South Charleston, WV, states, "If my optometrist had been qualified to diagnose and treat diseases of the eye, maybe this disease would have been caught in time and I could read with my left eye. The people who passed this law (West Virginia law permits optometrists to use drugs for diagnosis and treatment), should stop and think what they have done; apparently some of them have never had serious eye problems or they would have known better than to do such a thing."

Saying, "I am firmly against this law allowing optometrists to prescribe medications and treat diseases of the eye, because they are not qualified," Mrs. Dent emphasized she was not offering an opinion, but was speaking from experience. Mrs. Dent related that in May of 1975 she went to see an optometrist for a general eye examination. At that time, she points out, the optometrist prescribed new glasses and advised that there were no signs of glaucoma or any other diseases of the eye. Within two weeks, Mrs. Dent said, "I was seeing distorted. I phoned my optometrist and asked what could be the problem. I was told to come in and be checked. I went in and was told it was only astigmatism, to wear my glasses all the time, and the problem would be corrected.

"It did not improve, I continued to get worse. I phoned my optometrist back in three weeks and asked just how long it would take to improve, and also asked if my family doctor could help. I was told maybe so. I will phone him; go ahead and see him.

"I went straight to my family doctor; the optometrist did not phone him. My family doctor took one look at my eye and panicked. He said there was this tremendous deterioration in both eyes, he did not know what it was, but there definitely was a problem. He sent me straight to Dr. Rashid's office. Doctors Rashid and Toma (both ophthalmologists) checked my eyes and told me I had histoplasmosis (a disease caused by a parasitic fungus) and said it was presently active in my left eye. Since I had had numerous attacks in both eyes in the past, it was likely I had the disease all my life."

Mrs. Dent further relates that after six months of treatment, the condition did not improve and in September the laser was used to arrest the disease. She says, "It stopped the disease, but it did not save my vision. *Medical editor's footnote: Histoplasmosis is a chronic disease characterized by irregular active and inactive phases. Even during the inactive phases the lesions are easily seen. In the inactive phases, treatment is neither effective nor necessary. In the active phases, treatment is available and frequently helpful to retard or eliminate visual loss. Thus, the patient should be observed by a physician with an understanding of the disease process in order to minimize loss of visual function.* I have no central vision in my left eye; I have peripheral vision but I cannot read; I cannot watch TV or do any close work at all with my left eye." In June of 1978 Mrs. Dent suffered a repeat attack in her right eye. This time the laser was used and Mrs. Dent advises she "is in pretty good shape except for the fact that I have a small blind spot."

Noting that the diagnosis made by Doctors Rashid and Toma was confirmed by Dr. Finklestein at the Wilmer Eye Institute in Baltimore, Mrs. Dent says, "I have been told that there is no hope for my left eye and it could happen again at any time in the right eye."

Calling on the legislature to take action now, Mrs. Dent writes, "I wish you would reconsider and repeal this law because a lot of innocent people are going to suffer unknowingly and maybe even go blind because they are trusting an unqualified optometrist." ●

FOUNDER SALUTED BY AMA NEWS — PART III

Ochsner: "The Harder I Work, The Luckier I Get!"

The accomplishments of Alton Ochsner, M.D., PEN's International Advisory Board Chairman, are legend in the annals of American medicine. Terming PEN, "The most potent communications effort I have ever observed in medicine," Dr. Ochsner has said, "Ophthalmology — medicine's protectors of one of God's greatest gifts — eyesight — finds itself in the trenches, doing grim battle against a potential epidemic of ineptitude foisted on the American public by some legislators who have heard only the exaggerations and half truths of the optometric side of a non-argument."

Free-lance author Nancy Vance Hoffman, in an article titled "Alton Ochsner: 82 and Still Going Strong," which appeared in the AMA Journal on August 25, 1978, Vol. 240, No. 8, has captured the essence of this man's greatness. PEN wishes to express its appreciation to Ms. Hoffman and to the JAMA for permission granted to present this material in a series of articles.

"Alton Ochsner: 82 and Still Going Strong," Conclusion:

Genial, optimistic, Alton Ochsner says that if he had his life to live over again, he would do nothing differently. Nevertheless, what was his greatest disappointment? Huey Long's dictatorship over Charity Hospital, Tulane's only teaching hospital, in Ochsner's early days in New Orleans. A boy wonder, at 31 appointed as Tulane's professor of surgery, Ochsner came south from Wisconsin, where he had been associate professor. "My family didn't arrive for six months, and I literally lived in the hospital. I slaved — and I loved it. I gave it everything I had, developed a good teaching program as I had promised Dean Bass I would. Everything was going along fine." He pauses, shaking his head at the irony of Huey Long's legacy, and I didn't include his desire for revenge on me for refusing a doctor's desire for revenge on me for refusing a doctor's (the doctor) to the hospital staff. to appoint him (the doctor) to the hospital staff. He was incompetent." He shrugs. "And later, while I made rounds, a letter was stolen from the pocket of my coat while it was hanging in the doctor's room of the hospital."

ALTON OCHSNER, M.D.
PEN'S International Advisory Board Chairman

The letter was from the Medical College of Virginia inviting Ochsner to be professor of surgery there. As chairman ex officio of Charity Hospital's board and harboring no love for Ochsner's probity, Huey Long presented the purloined letter as evidence of Ochsner's "disloyalty" to the hospital. "Then and there, that Saturday morning, I was kicked out of the hospital. For two years, I couldn't go near our only teaching hospital. I decided that I couldn't stay in Louisiana under those circumstances, that I would take a job at the University of Illinois. But C. Jeff Miller, Tulane's professor of gynecology and my mentor, dissuaded me."

How? "Dr. Miller said, 'You can't leave under fire. You've *got* to stick it out.' 'But, Dr. Jeff,' I protested, 'Look what's happened to me. I've given this place everything I have and see how they've responded.' Dr. Jeff was adamant. He wouldn't let me quit. Because of him, I stayed." The big Ochsner smile creases his remarkably unlined face: "Sticking it out was one of the best things that ever happened to me."

Despite a life he describes as blessed by "Presbyterian luck" (defined by Ochsner as, "If you do the right thing, no matter what happens, you'll be all right"), Ochsner, who has been no stranger to Alton Ochsner. His own wife's long terminal illness and death was a devastating blow. In the early 1950s, he obtained some of the first Cutter polio vaccine, which he

Continued on page 4

OCHSNER *Continued from page 3*

administered to his grandchildren, as well as to many Ochsner pediatric patients. His daughter's eldest son contracted polio — possibly from the vaccine — and died. The intern who cared for the boy also got polio and both his legs remain paralyzed.

In those days, medicine had a few sharp peaks and lots of deep valleys. There were a few well-trained people, while the rest had almost no training at all. Today, medicine has progressed so that almost everyone is well-trained. By the late 1930s, New Orleans had lost its reputation as a major medical center.

"I saw that the city must do better medicine. And the only way to do this was through group practice. I had two ambitions: to build a medical referral center in the deep South that would give quality care reasonably, and to develop an institution that showed care and consideration — not only to the patient, but to the family." The Ochsner hospital maintains a Family Room, adjacent to the operating rooms and intensive care units, where families receive progress reports every half hour while a patient is in surgery and where coffee and doughnuts are dispensed.

"I went to five Tulane professors," Ochsner remembers. "Professors of otolaryngology, gynecology, orthopedics, and medicine. The surgeons were interested, but the medical man was not. This was in 1939, the end of the Depression. We had no money, only an idea. The banks wanted equity, not an idea. It looked as though we were going to have to give up." Alton Ochsner, however, doesn't give up easily; he persuaded Rudolph Hecht and the Hibernia Bank to finance that first Ochsner Clinic in an old building on Prytania Street.

Not every doctor was convinced that Ochsner's idea was a good one. On Good Friday in 1941, small leather pouches filled with thirty dimes were delivered to the five Ochsner Clinic founders' homes. Inside each pouch was an anonymous typewritten note: "To the Judases of the Orleans Medical Society." The local doctors felt threatened and resentful. Ochsner argues: "We have helped the local physicians, raised the level of New Orleans medicine so that it is much higher than when we founded this place." ●

THE PEN FORUM

Editors' Note: Optometry's burning desire to invade the field of medicine was blatantly displayed when the Board of Regents of New York State, a non-medical, politically-appointed body responsible for directing the policy of higher education in New York, was persuaded to endorse optometric drug legislation.

It is unthinkable that political appointees, whose duties and responsibilities are not directly related to the issue, and who have never been informed by medicine as to the ramifications of the issue, should take such a position.

It would appear that the 15-member Board of Regents has been manipulated by optometry into taking a public political stance which will not only endanger the eye health of every New Yorker, but one which could cause that august body considerable, unnecessary embarrassment. Alden Haffner, O.D., an optometrist, is the State University of New York Vice Chancellor for Health Sciences.

Recognizing that legislators across the nation might well view this interference as an optometric credential, unless challenged, PEN has asked ophthalmologists nation-wide to express their views to all involved. Following are but a few excerpts from the flood of letters sent to the New York State Regents, the Chancellor and the State Commissioner of Education:

"The recent decision by the Board of Regents to support the use of drugs by optometrists ill-serves the public welfare as it reflects a lack of objectivity concerning this very important issue. The Board of Regents should be in the forefront of the battle to prevent non-medical measuring practitioners such as optometrists from becoming quasi-physicians by legislative fiat. Our educational system has numerous checks and balances to insure first that only the most highly qualified applicants are admitted to medical school; thereafter a medical school curriculum and periodic examinations standardized on a national level further insures scholastic fitness. The proper application of textbook knowledge to actual clinical pathology continues for the ophthalmologist throughout one year of internship and three years of specialized residency training in the diseases and surgery of the eye. The back door approach to medical school — via legislative fiat — should be a concept flatly rejected by the Board of Regents. The medical education as I outlined above should remain as the prerequisite to the use of pharmacological agents in the eye — the taking of pharmacology courses in or out of optometry school is in no way a substitute. Any optometrist who desires to assume medical functions should apply to medical school and obtain the proper training."

Seymour R. Rosen, M.D.
Sunrise, Florida

"The most important objection to optometric use of drugs is that authorization to use drugs implies the ability to judge the information obtained from such use and use it to make a medical diagnosis. Just as the possession of a stethoscope does not make one a cardiologist, the use of drugs to dilate the pupil or numb the eye will not make the optometrist equivalent to a physician. Patients will, however, be misled into believing that the optometrist is in fact qualified to make medical judgments and serious errors in diagnosis with accompanying missed opportunities to save eyes and even lives will occur.

"One has only to observe the level of optometric care throughout the State to realize the crass commercialism of many of their establishments. A little over a year ago the New York Daily News published a series of articles highly critical of the quality of eye examinations and glasses provided by many optometrists. How can the Board of Regents approve a group, which is not as yet meeting the standards for which they are licensed, to take on responsibilities for which they are not qualified?"

J. S. Nauheim, M.D.
Merrick, New York

"The recent decision by the Board of Regents of the State of New York to support optometric drug use legislation is ill-advised and myopic. In taking this decision, the Regents are permitting a group (the optometrists) to legislate medical privileges rather than obtain the medical privileges by education as the physician has."

John B. Franklin, M.D.
Hartford, Connecticut

"It seems obvious that we cannot, at this time, compromise these standards. Your decision to support optometric drug laws is just such a compromise. It is the same as suggesting that chiropractors are as well qualified to practice medicine as are physicians. Even a school such as the University of Alabama in Birmingham, has recently defined the practice of optometry as a non-medical discipline. A resolution by the Physicians Advisory Board at the University of Alabama, states, 'This education in no way prepares these graduates with the knowledge to prescribe or use drugs to treat eye diseases'. I urge you, therefore, to reverse this decision and to serve the citizens of New York State by so doing."

William C. Frayer, M.D.
Philadelphia, Pennsylvania

"I am writing to protest the action of the Board of Regents of New York State endorsing optometric drug use. It is unthinkable that highly educated people could advocate the use of medications by untrained practitioners. Furthermore, the training of optometrists in diagnosing medical eye diseases is terribly inadequate so that misdiagnosis and delayed recognition of disease is a greater danger than the complications of the pharmaceutical agents. . . . Please reconsider this issue."

Thomas S. Harbin, Jr., M.D.
Atlanta, Georgia

"The support given to the optometric drug bill must have been made without due consideration for the possible effects the legislation would have.

"Last year this legislation was voted down in fourteen other states whose legislators were given factual information concerning this issue. Most of the states which had passed the bill previously are now considering recall of the bill after documenting the serious harm done by optometrists using medication during their eye exams. It is unfortunate that in the states that passed the law the public had to suffer because of the inappropriate action of the legislators."

Daniel W. Pieroni, M.D.
Sheffield, Alabama

UNITED STATES PHYSICIANS EDUCATION NETWORK

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.
- 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.

"M.D. IS THE MAJOR DIFFERENCE"

THE PEN...

PRO BONO PUBLICO

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VOL. 2, NO. 9 MAY 1, 1978

VIRGINIA VETO MESSAGE

Governor John N. Dalton: "There Is Concern"

Virginia Gov. John N. Dalton's courageous action in failing to sign House Bill 205 into law deserves high praise from both medicine and the citizens of the Commonwealth. Gov. Dalton has reaffirmed to his constituents and to the people of this nation that only through "education, not legislation," can a person become competent enough to use drugs on the human body.

The following is Gov. Dalton's comment after vetoing the bill:

"The bill defines what constitutes the practice of optometry; and defines requirements of persons who desire to be certified in the use of diagnostic pharmaceutical agents that they be examined in general and ocular pharmacology and in the use of approved topically applied diagnostic pharmaceutical agents. Although paramedics, physician assistants, and nurse practitioners may administer drugs in specific instances, this is done (a) under the supervision of a physician, and/or (b) under specifically developed protocols regulating such procedures. Given the rare, but devastating effects of adverse reaction following administration of diagnostic agents, there is reason for grave concern for patients' welfare where optometrists practice in isolation from medical backup. There is concern over public misunderstanding that complete medical care has been effected after having an optometric examination. Finally, *there is concern of legislative appointment of 'medical' responsibility and authority to non-medical personnel* prior to this matter being carefully studied as to its impact in the Commonwealth."

Honorable John N. Dalton . . .

63rd Governor of Virginia

Gov. John N. Dalton, the 63rd governor of Virginia, took office on Jan. 14, 1978. A graduate of the College of William and Mary, he received his J. D. degree from the Law School of the University of Virginia in 1957.

Following graduation from law school, Gov. Dalton practiced law in Radford, Va. and began his political career in 1965 when he was elected to the Va. House of Delegates. After being re-elected to this post three times, he ran successfully for the State Senate in 1972. In 1973, he was elected lieutenent governor.

A 33rd degree Mason and an Eagle Scout, Gov. Dalton is a past-president of the Moneton District of Boy Scouts and a member of the Blue Ridge Council of Boy Scouts.

Eight States Reject Optometric Drug Law Petitions In 1978

Gov. Dalton's veto marks the seventh 1978 rejection of optometry's attempts to utilize legislative "clout" to invade medicine at the expense of the public health. Other states refusing optometrists the right to use drugs this year are Georgia, Mississippi, Missouri, South Dakota, Maryland and Oklahoma. At presstime, an optometric drug bill in Nebraska was reported to have "died on the calendar," bringing the total to eight.

So far this year, only Wisconsin and Kentucky patients face eye damage as a consequence of new optometric drug laws. In Kentucky, the law was passed and signed despite charges of impropriety, plus a call for a veto by the *Louisville Times.*

Unfortunately, the public health remains imperiled in several states: Massachusetts, New York, Ohio, South Carolina, Alaska, Hawaii, Iowa, and Arizona, where "the jury is still out."

WHY "THE PEN?"

The files of state and national medical associations, all learned societies concerned with the public health, overflow with a preponderance of evidence that the quality of health care is threatened by the precedent of Government encouraging the lowering of professional standards by allowing medical functions to practitioners with no medical education. Medicine accepts the responsibility to respond to epidemics. Death and trauma are resulting, and Doctors of Medicine can do no less than warn potential victims through the continuous presentation of this evidence. The public press of America, given the facts, is supporting this cause, and concerned physicians throughout the nation are pooling their knowledge and resources to package and present the truth through the PHYSICIANS EDUCATION NETWORK.

DR. ALLEN'S

DIAGNOSES

James H. Allen, M.D.: founding president, New Orleans Academy of Ophthalmology; professor of ophthalmology, Univ. of Iowa and Tulane Univ. for 30 years; Senior Surgeon, Tulane Univ.; awarded the prized Gold Medal of the Ophthalmology Section of AMA, 1976.

Governor Dalton — We Know That Any Veto Takes Both Courage And Conviction!

Being the captain of a ship is a lonely job — and in Virginia, like all states, the ultimate decision rests with the Governor.

During the past few weeks, Gov. John N. Dalton has faced the challenge of difficult decision-making as to whether all bills passed by the 1978 Virginia Legislature should be signed into law.

The intensity of the public outcry in Virginia against non-medical optometrists being allowed to use dangerous drugs and eye drops in the practice of their profession must have made the decision as to whether to sign House Bill 205 most difficult.

In protecting the public of Virginia, Gov. Dalton did far more than simply refuse to sign the bill. He presented his own conclusions (see page one) utilizing new phraseology which convinces us that the Governor is dedicated to the welfare of all Virginians. Speaking out in support of his veto, Gov. Dalton revealed that he reached the same conclusion as 46 major metropolitan newspaper editors who studied what is actually a simple issue. He came to the conclusion that, "There is concern of legislative appointment of 'medical' responsibility and authority to non-medical personnel prior to this matter being carefully studied as to its impact on the Commonwealth."

The Governor's conclusion is simple logic. Medicine in Virginia, in the early days of the 1978 legislature, did fail to meet the challenge and provide adequate information for careful study. When it was apparent, however, that many legislators actually believed that the petition of optometry to use drugs and eye drops would in some way be of benefit, medicine rallied to the challenge.

Prior to medicine's challenge, optometry found conscientious, but uninformed (on this issue) legislators easy prey for half truths, exaggerations, and even prevarications.

When medicine rallied its forces, however, an interested delegate commented that "ophthalmologists suddenly came out of the woodwork." Indeed they did, and medicine is so proud of them.

Ordinarily, ophthalmologists stay behind the woodwork in order to concentrate on providing medical care to a steady stream of people with serious eye problems who need and deserve full attention, treatment and cure.

The political scene is unfamiliar to medical people, and it took M.D.s some time to realize that the woodwork must give way when the public health is threatened by the body politic and that they must respond as they would to an epidemic.

By the time the issue reached the Senate floor, it was obvious that medical truths had changed the minds of many of the legislators.

The Governor is right — the measure deserves more study. Make no mistake. Medicine in Virginia welcomes further study, and so does PEN. The Virginia assembly was generous in allotting time to advocates of "both sides" and so was the Governor.

While it is difficult for us in medicine to acknowledge that there are "two sides" to this issue, we know that a preponderance of evidence is on our side and we intend and welcome the opportunity to present it on behalf of the people anywhere in the United States.

Finally, if Gov. Dalton had rendered an opposite verdict, we would have concluded that he, too, ignored the facts so obvious to the press of America, and REPEAL bumper strips would have been on the way to Virginia. The people of the Old Dominion deserve no less than insistence on high quality health care, and both medicine and the Governor have demonstrated high resolve to preserve just that!

JHA

THE PEN....

VOLUME 2, NO. 9
MAY 1, 1978
ST. PETERSBURG, FLORIDA

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"A little learning is a dangerous thing . . . drink deep, or taste not, the Pierian Spring/Shallow draughts intoxicate the brain, and drinking deep largely sobers it again." . . . Alexander Pope

Massachusetts Wins Committee Victory

On Tuesday, March 28, 1978, the Massachusetts Senate by voice vote, accepted the recommendation of the Joint Health Committee that the optometric drug bill (Senate S 402) **"ought not to pass."**

Medicine throughout Massachusetts is saluting the Senators for their caution and awareness of the necessity of protecting the public health.

A Health Care Committee report is on the House calendar for debate. The bill, having been filed in both houses, requires that each act independently on the Health Care Committee report.

No action in the House has been reported.

BULLETIN AT PRESSTIME

An optometric drug bill in Nebraska "died on the calendar," according to PEN Advisory Board member John Ramsell, M.D. of Omaha. Nebraska becomes the eighth state to protect patients from this threat this year.

UNITED STATES PHYSICIANS EDUCATION NETWORK

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.
- 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.

THE PEN is a public newspaper, international in scope. Its readers include people from every walk of life. THE PEN is freestanding and independent of any national or state association, with the exception of its sponsor, Physicians Education Network, Inc. PEN, Inc. is a Florida non-profit corporation. Submissions to this newspaper are welcome and are published at the discretion of the editors. THE PEN does not accept paid advertising or paid subscriptions.

WOULD YOU LIKE TO RECEIVE THE PEN?

THE PEN, to be published 24 times annually, is an international publication — unique in that subscriptions cannot be purchased. Non-medical persons may petition THE PEN for a complimentary subscription. Just tell us who you are and why you are interested. Medical doctors can become subscribers by joining PEN as a dues-paying member (see application elsewhere in this issue). Elected officials — state or national — and executives of health care agencies can become subscribers upon request.

Industry Co-sponsors Portland Eye Exhibit

While medicine and ophthalmology concentrate on resisting the invasion of medicine at the expense of the public health, there are many painstaking efforts to provide education to encourage patients to protect themselves.

One such effort is a major new exhibit, the Sealy Ophthalmology exhibit, which opened Saturday, March 18, at the Oregon Museum of Science and Industry (OMSI), and promises to be a major tourist attraction this summer.

Funded by the Sealy Mattress Co., and enthusiastically supported by its president, Lloyd Rosenthal, the $30,000 display was co-sponsored by the Oregon Academy of Ophthalmology, which will be responsible for its annual maintenance costs. Under the leadership of OMSI's Exhibits Director Shabtay Levy more than a year of planning and construction has gone into the exciting display.

The focal point of the exhibit is a 3 ft. in diameter, stylized anatomical model of the human eye. The model demonstrates the anatomy and functions of the human eye, and also demonstrates some pathological disorders, such as cataract, glaucoma, retinal detachment and diabetes. The viewer can actually see how these diseases affect human vision.

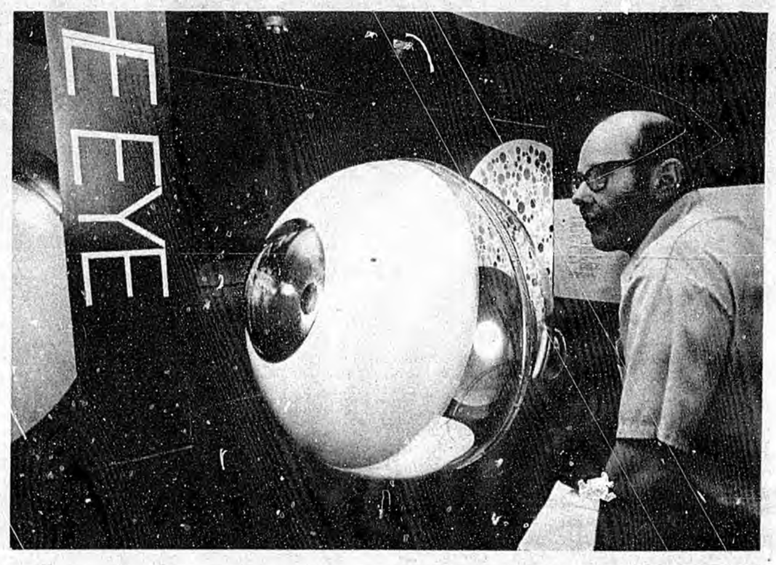
By pushing buttons, the viewer is able to activate functional parts of the exhibit to show how the iris changes its size related to changing levels of light. Supporting exhibits include visual acuity, peripheral vision, color vision, depth perception and even one which shows the viewer the pupil of his own eye dilating and contracting as light values change.

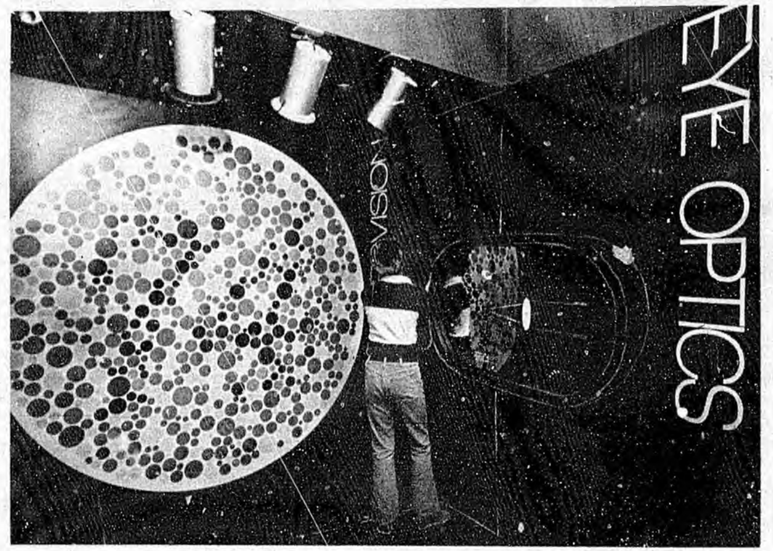
Under Mr. Levy's direction, and in cooperation with expert ophthalmologists, the entire concept, design and construction of the exhibit was completed by the OMSI Exhibits staff.

The Oregon Academy has prepared educational pamphlets complementary to the exhibit which cover various phases of eye care, including the "major difference" between ophthalmologists and optometrists, and advice on seeking out an ophthalmologist.

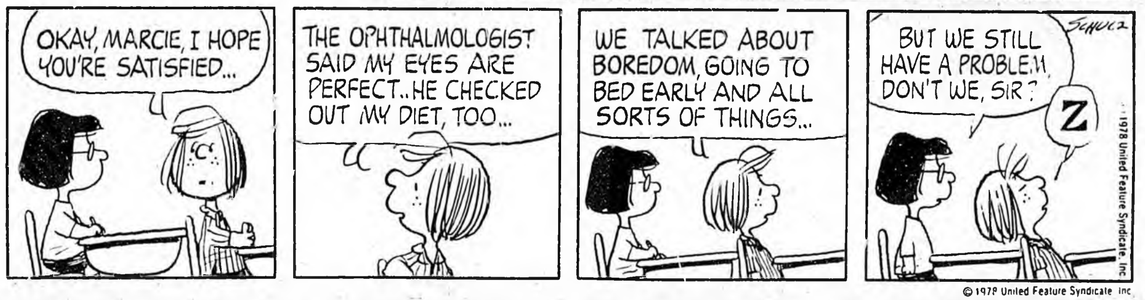
Members of the Oregon Academy of Ophthalmology working closely with the Exhibits staff include Merritt Linn, M.D., Donald Plumb, M.D., Robert Burns, M.D. and John Wobig, M.D., all of Portland.

The Sealy Ophthalmology exhibit opening is expected to be of great interest to the casual visitor to OMSI, and will be of special value for school tours and other interested groups for whom more detailed lectures and demonstrations will be offered.





The current "Book of Lists," a best seller, identifies PEANUTS, created by Charles Schulz, as the most popular cartoon strip in the world. At least creator Schulz, Lucy, Charlie Brown, Snoopy et al obviously know "The Major Difference," and hopefully, so do many of their readers. PEN is grateful to United Feature Syndicate, Inc. for permission to reprint this significant, educational, and as always, humorous, cartoon which has appeared in newspapers throughout the world.



MARYLAND DAILY NEWSPAPER ADVISES READERS

THE SUN

A 14 BALTIMORE, THURSDAY, MARCH 23, 1978

WILLIAM F SCHMICK, JR., President and Chief Executive Officer, The A.S. Abell Company

DONALD H. PATTERSON, Publisher • PAUL A. BANKER, Managing Editor • J.R.L. STERNE, Editorial Page Editor

Optometrists and Drugs

Optometrists are trained in four-year schools to fit glasses, using various optical methods to determine the kinds of lenses patients need for correction of vision problems. *Opthalmologists* have had more sophisticated training. Like optometrists, they fit glasses. But because they are physicians who have specialized in opthalmology after completing medical school, they are prepared to do a great deal more. For instance, they can use and prescribe drugs, treat eye diseases and do eye surgery.

Under current Maryland law, optometrists are not allowed to use drugs in their practice. But a bill now in the Maryland Senate would give them that right in certain cases. Optometrists make superficially plausible arguments in favor of the bill, pointing out that, with amendments they support, it would allow them to use only four types of drugs, all administered topically in the eyes, and only for diagnostic purposes; and that they would be required to take a minimum of 70 hours of training in pharmacology before they could use the drugs. They add that adverse side effects of the drugs are so rare as to be almost non-existent.

Unfortunately, say opthalmologists, the side effects are not all that rare. Allergies to the drugs might, in severe cases, result in death. Certain of the drugs can cause hallucinations, and others can result in detached retinas or acute glaucoma. Coping with these side effects requires the skills and equipment of a physician. A severe allergic shock reaction, for instance, might require adrenaline and cortisone injections which only a physician is qualified to administer. As the opthalmologists point out, 70 hours of training in pharmacology—as opposed to the 2,400 hours or more physicians receive—might not even qualify optometrists to recognize the side effects for what they are, let alone be able to treat them. The bill should be defeated

THE PEN FORUM

PEN has received more than 200 pieces of mail to Veterans Administration officials and congressmen from medical doctors concerning passage of Public Law 94-581, which gives measuring scientists with no medical training a primary health care role at VA hospitals throughout the country.

About 50 United States Senators and Representatives have responded to M.D.s' claims that raising optometrists to a primary health care level will jeopardize the public health.

The following letter to James H. Parker, Jr., M.D. of Wyomissing, Pa. from Rep. Gus Yatron is typical of letters from concerned congressmen received since the circular was signed Nov. 4, 1977:

Dear Dr. Parker:

Thank you for your recent letter expressing your continued interest and concern over the possibility of optometrists being allowed to take over part of the medical care of eye patients in the Veterans Administration.

Please be assured that I feel you have raised some valuable and serious points regarding such an action. Before such a proposal is approved, I feel that all possible questions pertaining to the adequacy of optometric education must be resolved. You can be certain that I will continue to scrutinize all of the implications and possible ramifications of this change, and that I will not endorse any action that could endanger the health of our nation's veterans. Additionally, I will not support any move to downgrade the quality of care offered in veterans' hospitals.

Sincerely,
Gus Yatron

Mail to: James H. Allen, M.D., 9104 Quince St.
New Orleans, LA 70118

Founded as O.P.E.N.

PEN CHARTER MEMBER APPLICATION

This is my statement of intent to be an active member of the United States Physicians Education Network — I endorse and support the statement of purpose.

In providing my resources to guarantee the continuation of a strong and viable international entity I acknowledge and understand the following:

— That my membership in PEN will bring me a minimum of 48 mailings annually including 24 issues of a national publication as described, in keeping with the statement of purpose.

— That, as a Charter Member, I accept the responsibility of attempting to recruit members. I further understand that my state society will automatically be qualified for WATS line telephone consulting services and direct public relations advice and counseling, tailored to my state, as soon as either ten percent (10%) of the membership of my state society, or 20 members, (whichever is the least) are recruited.

I desire to inform and to be informed and to join this movement, and hereby pledge my support through dues, not to exceed $300 annually.*

— I understand that as a Charter Member, I will be issued a silver lapel emblem signifying my Charter status as soon as available after formation.

Date_____ 1978

Name_____

Address_____

City_____ State_____ Zip_____

Telephone: (Area)_____ Number_____

Ophthalmologist?_____ Other specialty_____

Profession, other than M.D.?_____

Check enclosed ($300)_____ Please bill me_____

* Charter Members (enrolled before July 1, 1978) will be awarded a dues decrease as of the second full year.

Visual and Medical

The Visual Part can be performed by an optometrist or an ophthalmologist.

The Medical Part can *only* be performed by a qualified medical doctor (an ophthalmologist).

When having your eyes examined you should know whether you are receiving a *complete* eye examination or only a part. When an optometrist (O.D.) examines a person's eyes he is qualified and licensed only to perform the visual part. He is not educated nor trained to perform the medical part.

When an ophthalmologist (M.D.) examines a patient's eyes, he performs both parts on an inter-related basis. He not only evaluates visual functions and performance, but also analyzes and diagnoses diseases and physiological disorders.

Ask the individual examining your eyes whether he is an O.D. (optometrist) or an M.D. (ophthalmologist). Only an ophthalmologist M.D. can perform a *complete* eye examination -- both visual *and* medical.

While the Massachusetts Society of Eye Physicians and Surgeons (MSEPS) energetically resists attempts to endanger the eye health of Bay State citizens, the MSEPS also endeavors to educate the public to protect themselves. The centerfold of a small but potent folder being circulated by medicine in Massachusetts is reproduced above with permission of the Society.

Name	Organization	Address	Bill No.
DR. Boyd L. Walker	Alaska Optometric Assn.	1345 W 9th ~~Anca~~	79
DR. A. RON STERNBERG	" "	1016 W. 6th Ave, Suite A, Anchorage	79
JEFF LANDRY	AK. STATE MEDICAL ASSOC.	320 W. 3RD. ST. JUNEAU, AK.	79
Dr. John T. Shank	State Board of Examiners in Opt.	Box 827 Kodiak	
Dr Maynard Falconer			
Doris P. Falconer	AK Optometic Board of Examiners	1345 - W - 9th Anch	79
Dr. T.D. McLaughlin	A.O.A. ~~Auxilla~~ (Observer)	" " " "	
Rep Patrick M. O'Connell	~~Alaska~~ Optometric Association Board member	Box 498 Sitka	79
	Alaska optometrists - State Leg. - Dist 13	Juneau	79

POSITION PAPER/Department of Health and Social Services

POSITION PAPER
ON
HOUSE BILL NO. 79

"An Act relating to the practice of optometry."

This bill would permit the use of selected drugs including topical anesthetics, mydriatics, cycloplegics and myotics by optometrists, and as such would delete from the definition of optometry the restriction against the use of drugs.

The intent of the bill would be to permit optometrists to use certain prescription drugs. This significantly increases the scope of optometry as presently defined and poses some increased risk and complications. The use of mydriatics is occasionally associated with the development of acute narrow angle glaucoma which may necessitate emergency surgery. The use of topical anesthetics are occasionally associated with acute, allergic reactions and some risks of danger to the cornea by foreign bodies. Recognizing the unusual, but definite risks and complicating reactions, the Department of Health and Social Services feels the use of prescription medications by optometrists would not be in the best interests of the public.

Recommended by: Robert I. Fraser

Robert I. Fraser, M.D., Director — 2/14/79
Division of Public Health

Approved by: Helen D Beirne — 2/16/79

Helen D. Beirne, Commissioner
Dept. of Health and Social Services

Rep. Buchholdt

Alaska State Legislature

POUCH V
JUNEAU, ALASKA 99811

P. O. BOX 9
KENAI, ALASKA 99611

REPRESENTATIVE HUGH MALONE

24 January 1979

Peter E. Cannava, M.D.
Box 1629
Soldotna, AK 99669

Dear Peter:

I received your letter and court brief regarding the optometric drug bill and have forwarded a copy to Rep. Thelma Buchholdt. She is the new chairperson of the Health, Education and Social Services Committee. As yet, no legislation has been introduced regarding this issue, however, I expect it will be soon.

Thank you for the information.

Sincerely,

Hugh Malone

jk

Peninsula Eye Clinic
PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669

TELEPHONE 262-4462

Hugh Malone
State Capitol Building
Pouch V
Juneau, Alaska 99811

Dear Hugh:

I gave the enclosed talk to the legislators present at our political meeting and I thought it would be helpful to you to receive a copy of it considering your vote of last session.

The case illustrates the fact that the optometric drug bill represents more than a political "power play" but in fact has and will mean loss of eyes of our fellow Alaskans. We have at least two other cases documented where vision was lost because of inadequate medical knowledge on the part of optometrists.

The judges decision clearly states that there is no reason why optometrists can be permitted to make medical diagnosis on a legal basis. In addition the testimony by the "professor of optometry" clear illustrates the lack of medical knowledge on the part of optometrist educators.

Sincerely,

Peter

Peter E. Cannava, M..D.

PEC/bc

Hugh,
Please have one of your staff save the court brief as it will have to be used for the "HESS" committee hearings & also for future discussions I will have w you.
Good Luck this yr & I wish you a short 90 day session. P

Given to Legislative Meeting 13Dec78. Copy to DR

American medicine has estabilished a tradition which dates back well over 200 years! Despite the ups and downs of certain aspects of American medicine the very basic integrity of the system has never and will never be challanged. This is fact because the system rests upon a foundation of sound scientific principle. American people may not like what type of treatment is offered them but they at least can rest assured that any prescription promulagated by our traditional medical system is based upon a scientific method, and those practitioner licensed with-in the system have completed a satisfactory curriculum approved by both private and governmental bodies who attest to the fact that medical practitioners are qualified to practice with the use of drugs and other modalities. In addition to the traditional modality of medical care there are two other broad categories of health care which our people choose to utilize. One is not based upon scientific methodology, cannot be supported by established objective data. Examples of these would be naturopathic healing and chiropractic. The second category of non-medical health care sought by Americans is based upon scientific principles but is not traditionally associated with medical education. Examples of those are psychology and optometry. In past years no major conflict has arisen between traditional medicine and other forms of health care. However, of late there is a movement on by non medical people to seek enactment of legislation which would grant them privileges which traditionally have been the provence of medical practitioners. Examples would include attempts by chiropractors to utilize medical facilities for laboratory testing and more germane to our state the attempt by optometry to seek legislation approved for their use of drugs within their practice.

Legislators must be aware of the short and long term implications of such legislation! Granting non-medical practitioners medical priveleges obscures the traditionally clear cut lines between the dicipline of medicine and the non-medical practices. Such obscuration of lines of deliniation serves to thoroughly confuse the public as to what type of health care is to be expected from each type of practitioner! In such confusion the public will have no clear concept of what type of "product" to expect of each health care practitioner. I wish now to focus upon a problem which confronted last years legislators and may surface again! Optometrists as you may be aware are non-medical practitioners by virture of their ancestory, training, current definition and as of several months ago defined by U.S. District judge for Alaska. They are requesting the legislature to grant them privilege of using drugs in their practice! Such a priviliege would have two fold effect and firstly it would set a precident with-in our state and open the door to all non-medical health personell to seek similar privilege. Secondly it would further endanger the people of Alaska to the risk of loss of sight because of the injudicious use of drugs and false sense of security the use of drugs imparts upon the recipients of such treatment. Indeed as time goes on I will supply you with case histories of Alaska residents who have lost eyes because they were lured into feeling they had been examined by eye physicians or ophthalmologists. I will also supply you with a legal suit prompted by such a loss of eye and additional pertinent information. I urge you not to grant non-medical health practitioners by legislation what they should rightfully earn by education that is the right to join the ranks of traditional medicine thru time honored institutions, estabilished testing procedures and time tested licensing procedures.

AEdamawa, M.D.

Rep. Buchholdt

5 February 1979

Peter E. Cannava, M.D.
Peninsula Eye Clinic
Box 1629
Soldotna, AK 99669

Dear Pete:

Yes, I did receive your packet of information and I apologize for the length of time it took me to respond.

I will forward the new information to Rep. Buchholdt as I did earlier for her files.

Again, thank you.

Sincerely,

Hugh Malone

jk

Peninsula Eye Clinic
PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669
TELEPHONE 262-4462

February 1, 1979

Representative Hugh Malone
Pouch V
Juneau, Alaska 99811

Dear Hugh:

I hope you received my last packet of information on HB79 (optometric drug bill) As you will recall it included a copy of Judge Fitzgeralds decision regarding the loss of a childs eye because of optometric mis-managment! Since I have not heard from you I presume you are quite busy and I wish you luck in your difficult task.

Enclosed please find two items: 1. the copy of "P E N" describing optometric education, 2. Veto message of Gov. Rhodes, Ohio.

Sincerely,

Peter E. Cannava M.D.

Peter E. Cannava, M.D.

PEC/bc

Governor's Veto Message

(Unofficial Copy)

December 15, 1978

Pursuant to Article 2 Section 16 of the Constitution of Ohio, I return herewith to the Clerk of the Senate for presentation to the Senate Amended Substitute Senate Bill 163 which I disapprove and have not signed. Amended Substitute Senate Bill No. 163 would expand the definition of the practice of optometry to allow the use by optometrists of specific diagnostic drugs to the eye in the form of eyedrops. If the specified drugs are used solely for the purpose of detecting disease and are of a specific level of potency the matter of health care is of vital concern they must insure to all Ohio citizens that they receive the highest quality health care possible. Health care is an area in which we can take no risks because any mistakes can bring tragic and irreversible results. We must be committed to our citizens to provide practitioners that are highly skilled individuals and who will at the same time provide the best health care at the lowest cost.

Optometrists have been doing an excellent job in working with the medical profession to bring quality eye care to Ohio citizens. The tools that the optometrists are presently using are not dangerous and are effective in screening for eye disease. However, Amended Substitute Senate Bill No. 163 would allow optometrists to use drugs in order to make a full diagnosis of the medical condition of the eye. If the individuals involved were properly trained this procedure would be in the best interest of Ohio citizens, however without proper training the bill would allow unwarranted risks without corresponding benefits. The drugs involved are dangerous and have a potential of causing a great deal of pain including blindness. The adverse reactions associated with these drugs are not common but they do occur and medical and emergency treatment must be administered in those instances. While this bill does provide for mandatory training of 180 clock hours this amounts to little more than a month of isolated training in a clinical use of the drugs involved. The goal of this legislation should be to build a working relation between optometrists and the medical community. The issue of using drugs should be an issue decided by the professions rather than by the legislature. Both professions have taken an oath to provide quality health care, they should work together toward that end. I pledge the aid of my office for that purpose. For the foregoing reasons I have vetoed Amended Substitute Senate Bill No. 163 and urge the General Assembly to sustain my veto.

James A. Rhodes
Governor

Official Business

House ... Committee on
Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

February 7, 1979

Peter E. Cannava, M.D.
Peninsula Eye Clinic
Ophthalmology
Box 1629
Soldotna, Alaska 99503

Dear Dr. Cannava:

Thank you very much for your letter and back up material regarding HB-79. I do appreciate your taking the time to send this information to the committee.

We have, to date, received this same information from Rep. Hugh Malone, and I am sure it will be of help to members of this committee.

At this time, I have not yet scheduled the bill for hearing, but I will keep you informed as to when the bill will be up for a hearing.

Again, thank you for your interest.

Sincerely yours,

THELMA BUCHHOLDT
Chairman
House HESS Committee

TB/ch

Peninsula Eye Clinic
PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669
TELEPHONE 262-4462

February 1, 1979

Thelma Bucholt, Representative
Pouch V
Juneau, Alaska 99811

Dear Mrs. Buckhodt:

HB 79 (optometric drug bill) has been sent to your committee for review. It is essential that you review the enclosed court decision concerning the loss of a young Alaskans eye due to optometric irresponsibility. As you will recall the issue last year was whether ot not optometrists were qualified to use dangerous drugs on the eyes of Alaskans. Judge Fitzgerald's decision should settle that question in the minds of Alaskans.

In addition you will find enclosed the Ohio Governors veto message of such a dangerous bill.

I would appreciate your response to the material.

Sincerely,

Peter E. Cannava, M.D.

PEC/bc

Governor's Veto Message

(Unofficial Copy)

December 15, 1978

Pursuant to Article 2 Section 16 of the Constitution of Ohio, I return herewith to the Clerk of the Senate for presentation to the Senate Amended Substitute Senate Bill 163 which I disapprove and have not signed. Amended Substitute Senate Bill No. 163 would expand the definition of the practice of optometry to allow the use by optometrists of specific diagnostic drugs to the eye in the form of eyedrops. If the specified drugs are used solely for the purpose of detecting disease and are of a specific level of potency the matter of health care is of vital concern they must insure to all Ohio citizens that they receive the highest quality health care possible. Health care is an area in which we can take no risks because any mistakes can bring tragic and irreversible results. We must be committed to our citizens to provide practitioners that are highly skilled individuals and who will at the same time provide the best health care at the lowest cost.

Optometrists have been doing an excellent job in working with the medical profession to bring quality eye care to Ohio citizens. The tools that the optometrists are presently using are not dangerous and are effective in screening for eye disease. However, Amended Substitute Senate Bill No. 163 would allow optometrists to use drugs in order to make a full diagnosis of the medical condition of the eye. If the individuals involved were properly trained this procedure would be in the best interest of Ohio citizens, however without proper training the bill would allow unwarranted risks without corresponding benefits. The drugs involved are dangerous and have a potential of causing a great deal of pain including blindness. The adverse reactions associated with these drugs are not common but they do occur and medical and emergency treatment must be administered in those instances. While this bill does provide for mandatory training of 180 clock hours this amounts to little more than a month of isolated training in a clinical use of the drugs involved. The goal of this legislation should be to build a working relation between optometrists and the medical community. The issue of using drugs should be an issue decided by the professions rather than by the legislature. Both professions have taken an oath to provide quality health care, they should work together toward that end. I pledge the aid of my office for that purpose. For the foregoing reasons I have vetoed Amended Substitute Senate Bill No. 163 and urge the General Assembly to sustain my veto.

James A. Rhodes
Governor

February 14, 1979

Representative Thelma Buchholdt
Pouch V
Mail Stop Number 3100
Juneau, Alaska 99811

Dear Representative Buchholdt:

House Bill 79 (Senate Bill 75) relating to optometrists (nonphysicians) using medications has recently been introduced this session. I hope you can take a few moments from your busy schedule to read a brief summary of what I feel are important points as regards this legislation.

1. Optometrists are not physicians. No optometrist in Alaska has had any instruction in pharmacology or drug side effects from anyone with a Ph.D. or masters degree in pharmacology, no optometrist in Alaska has ever had any instruction in anything from a full-time M.D. on any optometric school staff, and no optometrist in Alaska has ever had any formal classroom or clinical training by an ophthalmologist (a physician with specialty training in eye disease and management).

2. Legislation, as presented, would let the Optometric Board evaluate the qualifications for drug use by optometrists. The Legislative Audit Performance Review of 11-1-78, noted:

   a. The state licensing examiner was asked not to attend the last examination given by the Optometric Board.

   b. The Audit Committee also found evidence of examination results being changed, regrading of examinations, and deletion of examination questions.

   c. The Audit Review was unable to find recent oral, written, or practical exam questions and answers.

   How can this Board, who has apparently compromised its integrity and responsibility given them by state statute but has also never had any experience in pharmacology, be expected to fairly pass on the qualifications of one of its own practitioners to use medicines in the eye.

3. The trend across the country is to defeat this sort of legislation. In 1977, this type of legislation was defeated in 17 states and passed in four; in 1978, it was defeated in 15 states and passed in two; and already in 1979, it has been defeated in one state and passed in none. This legislation is not beneficial to the public welfare, further confuses the consumer as to who he is entrusting the care of his eyes, and endangers the public at the hands of nonphysicians.

4. "Diagnostic drops" is a misnomer. The drugs don't diagnose - people diagnose. Dilating the eye is not a prerequisite to making a diagnosis of eye disease, dilating the eye is not a prerequisite to supplying children with the proper correction for glasses, and anesthetic drops are not a prerequisite for the diagnosis of glaucoma.

5. Optometrists (non-M.D.s) have no training in the management of side effects of these medications; e.g., myocardial infarction (there were seven cases of documented heart attacks due to these drugs in the United States in the past 12 months) or narrow angle glaucoma caused from dilating the eyes (there's an extremely high incidence of this condition in Alaskan natives).

6. Optometrists are not trained in the detection of pathology. An optometrist, currently a member of the Alaska Optometric Board, caused an eye to be lost in a four year old child because of his inability to recognize disease and refer the child in a timely fashion. Please find enclosed an issue of PEN newsletter which, in detail, describes Judge James Fitzgerald's findings in the Fourth Judicial District, U.S. District Court in the State of Alaska in October of 1978.

7. Let me suggest some appropriate amendments to this legislation if you feel it is in the public's best interest:

   a. There should be mandatory referral if the vision cannot be corrected to 20/20 in each eye in an adult or 20/30 in a child under eight years of age (this is a current law in England).

   b. There should be no "miotic drop" inclusions. No one considers miotic drops as a diagnostic drug.

   c. It would be appropriate to ensure the availability of malpractice insurance to optometrists to protect the public.

   d. There should be no grandfather clause.

   e. Any pharmacology or pathology testing should be done by the American Board of Ophthalmology. They are the most experienced group and the logical group to design such an examination.

   f. There should be mandatory referral, as per Dr. Alfred Lemoine who is often cited by optometry as an ophthalmologist in favor of diagnostic drug use by non-M.D. optometrists (see enclosure - 10 points in the history, 33 points in the clinical evaluation).

The regulation of the practice of the various professional and paraprofessional groups is not for the benefit of the licensee but for the benefit of the state and its people. No where does case law suggest 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 and the language is explicit.

A disregard for excellence, as would result with passage of House Bill 79 (SB 75), as it is presented to you, will adversely affect the superior level of eye care currently offered to the citizens of Alaska. A little bit of this Bill is like a little bit of syphilis.

Thank you for the time you have taken.

Sincerely,

Sam A. McConkey, M.D.

SAM:ls

Submitted by
Dr. Sam McConkey

SUMMARY

Albert N. Lemoine, M. D., F.A.C.S.

There are ocular complaints obtained in the history and findings during an ocular examination that almost without exception are an indication for referral to an ophthalmologist for definitive diagnosis and therapy.

HISTORY

1. Rapid visual loss - over a period of minutes or hours.
2. Episodes of intermittent periods of reduced vision.
3. Sudden onset of "floating spots" in the field of vision.
4. Flashes of light in the visual field.
5. Defects in the field of vision, scotomas.
6. Distortion of objects or lines.
7. Rapid onset of visual haze with no specific complaint of decreased visual acuity.
8. Severe pain around the orbit or in the eye.
9. Prolonged severe pain in the occipital area.
10. Diplopia or visual confusion.

CLINICAL FINDINGS

1. Best corrected visual acuity 20/40 or less, unless they nave had a prior diagnosis by an ophthalmologist.
2. Any patient whose refractive error changes one half a diopter or more, especially on the hyperopic side, within ninety days except for children with myopia.
3. Masses of the lids or adnexa either with or without inflammatory signs.
4. Defects in the lid margin.
5. Redness that is most marked ir the 2 mm. zone adjacent to the cornea.
6. Any type of corneal clouding or infiltration either with or without congestion of the conjunctiva.
7. Cloudy anterior chamber.
8. Blood in the anterior chamber.
9. Small, poorly or nonreactive pupil.
10. Dilated, poorly or nonreactive pupil.
11. White pupil reflex.
12. Cataracts or lens opacities before the visual acuity is reduced to 20/40 or less.
13. Vitreous "floaters".
14. Blood in the vitreous.
15. Papilledema.

16. Optic atrophy, primary or secondary.
17. Larger or smaller than normal disc.
18. Abnormal disc cupping.
19. Dilated veins with or without retinal hemorrhage.
20. Narrowed arteries with or without retinal hemorrhage.
21. Any masses seen in the fundus, pigmented or nonpigmented.
22. Retinal hemorrhages, one or both eyes.
23. Pigment disturbance, either increase in pigment or decrease other than the dark fundus of the black race or lack of pigment in blond or albino patients.
24. Any areas of retinal elevation.
25. Retinal tears.
26. Presence of diplopia.
27. Nystagmus.
28. Scotoma.
29. Distortion of lines Amsler Grid or objects.
30. Any visual field defect other than blind spot.
31. Ptosis.
32. Intraocular tension of 22 or more on two or more occasions.
33. Exophthalmos, unilateral or bilateral.

Don Hostak, Director
Div. of Occupational Licensing

XXXXXXXXX
02 13 79

Byron Perkins BP
Licensing Examiner

I spoke with Eldon Ulmer, President of the Board of Pharmacy, and he asked me to convey the following to you in response to your teletype to him last week.

RE House Bill 79 XXXXXXXXXXXXXXXXXXXXXXXXXX regarding optometrists and particularly their ability to prescribe legend drugs and pharmaceuticals, the Alaska Board of Pharmacy has not changed its position on this issue. The board is not primarily concerned with whether or not an optometrist should be given this priviledge, but rather, that the proposed bill in no way addresses the legal question of how they are to obtain legend drugs. Current Federal and State statutes do not permit pharmacists to fill prescriptions for legend drugs by any one but Medical Doctors, Veterinarians, and Dentists.

Re House Bill 101 and Senate Bill 65, the Uniform Controlled Substances Act, this is the number one legislative priority for the Board of Pharmacy, and the board supports it conceptually. However, the current bill is primarily a police bill, and needs to be ammended substantially to make it palatable to the industry. There is not enough language addressing the rights and responsibilities of professionals authorized to handle controlled substances. The Board of Pharmacy is pushing for a Uniform Controlled Substances Act that parallels the federal guidelines.

cc: Eldon Ulmer, R.Ph.
Chairman, Board of Pharmacy

Don Hostak, Director
Div. of Occupational Licensing

02 13 79

Byron Perkins BP
Licensing Examiner

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DR. M. C. FALCONER
DR. J. C. FALCONER
DR. G. L. HALL
DR. T. F. HARBOUR
DR. B. L. WALKER
DR. W. D. FAULKNER
OPTOMETRISTS

ANCHORAGE EYE AND CONTACT LENS CENTER
1345 W. NINTH AVE. PHONE: 272-2557
ANCHORAGE, ALASKA 99501

March 7, 1979

Honorable Thelma Buchholdt
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

It has been brought to my attention that information in opposition to HB 79 has been distributed to all legislators. Some of this information contained in an ophthalmological tabloid newspaper entitled The Pen, although a sensational distortion of fact, demonstrates the responsibility of optometrists to detect and refer pathological eye conditions. The use of drugs (DPA's) requested by optometrists in HB 79 is simply a tool to help better serve the public, so that unfortunate incidents such as those described in The Pen will be more easily detected.

I urge you to consider the following facts prior to making a committment for or against this bill. These facts are excerpted directly from a report to the United States Congress by the U.S. Department of Health, Education and Welfare which I am enclosing.

1. It is the responsibility of optometrists to detect and refer pathological eye conditions.

2. Optometrists currently receive training in detection of ocular disease as well as in the use of pharmaceutical agents including management of side effects.

3. H.E.W. consultants on this report unanimously recommended that state licensure laws be revised to allow the use of diagnostic pharmaceutical agents by optometrists. (24 states now allow this practice)

If you have any questions regarding this bill or statements made in opposition to it, I would like to have the opportunity to respond with documented facts from objective sources. I appreciate the time you have taken to consider this very important legislation.

Thank you.

Sincerely,

Boyd L. Walker, O.D.

Boyd L. Walker, O.D.

BLW:ah

REPORT TO THE CONGRESS: REIMBURSEMENT UNDER PART B OF MEDICARE FOR CERTAIN SERVICES PROVIDED BY OPTOMETRISTS

• U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE • Public Health Service • Health Resources Administration •

The Bureau of Health Manpower projects the overall number of active ophthalmologists in the United States to rise to 13,300 in 1980 and to 18,400 by 1990; this compares with projected levels of 22,000 and 28,200 for optometrists in the same time intervals. The proportion of ophthalmologists as a percent of total professional vision care manpower is projected to grow from 35 percent in 1973 to 38 percent in 1980 and 39 percent in 1990. These estimates should be interpreted cautiously, and should be undertaken in the context of written documentation available from the Bureau of Health Manpower. Available data preclude such projections on a detailed geographic basis.

More specific data indicates that in recent years many areas of the country, particularly non-metropolitan areas, are served only by optometrists. Approximately 40 percent of counties have an optometrist but no ophthalmologist. Another 27 percent have neither.

Optometric Practice

The Institute of Medicine of the National Academy of Sciences, in describing primary health professions who are direct providers of patient care, defined optometry as follows: "The Doctor of Optometry (O.D.) is a health professional who performs eye examinations to determine the presence of visual, muscular, or neurological abnormalities, and prescribes lenses, other optical aids, or therapy, such as eye exercises to enable maximum vision. Optometrists are trained to recognize disease conditions of the eye and ocular manifestations of other diseases, and to refer patients with these conditions to the appropriate health professional."

This definition, as well as available documentation on the utilization of optometric services, points to the optometrist's role as a provider of primary health care services. In this role, the optometrist functions as a principal point of contact within the health care system for persons having visual complaints, including certain numbers who have symptoms or conditions that require referral to other health practitioners.

The scope of practice for optometry, similar to that for other health care providers, is difficult to define precisely. However, information is available from a number of sources to develop valid concepts of a profession's role and function. Such sources include State laws, judgments of courts concerning the responsibilities of practitioners, the usual and customary practices of the profession, and the objectives, content, and standards of education and training for the profession.

An examination of a variety of such sources suggests that optometry is a profession qualified to provide a broad range of services which are effective in patient management, including the management of aphakic and cataract patients. (See discussion in Part II of this report for detail on sources cited and information examined.) It is reasonable to infer that such services correspond to many specific

ATTACHMENT B

BASIC ELEMENTS OF THE CURRICULUM OF SCHOOLS OF OPTOMETRY

1. Biological science knowledge base.

   a. Gross human anatomy and microscopic anatomy, with emphasis on head, neck, and thorax.

   b. Embryology, gross and microscopic anatomy of the human nervous system - concentrating on the central nervous system.

   c. General human physiology, including the study of the fundamental organ systems and the mechanisms which regulate body function. Emphasis is on the sensory, motor and cardiovascular systems.

   d. Basic concepts of general and cellular biochemistry, with study of nomenclature, structure, and reactions of organic molecules. Emphasis is on the visual system - tears, intraocular fluids, lens, retinal photochemistry, and actions of drugs upon these.

   e. Concepts of human genetics and genetic disorders, including the frequency and distribution of genetic disease, inheritance patterns, polygenic inheritance, chromosomal abberration syndromes, multifactorial genetics, and principles of genetic counseling.

   f. Gross and microscopic anatomy of the lids, orbit, orbital content, globe, muscles, nerves, and vessels, and embryology of the eye.

   g. Vegetative physiology of the eye, extraocular and intraocular fluids, corneal and lens metabolism, ocular circulation, retina and optic nerve metabolism.

   h. General pharmacological principles, methods of administration, various systemic drugs and their pharmacological action and side effects with emphasis on those that affect the visual system, such as cataractogenic and glaucoma-producing drugs.

   i. Pharmacology; uses, doses, contraindications, and adverse effect of drugs producing miosis, mydriasis, cycloplegia, accommodation, and ocular anesthesia. The pharmacology, use contraindications, and adverse effect of drugs commonly used in treating visual and ocular problems.

As is evident from the discussion above, the Department endorses the first recommendation. For reasons cited, however, Department endorsement of the second recommendation is viewed as inappropriate and premature at this time.

During the course of the study effort, a number of additional issues and concerns were identified by the expert consultants which, although important considerations, represent matters not directly responsive to the specific legislative charge as interpreted by the Department. These recommendations and comments, made unanimously by the consultants, are presented here to provide an opportunity to bring these matters to the attention of Department Agencies and the Congress. Because the following items go beyond the requirement of this report, the Department has not fully examined them and makes no recommendation at this time.

1. Refractive services for aphakic patients

Aphakic patients, specifically, should be considered as having special needs given their disabled condition. Refractive services for such patients represent non-routine and necessary services in the provision of prosthetic devices, i.e., lenses.

Study advisors recommend that consideration be given to extending coverage under Part B of Medicare to include refractive services for aphakic patients when provided by either ophthalmologists or optometrists.

2. Low vision services and aids

For those patients who have inoperable cataracts or have less than optimal results from cataract surgery, that is, those who have reduced visual acuity, low vision services and aids represent essential components of reasonable and necessary health care services for these patients.

Study advisors recommend that coverage under Part B of Medicare be extended to include the provision of appropriate low vision services and optical aids for the above-referenced patients, when provided by either ophthalmologists or optometrists.

3. Prevention, health maintenance, and health education

In the interests of health care cost advantages, effects on productivity, and the overall improvement of benefits that can be afforded our population, the expert consultants recommend that a more effective effort be made to improve preventive, health maintenance, and health education measures. While this is needed in all areas of health services, the vision/eye care field offers a particularly promising area for such approaches.

4. Other service provided by optometrists

Vision/eye care services currently covered by Part B of Medicare, when provided by ophthalmologists or other physicians, include eye conditions other than cataract and aphakia. Optometrists can provide appropriate services for some of these conditions. It is recommended that extension of reimbursement to include the services of optometrists for such appropriate conditions is a desirable subject for further consideration.

5. Administrative considerations

Also during the course of the study effort, expert advisors raised several concerns pertinent to the administration of the Medicare program. These issues, also applicable to other Medicare services, include the following: (a) inconsistent application of coverage and reimbursement policies by individual carriers, (b) the problem of payment duplication for services and reimbursement for similar diagnostic procedures when performed for specific individuals by more than one provider, and (c) need of improvement in coding and billing procedures for vision/eye care services.

6. Cooperative working relationships between vision/eye care professionals

It became clear during the course of this study that more effective working relationships between optometry and ophthalmology and other providers in the vision/eye care field would enhance patient care and result in improved services to individual patients. While improved interdisciplinary coordination applies to all the health disciplines and specialties, it is a problem of particular concern in the vision/eye care field. Such working relationships could be significantly strengthened by

a. Development of joint educational programs at the undergraduate and graduate levels, including rounds, clinics, conference, and meetings and publications.

b. Establishment of interdisciplinary clinics with optometrists and ophthalmologists working together.

c. Facilitation of referral of patients between the optometrist and the ophthalmologist when in the best interest of the patient.

d. Joint development of quality standards for service and materials by peer review mechanisms. By materials, particular reference should be assigned to varying quality of lenses and frames and the need for furnishing laboratory invoices of material costs for reimbursement.

e. Joint development of appropriate revision to State licensure laws to permit use of diagnostic drugs (mydriatics and local anesthetics) by optometrists.

While such joint endeavors are evident in various areas of the country, they need to be broadened and routinized.

Eye-To-Eye 3/2/79

Currently before the House Health, Education and Social Services Committee is a bill (HB 79) which would allow optometrists to use certain drugs in eye drops for the purpose of making diagnoses. Optometrists could use these drugs only after completing an approved pharmacology course and passing an examination administered by the State Board of Optometry. The drugs involved would either open or paralyze the pupil of the eye or deaden pain.

Though the bill is relatively straightforward on the surface, it has acted to draw battle lines in the field of medicine in general and eye care in particular.

On one side of the line are optometrists, who historically view their profession as measuring the eye and fitting it with corrective lenses when needed. Optometrists in Alaska are required to have completed a six-year program through which they receive a doctor of optometry degree. They still may not prescribe drugs for the treatment of patients or perform surgery.

Optometrists argue that the use of the drugs would allow them to detect better problems with the eye. And as a result they argue, they could offer a higher level of service to their patients.

On the other side of the line are opthalmologists, who argue that as medical doctors who specialize in the treatment of diseases of the eye, they should retain the sole right to administer drugs, diagnostic or otherwise, to patients. Other branches of the medical profession generally agree. Ophthalmologists also point to the potential danger of adverse reactions of patients to the drugs.

To understand the basis for the argument it is essential to clear up the blurred distinction between the two professions. As we stated previously, the optometrist is not a medical doctor as such. An optometrist concentrates on detecting defects and faults in the eye and prescribing correctional lenses or exercises but not drugs or surgery. Historically, optometrists refer their patients to ophthalmologists should the problem be beyond the scope of their practice.

Ophthalmologists, on the other hand, are medical doctors, who after completing medical school continue to specialize in their field. To complete the entire program of medical school and the study of ophthalmology requires 12 years.

The crux of the problem, however, revolves around the drugs the optometrists are asking to use. There are four types: mydriatics, which open the pupil; cycloplegics, which open the pupil and paralyze the focusing mechanism; miotics, which constrict the pupil; and anesthetics, which take away the feeling.

In rare instances, though, complications can arise from the administration of these drugs. Some of them can even be dangerous. Nervous disorders, convulsions and death are known to have resulted from the administration of these drugs in rare cases, according to the Boston Globe.

But one person seems to be lost in the argument between optometrists and ophthalmologists—the patient. Will the optometrists' ability to use diagnostic drugs override the potential hazard of an adverse reaction to the drug? There is no black-and-white answer, but one conclusion can be drawn safely. The best-trained ophthalmologists in the state have agreed that the potential danger to the patient exists and that the bill under consideration contains inadequate safeguards to the public.

The question that has to be asked is if a patient of an optometrist does have an adverse reaction to one of these drugs, what would he do? Most sources agree that he would probably have to call a doctor—an ophthalmologist, to correct or treat the problem.

When it comes to the public's health, the Legislature, when approached with bills such as this, should take the prudent course and turn them away, unless there is overwhelming evidence that the public would benefit.

Without a doubt, the prudent course is to turn away HB 79.

HB 79

JAMES H. PATTERSON, M.D.
Diseases and Surgery of the Eye
Subspeciality Pediatric Ophthalmology
3500 LATOUCHE
ANCHORAGE, ALASKA 99504

Telephone 907: 274-2252

February 26, 1979

Senator Thelma Buchholdt
Chairwomen, Senate Judiciary
Committee
Pouch V
Mail Stop Number 3100
Juneau, Alaska 98111

Dear Senator Buchholdt:

As a physician and surgeon I am most concerned about SB 75 and HB 79 which propose to give nonmedical eyecare practicioners (optometrists) the privilege of applying potent medications to the eye for diagnostic purposes.

The proposed bill lists only broad general categories of the desired eye medications, not specific drug names and concentrations. The classes of drugs include such potent substances as Cocaine, Atropine, Scopolamine, Phenylephrine and Phospholine Iodide. All these drugs when applied to the eye are readily absorbed into the bloodstream and are capable of producing a wide range of total body effects.

Cocaine, a topical anesthetic and mydriatic (dilater of the pupil) is a controlled substance which is subject to wide spread abuse by addicts and requires a controlled substance registration certificate to dispense. Atropine and Scopolamine are cycloplegic agents which paralyze the eyes focusing power and in sufficient doses produce irritability, hallucinations and even coma. Phenylephrin (a mydriatric) has the ability to raise the blood pressure markedly and to alter the rhythm of the heart and has been implicated in deaths in older people through strokes and in children through cardiac arrhythmias. Phospholine Iodide, a miotic which constricts the pupil, is used in the treatment of glaucoma (elevated pressure in the eye) and in certain cases of crossed eyes, the active ingredients are related to the active substance in certain insecticides and nerve gas. This medication has been shown to produce retinal detachments and cataracts. Miotics are a therapeutic class of drugs and are listed incorrectly in the proposed bills as diagnostic drugs.

The above are only a few examples demonstrating what potential dangers exist is the various classes of the drugs listed in the proposed bills. By allowing wide spread use of these drugs by nonmedical persons the overall risk to the general public of potentially serious effects or untoward reactions are markedly increased.

This type of legislation is not unique to Alaska. The initial nationwide optometric movement, in attempting to enter the practice of medicine, was successful and approximately 20 states have some type of optometric drug legislation. In the past 2-3 years as the full implications of such legislation became known optometric drug bills have been going down to defeat by about a 3 to 1 margin.

I would appreciate your support in helping prevent these bills from becoming law. I not only can but will readily answer any questions or document any items that I have commented on in this letter.

Sincerely yours,

James H. Patterson M.D.

JHP:plz

HB 11

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

February 26, 1979

Respresentative Thelma Buchholdt, Chairman
House of Representatives
Health, Education, and Social Services Committee
Pouch V, Mail Stop #3100
Juneau, Alaska 99811

Dear Ms. Bushholdt:

The Alaska State Medical Association Legislative Committee has reviewed House Bill 79, an act relating to the practice of optometry.

Enclosed is a copy of correspondence relating to the issue during the 1978 Legislative Session. The position of the Association remains essentially the same, namely:

(1) We are unable to determine how this legislation will improve eye care or specifically benefit the public.

(2) Specifically, we know of no diagnostic use for the drug class, miotics, requested; in converse, their use would be appropriate for treatment of narrow angle glacoma, precipitated by a mydriatic/cycloplegic use. This condition, we understand, is more prevalent amongst the Alaska natives than the general population, such that bush use of these drugs could carry increased risk.

(3) We approve the educational requirements added in the 1979 legislation. It follows that should the Legislature believe the proposed legislation is in the broad public rather than for special interest, no grandfather type clause should be allowed.

Sincerely,

W Fish

Winthrop Fish, M.D.
Chairman, Legislative Committee
Alaska State Medical Association

WF:mlm

Enclosure

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 ex nded 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,

WFish

Winthrop Fish, M.D.
Chairman, Legislative Committee

WF:mlm
cc. ASMA Council
ASMA Legislative Committee

PUBLIC DANGER DOCUMENTED

SPECIAL SUPPLEMENT

ANNUAL REVIEW OF SELECTED CASE HISTORIES

As published in THE PEN...— during 1977-78

TUMOR OVERLOOKED

Mrs. Lois McWalters

•

Massachusetts Widow

Vol. 1, No. 1, July 15, 1977

The first issue of THE PEN featured a tragic testimonial headlined "Massachusetts Widow: 'It Seems Bizarre.'" Excerpts follow:

Five years ago my husband began complaining about his eyesight. He decided to see an optometrist and he continued to do so for 2½ months. As his vision deteriorated at this time, he experienced headaches so violent they would awaken him from a sound sleep. I pleaded with him to see an ophthalmologist or some person with a medical background. He became increasingly irritated at my suggestions and I was forced to bow to his decision or submit to an unhappy home life.

As each day passed, before my eyes his personality changed; this sweet gentle man became verbally abusive and the general tenor of our home was unbearable. At that time our four children were 6, 7, 8, and 9 years old. They watched their father hold a cup of coffee, his hand tremors so pronounced he would spill it and leave the table in a terrible rage.

I pleaded again, to no avail. How does a wife forcibly take a grown man to a doctor? He *trusted* the optometrist. The optometrist changed his glasses three times - each prescription being for stronger lenses - during those 2½ months. Each time his eyesig[illegible]d the pain was not even slightly improved by the [illegible]ge of glasses. He was told it would take time to get used to them. The optometrist never suggested he see a medical person.

His suffering increased to such a point he could not work or concentrate. I suggested a vacation and he agreed. . . . He now had a black patch over one eye "to rest it" prescribed by the optometrist.

I was frightened; I felt he was dying and I was helpless. After a few days of rest I gently broached the subject again and very unlike me, burst into tears. . . .

Our vacation was cut short because he was so ill. He insisted upon going to work when we got home, but surprised me by phoning from the hospital. He had seen an ophthalmologist who immediately spotted the problem and within minutes called in a neurosurgeon. The neurosurgeon admitted him to the hospital at once. I discovered later that when the ophthalmologist's *secretary* heard the symptoms over the telephone, she had insisted Dick come to the office immediately.

The neurosurgeon told me frankly he felt that Dick had a brain tumor. At our community hospital, tests were done in the next few days; the consensus was a brain tumor.

Surgery was at nine. . . .

Bad news it was, a malignant brain tumor called an astrocytoma. "I would give him about eighteen months," the doctor said, "but be prepared for some horrible times ahead." Twelve days later God mercifully took his beautiful soul and left his tired, worn body. . . .

In retrospect, it seems bizarre to me that when one (in this case the optometrist) realizes a situation is out of his control, that he wouldn't immediately make a referral, especially when seeing a patient suffer so much. •

SPECIAL ANNUAL PERSONAL EXPERIENCE REVIEW ISSUE

During its first year, THE PEN has published numerous carefully documented cases of eye damage resulting from attempts by non-medical practitioners to practice medicine. These four pages are a collection of selected excerpts of those cases which have prompted expressions of maximum interest from readers.

While there has been no official response or challenge from organized optometry, individual optometric lobbyists have advised legislators that these cases are "isolated instances." The steady flow of similar testimony pouring into PEN headquarters prompts us to suggest that the cases are not "isolated," but rather "the tip of an iceberg."

The Editors

OPTOM-PSYCHIATRY

Barbara Cosgrove

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"Lack of Love"

Vol. 2, No. 3, Feb. 1, 1978

A Connecticut woman, interviewed by Jeffrey Gold, M.D. of New Haven, told how an optometrist claimed her child's blurred vision could be cured with "more love and understanding at home" in a story headlined "O.D. Calls Diabetes A 'Lack of Love'." Passages of that interview follow:

Dr. Gold: "Mrs. Cosgrove, why did you bring Barbara to me?"

Mrs. Cosgrove: "We were referred here by our family doctor who just found diabetes in Barbara. She is 11 years old. I told him I had just had her eyes checked by an optometrist."

Dr. Gold: "Do you mean Barbara was examined by an optometrist lately?"

Mrs. Cosgrove: "Yes, she failed the school vision test in November and they said to have an examination. He (the optometrist) has a great big sign out in front, that says 'Doctor,' and I thought he was one."

Dr. Gold: "What did he find?"

Mrs. Cosgrove: "He said there was nothing wrong with her eyes and when I asked him why she kept getting blurred vision, he told me that she was a nervous child and when she gets up-tight, her eyes get blurry. My reaction was to take her to a social worker, but he (the optometrist) told me she just needs more love and understanding at home and that there was no reason to do any more than see him again next year."

Dr. Gold: "Then what happened?"

Mrs. Cosgrove: "I thought I was some kind of a rotten mother with such a nervous child, and I cried that night."

Dr. Gold: "Did you pursue the blurred vision at that time?"

Mrs. Cosgrove: "During December, Barbara seemed to have the flu, but it didn't go away and by Christmas Eve, I real-

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DANGER AND WASTE IN THE VA

Robert B. Nolan

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Disabled Veteran

Vol. 2, No. 8, April 15, 1978
Vol. 2, No. 11, June 1, 1978

In these issues, a totally and permanently disabled veteran told how he got less than the deserved in-depth investigation into the problem of allowing VA optometrists medical functions. Mr. Nolan again found more evidence of danger and waste in the VA. Excerpts from the first story follows:

". . . The VA would not permit me to receive outpatient treatment from a private physician unless I lived 30 to 50 miles from a VA treatment center. I didn't, so I decided to pay for my own doctor and then go to the VA and see their M.D. for medication only.

"My wife called the VA in the federal building in downtown St. Petersburg for an appointment early in August of 1977. She told the girl on the phone that I needed an eye doctor because I had glaucoma.

"My first visit to the VA eye 'doctor' was Augus[illegible] 22, 1977. I presumed that the doctor I saw was a[illegible] M.D. ophthalmologist. His name was on the do[illegible] and it said 'doctor.' . . .

"T[illegible]e 'doctor' finally tested my tension with [illegible] and said the pressure was 16 in each eye. I showed him the prescription I had received from Kenneth Safko, M.D., my own ophthalmologist, and he said, 'Wait until I xerox this as it is no good here. I will have to write my own prescription.'

"After copying Dr. Safko's prescription and putting it in my file, he wrote his own prescription and took it next door to get it co-signed. . . .

"On my way to the pharmacy with my wife, she looked at the prescription and said it didn't look right. We took it back and the 'doctor' changed it from pilocarpine to 3/4% carbachol with six refills. Another doctor (probably an M.D.) cosigned the new prescription. . . .

"On our next trip to the VA center, my wife asked the woman at the front desk if the doctor we saw was an M.D. and an ophthalmologist. The woman at the desk replied, 'Yes, he is a full-fledged doctor and an ophthalmologist fully qualified to treat eyes.' . . .

"When I finally got the glasses, sometime in late November or early December of 1977, I discovered I could see much better without them.

"On my next trip to the VA on December 19, 1977, I returned the glasses. The 'doctor' told me the reason the glasses had been so long coming was because he rejected them two or three times, since they were not to his prescription. When he took the glasses to the next office to check them, my wife and I looked at his diploma on the wall. It said 'Doctor of Optometry.' When I told him we thought he was an ophthalmologist, he became very angry and said, 'Do you question my qualifications?' I told him I certainly did question his qualifications to treat glaucoma or any other eye disease. He told me that the people at the front desk didn't know the difference between an ophthalmologist and an optometrist. I said, 'If this is true, what if my eyes need surgery?' He said if that were the case I would have to go to the Tampa VA Hospital or the Bay Pines VA Hospital and some other doctor would operate. . . .

"Talking to people in the waiting room, we

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Tragic Case Histories Dramatize The Need To Protect The Public From Sub-Standard Eye Care

NETWORK TV WARNING

Totie Fields

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Comedienne

V 1, No. 8, Nov. 1, 1977

The following is a portion of an interview between TV-talk show host Merv Griffin and comedienne Totie Fields, during which she warned all diabetics to seek eye care only from ophthalmologists:

MERV: It was kept very quiet; but all of a sudden, about two months ago we all heard rumors that, now you were losing your eyesight from the diabetes.

TOTIE: It's true, it's true! — and you know why I want to talk about it?

MERV: Blue Cross must hate you!

TOTIE: They have lost so much money on me.

MERV: Have they?

TOTIE: Yeah, but you want to know? I didn't know it, Merv, I swear to you I saw 20/20! . . . this is what I want to make a point of, I went to an optometrist all the time and he said, "Totie you're doing wonderfully, everything is fine," . . . I've been a diabetic since I was nineteen years old, and you know how I watch myself; I weighed 200 pounds; all I ever thought about was eating. I swear to God they told me I couldn't eat and that was the end of it!!! I mean, I just ate myself into oblivion!! I used to do a show and in the middle I used to think where could I get a pizza around here; you know I thought of nothing but food, Mallomars, if I could only eat a Mallomar! Oreos, you know I was an Oreo freak . . . Oh, I talk about them and my mouth gets filled with saliva!!! **I saw a little thing floating in my eye like a little hair, you know, that you couldn't get rid of and so I went to an ophthalmologist. Diabetics should never go to an optometrist, they must go to ophthalmologists because they see behind the eye.** He said, "Totie, you've got to go . . . the best man in the country is in San Francisco and you must get to him right away." The next morning I was there and this man was telling me I was going blind, and I said, "You're crazy! Why didn't anybody else . . ." Well, they were so busy worrying about everything else, no one thought of my eyes, and I've never (incidentally, no one's ever heard this story before) — Well, to make a long story longer . . . yeah! I want, because I really want diabetics to be so aware because this operation is only two years old, Merv, and ironically enough, my dad died blind, my brother died blind, and I would have. . . .

One day you get to that age where all the print is gone and the paper comes and you say why did they send me a white paper (laughter) — you know, and you'd go to the toilet and drop it on the floor and read it there (laughter) . . . you know what I mean. But, I can read proof! I mean, to open a menu and be able to see it without looking for my glasses is the most exciting thing, but I want you to know, everybody out there that is a diabetic, please, please go to an ophthalmologist . . . because you can be saved! You know the ironic part of this entire story, I did "Fight for Sight" — the benefit "Fight for Sight" for about five, six years in a row and that's the money that helped this whole thing! (applause) To get this discovery! Isn't that incredible? (applause) And you won't believe how I can see every wrinkle in your face, Merv, every wrinkle in your face, I never could see them before . . . ●

GLAUCOMA UNDETECTED

Mrs. Agnes Karrman

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Connecticut Housewife

Vol. 1, No. 5, Sept. 15, 1977

Appearing in this issue of THE PEN under the headline "Conn. O.D. Tells Housewife: 'You Don't Have Glaucoma'," a Conn. woman told of an optometrist who failed to recognize her glaucoma. Excerpts follow:

"I was a nervous wreck before I visited the ophthalmologist that day in October, 1975, and then the bottom had just dropped out of everything. My fears had been justified because the ophthalmologist had just told me that I was suffering from far-advanced glaucoma. For some time I had experienced increasing difficulty with my vision. I couldn't read the paper without a magnifying glass. My eyes were constantly watering and sometimes I awakened at night with a headache. I could no longer see well enough to play the piano or organ.

"...Yet, despite these complaints, my optometrist had assured me for over a year there was nothing seriously wrong with my eyes.

"I had been going to an optometrist regularly for about seventeen years — ever since he had opened his office. He was always pleasant and the glasses he fitted for me were generally satisfactory. In 1974 I went to him complaining of blurred vision. He gave me new glasses but they didn't help. I went back to him and he told me that they were the right glasses and that I just hadn't allowed enough time to get used to them. I told him that I was worried about glaucoma because my brother had had surgery for glaucoma and is almost blind, and my sister was being treated for glaucoma by an ophthalmologist. She is doing well because her problem was discovered early. The optometrist assured me that he had checked for glaucoma **and that I didn't have it.**

"Several months later, because of increasing trouble with my vision, I returned to the optometrist . . . He again changed my glasses. At that visit I again voiced my fear of glaucoma and once again he assured me that my eye pressure was normal and that I didn't have glaucoma. He said my eyes were just tired. Well, the new glasses didn't help at all. They seemed to be no different than the previous pair he sold me . . .

". . . After another month and a half had passed I returned to the optometrist because my eyes pained at times and I often awoke at night with headaches. My vision was getting worse and my eyes watered constantly. This time I really pressed about my fear of glaucoma. He re-examined me and again sold me a pair of glasses — the third pair in less than a year! He told me that his $3,000 special instrument measured accurately for glaucoma and that a referral to an ophthalmologist was not necessary. In fact, he told me that I had nothing to worry about, that my eyes were perfectly clear. He said, *'You don't have glaucoma and you don't have cataracts.'* He gave me some eye drops to use three or four times a day. I used them regularly for the next four months until my sister finally persuaded me to see her ophthalmologist. In the meantime, my vision had continued to get worse and I could no longer enjoy any activities that required good eyesight.

"As I said earlier, my first visit to the ophthalmologist was a shocker. It was such a different examination! Not only did the ophthalmologist find that my pressure was higher than normal, he also found that my optic nerves had been severely damaged by this long-standing pressure and that my side vision had been destroyed. I could only see as though I were looking down a gun barrel . . . He discovered that I did have cataracts, but they were only a small part of my eye health care difficulties.

"The ophthalmologist's diagnoses and explanation of the extent of my problems not only added to my nervousness but made me very angry. I was angry with myself for not having listened to my sister's advice months ago to see an ophthalmologist and not an optometrist, and I was plenty angry with the optometrist! The doctor told me that an optometrist is not trained in medicine nor to diagnose or treat eye diseases. How can an optometrist act like an 'eye specialist' and flatly assure people that he is capable of this type of decision making? How can he keep peddling new glasses and sell eyewash types of eyedrops with implied assurance that they can cure? How can he stand by and literally watch one of his long-time customers go blind?" ●

EXTENSIVE EYE DAMAGE

Denton Livensparger

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Double Jeopardy

Vol. 2, No. 7, April 1, 1978

In a story headlined "Misuse of Drugs Plus Misdiagnosis Puts Floridian In Double Jeopardy," a Florida ophthalmologist told of how an optometrist missed signs of glaucoma and serious corneal abrasions requiring surgery in both eyes of a male patient. Excerpts follow:

"Misdiagnosis combined with the misuse of powerful drugs by untrained practitioners poses a frightening threat to public health and places our citizens in double jeopardy," says John D. Mallonee, M.D., a practicing ophthalmologist in Ft. Pierce, Florida. "The advanced years of many of our patients makes this menace even more serious and the public must be made aware of this grave danger," Dr. Mallonee said.

In support of his forthright statement, Dr. Mallonee detailed the following case history.

"On February 4, 1978, I first saw Denton Livensparger. This 65-year-old man came to my office of his own volition, and without referral. He told me he lived at 1196 Proctor Lane in Port St. Lucie, Florida, a nearby retirement community, and had been suffering severe pain in both eyes for some time. Mr. Livensparger voluntarily gave the following account of his experience to date."

"In early November 1977, I think it was the 8th," the patient said, "I went to see an optometrist about the pain I had in both eyes . . . I told them that for a long time, maybe nine or ten months, I felt as though I had something in both of my eyes, and that the pain was just getting worse all the time. After they examined me, they told me all I had was an eyelid infection and they gave me some antibiotic drops called Neodecadron. I went back again the next day and they told me I didn't have glaucoma, and all that was the matter with me was a minor eyelid infection that would clear up if I used the drops."

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GLAUCOMA UNNOTICED

Mrs. Florence Hubbard

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Blinded High School Student

Vol. 1, No. 2, Aug. 1, 1977

The following excerpts are from a byline story by a Massachusetts student headlined "'They Call Themselves Doctors' - . . . Blinded High School Student," in which she told how an optometrist could not recognize advanced glaucoma.

"In August 1967 I was walking home from a friend's house when I knocked over a trash can because I didn't see it. A couple of days later I noticed that things looked blurry. I couldn't read signs or make out faces and when I looked at lights, there was a rainbow around them.

"I went to an optometrist in September and told him about all of this and that I had a throbbing pain in my eyes. My left eye was worse than my right eye. The optometrist asked me to read his eye chart but I couldn't see where it was. He examined my eyes and told me not to worry, he could help me. He said I had a lazy left eye and astigmatism, and he had just the cure for me — he was going to prescribe some glasses.

"Before the glasses were ready, the pain got much worse and my eyesight got more and more blurry. However, I trusted the doctor. I figured you go to a doctor and he knows how to treat you. I had always thought optometrists were doctors. They call themselves doctor.

"When I went in to get my glasses in October, I told him that my vision was much worse and he got out the glasses and said, 'These should take care of you.'

"I went home with the glasses but they weren't helping. I was banging into desks at school, I kept banging into people, I couldn't see the blackboard. I must have called the optometrist about 10 times and he kept telling me I would be all right, that I was getting too worked up and making myself not see.

"When my mother and I went to see him the next day, my mother said he looked a little worried. He told us that I lacked something in my body, that I had a deficiency, and he would make an appointment for me with an ophthalmologist but not until after Christmas. He said I should go home and have a nice Christmas.

"When my mother and I went to the ophthalmologist on December 27, it was the first time I heard the word 'glaucoma.' He said I had all the classic signs.

"The ophthalmologist found that I had a pressure of 95 in both eyes — normal is 20, and total blindness is 100, he said.

"In April the pressure in my eyes went up again and this time the ophthalmologist thought it would be necessary to operate. By now my parents were so upset they had decided that they should be extra careful and get another opinion and I should go to Massachusetts Eye and Ear Infirmary. I did and it was decided I should have surgery on both eyes, to save what little sight I had left. I've lost 99 percent in my left eye and I have only the very center of the vision in my right eye — I can only see things that are straight ahead.

"After I got out of the hospital and began to feel better, my little eight-year-old cousin began to take me all around Gloucester by the hand so I could learn my way around. I still don't like going to new places and there are some things I can't do for myself. Once I set myself on fire trying to reach something over the gas stove and I didn't even know it. I was lucky my husband was home and saw it." ●

Similar heartbreaking circumstances have accompanied many of the cases in PEN's growing file. Here's a random sampling.

● From the Wills Eye Hospital, a division of the Thomas Jefferson Medical School in Pennsylvania, - when a female patient complained of pain in the eye, an optometrist gave her an anesthetic drop to use. Later, he refused to see her. She developed a pseudomonas ulcer (infection) and the eye had to be removed.

● Also from Wills, a female patient told an optometrist that for seven years she had episodes of blurred vision brought on by reading. They usually lasted about an hour and when severe were associated with headaches. She was followed by an internationally famous optometrist throughout the seven years and was reassured nothing was wrong. Later, an M.D. found textbook symptomatology of chronic angle-closure glaucoma and advised immediate surgery on both eyes.

GOING BLIND

Mrs. Anita Oliver

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Baltimore Cook

Vol. 1, No. 10, Dec. 1, 1977

The following passages are from an interview between a blinded Baltimore cook and ophthalmology resident Larry Thompson, M.D. In a story headlined "Mrs. Oliver: 'I Told Him These Are My Eyes'," she told how a vision-center optometrist became annoyed when she told him the glasses he prescribed did not work:

Mrs. Oliver: "I came to University Hospital because I was getting this blindness, and I couldn't see. I was at church on the fourth Sunday in July, and I fell down those steps."

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Dr. T: "You were seen for your eyes before coming here — when, back in February of 1977?"

Mrs. O: "Yes, it was February."

Dr. T: "And you were seen at - - - - Vision Center?" (an enterprise which employs optometrists, but has no medical personnel.)

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Mrs. O: "Yes, I was there for glasses. They examined me but they didn't tell me anything. I asked the doctor why I couldn't see. The doctor got angry with me when I said I could not see out of my left eye like I should. I was trying to read the board, the letters and the numbers. And when he put the glass to my eye, I couldn't see and I told him that I couldn't see. He got very, very angry. He told me that he was doing the examination, not me. *I told him that these were my eyes and I should know whether I could see or whether I couldn't.*"

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Dr. T: "OK, he prescribed new glasses for you at that time. After you got those glasses, you could not see with those glasses, is that correct?"

Mrs. O: "Yes. I went back to them again and had that left lens changed. It was supposed to have been changed."

Dr. T: "Did they ever measure the pressure in your eye, touch your eye with anything to measure the pressure?"

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Dr. T: "Did they ever measure the pressure in your eye, touch your eye with anything to measure the pressure?"

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LED TO BLINDNESS

Charles B. Wilson

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Arizona Steelworker

Vol. 1, No. 10, Dec. 1, 1977

The following are excerpts from the story of an Arizona man headlined "Arizona Steelworker 'Led To Blindness'," in which he told how an optometrist informed him he would eventually go blind, but gave no reason, and his misadventures with more optometrists:

"When I first thought I needed glasses 25 years ago, there was only one place to go in my home town in Ohio — and that was to an optometrist. He had the whole works — he gave examinations and sold glasses.

"He checked me one time, gave me glasses and then he said, 'In about 20 years, you're going to think you're going blind.'

"I asked him why, but he wouldn't give me a definite answer. He just said, 'Well, your eyes are going to change that much and you're going to think you're going blind.' To this day, I still don't know what he was talking about.

"I just figured it was my nearsightedness or the opposite, whatever that was. I wasn't bothered with anything until I came out here 17 years ago.

"I worked in a steel mill and once my glasses got all burned up in there, so I went to an optometrist in Mesa.

"He just checked my eyes like everyone else does. I got a new pair of glasses there.

"In the meantime, the Union got into the plan — a the company had to furnish eyeglasses. So, another optometrist in Tempe gave me a cut-rate price for an eye examination, since I was an employee. It was a ridiculously low price. After that exam, I went to that optometrist all the time, about every two years. I went through this same routine for about 10 years.

"I started noticing that I was stumbling a lot out at the steel mill. I was falling and tripping over things, which I don't ordinarily do. I tried to get an appointment with the optometrist, but most of them in town were at a convention. I finally found one to examine my eyes.

"He examined me and said he saw something in one eye, but he admitted that he didn't know what it was. He recommended that I see an ophthalmologist.

(At this point, Mr. Wilson was asked whether or not the optometrist who checked him every two years for a decade ever checked anything besides his vision, such as his eye pressure.)

"No, sir, he never did anything like that. I figured I was getting a complete eye exam, like I'd had all of my life. He was called a doctor, and to me an eye doctor was an eye doctor.

"An ophthalmologist was just a long word as far as I was concerned! I'd never been around one, and where we came from there wasn't any. This last optometrist I asked point blank what was in my eye and he said he did not know and that he recommended my coming to see one of you fellas. He said you would have to 'lift the pupil up and look behind it and see what was in that eye.' . . .

"Well, here I am. I was legally blind. Now I've had surgery to save what vision I had left, but I'm still in bad shape. I believe this other guy that I went to should have seen something and checked it. But I didn't know he should have looked into my eyes with all those lights and stuff that he didn't do it. He never gave me a pressure check or anything like that.

"So now I'm disabled. I was led to blindness for 25 years." ●

OPTOM-PSYCHIATRY

Continued from page 3

ized that she had lost her appetite and was losing weight; also she was always thirsty and urinating excessively, so I took her to our family doctor."

Dr. Gold: "What did he find?"

Mrs. Cosgrove: "He found diabetes. Her sugar was 790!" *(Normal is around 100)*

Dr. Gold: "Did the optometrist ever mention to you the possibility that variably blurred vision could be a sign of diabetes?"

Mrs. Cosgrove: "No, never. I don't think he should be allowed to be out there, on the street, calling himself a doctor! He doesn't know anything about disease. Why is he there? What's wrong?"

Dr. Gold: "Mrs. Cosgrove, do you give us your permission to publicize the danger to people inherent in Barbara's story?"

Mrs. Cosgrove: "Yes, I do."

Dr. Gold: "Thank you very much." ●

NEW YORK SPECIAL REPORT

The following case histories of optometric failure to recognize and refer medical eye patients were collected by Karl J. Marchenese, M.D. of Rochester. All patients except one were personally interviewed by Dr. Marchenese. Except where indicated, the source of information was the patient. All cases came to the attention of Dr. Marchenese within the past 12 months through his practice as an ophthalmology resident. The patients reported in this paper as incidents of failure to recognize or refer medical eye problems, outnumber appropriate referrals to the clinic by four to one.

● A young college student called a local HMO (prepaid health insurance in which the patients have little choice of physician) with complaints of an irritated red eye. He was seen the same day by an "eye doctor" whom he believed was a physician but was in fact an optometrist. The optometrist diagnosed "iritis" and gave the patient a prescription for two therapeutic eye medications (homatropine and a steroid preparation) which was filled in the HMO pharmacy. The patient reports that the prescription had another physician's signature preprinted on it. The patient was examined only by the optometrist. He was subsequently examined by the optometrist four additional times over a six-month period. The optometric records were obtained and revealed that several therapeutic agents had been prescribed and no mention was made of consultation with or referral to a physician. Ocular examinations and evaluations for systemic disease were inadequate. The optometrist was unsure of the diagnosis, at times referring to "recurrent coniunctivitis" and "eposcleritis" as well as iritis. Finally on the last visit the patient was referred to an ophthalmologist.

Comment: The optometrist clearly exceeded the limits of his licensure by attempting to make a medical diagnosis and prescribing therapy. It is illegal for an optometrist to fill in (and for an organization to provide) presigned prescription forms. It is inappropriate for an HMO to use an optometrist to care for patients with acute eye problems.

● A 73-year-old woman with diabetes was followed for 15 years by an optometrist who knew about her disease but referred her for a medical eye evaluation only when cataracts caused a significant deterioration in her vision. The patient had evidence of diabetic retinopathy (blood vessel disease of the back of the eye) which was more difficult to evaluate because of the presence of cataracts.

Comment: All patients with diabetes are at a significant risk of major ocular complications (including total blindness) and should have a medical eye examination at regular intervals. The examination requires special expertise which only the ophthalmologist can provide. Treatment is available for retinopathy at some stages.

GOING BLIND

Continued from page 5

Mrs. O: "No."

Dr. T: "Did they ever suggest that you see a medical doctor?"

Mrs. O: "No, never."

Dr. T: "Do you feel that poor people — people that haven't had a lot of education — are at a particular disadvantage since they probably do not understand the difference between an optometrist and a medical eye doctor?"

Mrs. O: "I sure do think so. I was getting blind."

Dr. T: "Do you realize that you would have been totally blind in another couple of months if you had not come down here?"

Mrs. O: "I sure do." ●

EXTENSIVE EYE DAMAGE

Continued from page 4

Mr. Livensparger continued, "I took the drops just like they told me, but my eyes got even worse and I went back to see them on November 14. They told me just what they said before, that I had an eyelid infection that would go away if I kept taking the drops, even though I told them my eyes felt worse, not better. I continued using the medicine they gave me but it didn't help at all and I went back again to see them (the optometrists) on January 10th of this year.

"Again, they examined my eyes. They didn't mention glaucoma or pressure — just looked into my eyes with a light. They told me the medicine I was using wasn't doing the job and gave me something called Vasocidin. I used the new drops for about eight days and my eyes only got worse, so I went back again on the 18th of January. They said just keep using the new stuff and your infection will go away.

"Since I was getting worse all the time and the medicine wasn't helping, I thought I should see somebody else," Mr. Livensparger concluded.

"When I talked to Mr. Livensparger on Feb. 4," Dr. Mallonee said, "he told me, 'I have continuous pain in both of my eyes. I can't stand the light, and keep my eyes closed most of the time because they water when I try to open them. The pain is bad, and I have it all the time.' "

Dr. Mallonee reported that his external examination revealed a very obvious problem. A condition existed whereby the patient's lower lids had turned in, causing the lashes of the lower lids in both eyes to rub against the corneas causing recurrent and chronic corneal abrasions. It was lashes rubbing on the cornea that gave the patient the feeling he had a foreign body in his eyes. He was in so much pain that he kept his eyes closed almost constantly since the abrasions were causing him severe pain.

"I found on further examination that much of the corneal tissue was gone due to the constant irritation," Mallonee said. "I also found early vertical cupping of the optic nerve head — an early sign of glaucoma.

"I recommended immediate surgery on both lower lids to eliminate the severe irritation. This has been done since and the patient is much better at this point in time. I also discontinued the medication prescribed by the optometrists, both of which cause glaucoma in susceptible patients. The eye pressure is now down, verifying that the long use of drugs had contributed to increased pressure. In addition, we performed a complete glaucoma work-up, which was clearly indicated." ●

● A 30-year-old woman was seen six weeks previously at work by an industrial nurse for complaints of a red, irritated eye. She was referred that day to a local HMO where she was seen by an "eye doctor" whom the patient thought was a physician, but was in fact an optometrist. He diagnosed an allergic problem, recommended "Sinutabs," and referred her to an internist in one to two weeks.

Comment: The patient was inappropriately evaluated by an optometrist for an acute eye problem. HMO's should not use optometrists to evaluate patients with acute eye problems without direct physician supervision.

DANGER AND WASTE

Continued from page 3

found many had gotten the wrong glasses. One man didn't get bifocals and he had used them all of his life. This whole farce left me with little faith in the VA health care system. . . .

"On February 27, 1978, I returned to the VA and asked to see the M.D. I had seen on my last visit. I was told that he had retired, so they sent me to another M.D. This doctor assured me that he was an M.D. and an ophthalmologist, and when I told him of my previous experience, he agreed that optometrists should not treat eye disease, but explained that since he was new with the VA, he couldn't change the rules, and he didn't want to 'make waves.' He told me that he also co-signed prescriptions for the optometrists even though he never sees the patients. This doesn't seem right to me . . ." ●

TREATMENT DELAYED

Mrs. Clara Jones

●

Writes Iowa Legislature

Vol. 2, No. 2, Jan. 15, 1978

The following excerpts are from a story headlined "Damaged Patient Writes Lawmakers," which carried a letter that an Iowa woman wrote to the entire Iowa Legislature, reminding them that optometrists have no medical training:

"For the last 25 years my family has been going to an optometrist for our eye care needs.

"Some time after the most recent change of lenses, I began experiencing difficulty with my vision. Consequently I returned to my optometrist and told him my sight in my right eye was blurred and that something was wrong. After his examination he told me my glasses were correct, the blood vessels were healthy, and further there were no signs of glaucoma or cataracts.

"I still believed that something was wrong in my right eye but believed the doctor must know, so accepted his diagnosis. However, as the difficulty continued and gradually increased, after five months I decided to consult a medical eye specialist. In his preliminary examination he immediately suspected glaucoma which was subsequently verified in both eyes and that the disease had been there for a long time. Also the cataracts are starting. I am informed that a considerable portion of my vision has been lost due to the delay of treatment and cannot be restored, all due to a false sense of security given me by my optometrist.

"My medical doctor tells me that an optometrist is not trained in medicine nor to diagnose eye diseases.

"Because of this lack of training, the optometrist, in my opinion, should be severely penalized when he tries to perform such services which could well end in blindness for his patient.

"I strongly urge you to give this matter your most rigid study and action."

Mrs. Jones later told her ophthalmologist that vision loss was not the only way she suffered due to the optometrist's bold attempts to practice medicine.

"I fell twice," she said, "broke my right arm near the shoulder and the second time my left wrist. I still can't see a step."

Her physician, Leo J. Plummer, M.D., reports that her glaucoma is currently under control, on a program of medications. The Des Moines ophthalmologist notes that dense and extensive visual defects in both eyes are permanent, and that it is necessary for her to learn to walk with her head down to avoid tripping. Dr. Plummer has noted that the drugs Iowa optometrists seek to use are not necessary for the trained physician to suspect, or in most cases, diagnose glaucoma. ●

Don Hostak, Director
Div. of Occupational Licensing

02 13 79

Byron Perkins BP
Licensing Examiner

I spoke with Eldon Ulmer, President of the Board of Pharmacy, and he asked me to convey the following to you in response to your teletype to him last week.

RE House Bill 79 regarding optometrists and particularly their ability to prescribe legend drugs and pharmaceuticals, the Alaska Board of Pharmacy has not changed its position on this issue. The board is not primarily concerned with whether or not an optometrist should be given this privilege, but rather, that the proposed bill in no way addresses the legal question of how they are to obtain legend drugs. Current Federal and State statutes do not permit pharmacists to fill prescriptions for legend drugs by any one but Medical Doctors, Veterinarians, and Dentists.

Re House Bill 101 and Senate Bill 65, the Uniform Controlled Substances Act, this is the number one legislative priority for the Board of Pharmacy, and the board supports it conceptually. However, the current bill is primarily a police bill, and needs to be ammended substantially to make it palatable to the industry. There is not enough language addressing the rights and responsibilities of professionals authorized to handle controlled substances. The Board of Pharmacy is pushing for a Uniform Controlled Substances Act that parallels the federal guidelines.

cc: Eldon Ulmer, R.Ph.
Chairman, Board of Pharmacy

POSITION PAPER
ON
HOUSE BILL NO. 79

"An Act relating to the practice of optometry."

This bill would permit the use of selected drugs including topical anesthetics, mydriatics, cycloplegics and myotics by optometrists, and as such would delete from the definition of optometry the restriction against the use of drugs.

The intent of the bill would be to permit optometrists to use certain prescription drugs. This significantly increases the scope of optometry as presently defined and poses some increased risk and complications. The use of mydriatics is occasionally associated with the development of acute narrow angle glaucoma which may necessitate emergency surgery. The use of topical anesthetics are occasionally associated with acute, allergic reactions and some risks of danger to the cornea by foreign bodies. Recognizing the unusual, but definite risks and complicating reactions, the Department of Health and Social Services feels the use of prescription medications by optometrists would not be in the best interests of the public.

Recommended by: Robert I. Fraser

Robert I. Fraser, M.D., Director — 2/14/79
Division of Public Health

Approved by: Helen D. Beirne — 2/16/79

Helen D. Beirne, Commissioner
Dept. of Health and Social Services

Name	Address	Organization	Bill
John R. Boyer	Pouch H-05	Dept. of H&SS	HB
Bill Ray			
Randy Phillips	Pouch V	Home District 8	HB#
George Mundell	Pouch H 05 F	Office of Alcoholism & D.A.	# SB
Clarice Nestell			
William Palmer	RT 5 Box 5524 Juneau 99803	Occupational Licensing Physician	# 7
Robert Paye	RT 5 Box 5525 Juneau 99803	Physician	# 7
			# 7

3701 Richmond St. #16
Anchorage, Ak. 99504
June 13, 1979

Legislative Affairs Agency
1024 W 6th Ave.
Anchorage, Alaska 99501

Dear Sir:

Enclosed is a copy of a survey undertaken by myself in March 1979 on the use and experiences of ophthalmic pharmaceutical agents by all ophthalmologists in the state of Alaska.

The impetus for this survey to have been conducted was due to the fact of House Bill 79 in deliberation under the house Health, Education and Social Service committee. In view of this I believe that the resulting responses to questions two,four,five and six are significant indicators . To wit, pertinent information for the House HESS committee members material packets.

Upon your review of this survey, I would appreciate your consideration in submitting this as relevant data and information for the HESS committee members use &/or at their disposal.

Thank you for your time and consideration in this matter.

Sincerely,

Maureen C. Roche

Maureen C. Roche

A SURVEY

of the
EXPERIENCES IN THE USE OF
OPHTHALMIC PHARMACEUTICAL AGENTS

A survey was conducted in March, 1979 among the Ophthalmologists in the state of Alaska concerning their experiences utilizing dilating drops.

The format of that survey was patterned after a similar survey undertaken by the Texas Ophthalmological Association in 1976. In addition to the three questions posed by the Texas Ophthalmological Association, four more were composed for the survey undertaken in Alaska. A form was devised and mailed with an enclosed addressed envelope to all twenty three Alaskan Ophthalmologists as provided from the listings on record with the Alaska State Medical Association.

As of May 8, 1979 16 (71.8%) of the 23 survey forms had been returned and those responses compiled & calculated. Below is a summary of these seven questions and the results received.

Question 1. Do you see cases in your office that must be dilated cautiously & require close medical observation?

16 (100%) of all received survey forms had responded yes to this question.

In regards to this, several respondents reported that they were more concerned with cautious dilation in the native, elderly and infant individuals and group of peoples. One Ophthalmologist reported these individuals he sees are examined carefully with the slit lamp employing the goniscope lens prior to use of dilating agents.

Question 2. Have you had cases of acute angle closure glaucoma from dilating drops that required medical &/or surgical care?

13 (81.3%) of the 16 respondents answered yes they had cases of acute angle closure glaucoma from dilating drops that required medical &/or surgical

care. 3 respondents of the 13 that replied affirmatively reported that they had seen "several" and "a number" of such cases. Yet, no specific number was supplied. 1 respondent commented that he had not seen this ocurrence since his training. A total number of cases reported among these 13 respondents was three. Two of these cases required emergency surgery to remedy the situation.

2 of the 3 (18.8%) respondents whom replied no they had not seen cases of acute angle closure from dilating drops stated they employed the method of goniscopy frequently if "suspicious of the safety of dilation". And if dilation be needed after this it would be performed with weak agents that could be counteracted readily.

Question 3. If you are aware that a patient has extremely narrow angles anatomically, and must be dilated for further studies and evaluation of the retina...
a) Do you dilate them in your office?
b) Admit them to a hospital for dilation and observation?
c) Request for a consult &/or refer them to another Ophthalmologist?

15 (93.8%) responded a)they dilate their patients within their office. Of these affirmative responses various comments were reported such as: "dilate with a weak agent that is reversible","cautiously","with phenylephrine","dilate the patient in my office but do not let them leave my office until the pupil has returned to normal","usually","also prepare my patients for admission to a hospital if necessary". One respondent answering question 3 stated that he dilates his patients in his office and then stated "there is no way to predict what the patient will choose".

3 of the 15 replying affirmatively, revealed that they have offices in a hospital complex (2) or adjacent to a hospital complex (1).

1 respondent whom did not indicate whether or not he dilates patients in his office did state "if I have a patient with extremely narrow angles that appear occludable I admit the patient to the hospital and do peripheral iridectomies. Then I dilate and examine the peripheral fundus".

Question 4. Estimate or if able, specify the number of patients you see in a year with narrow angles potential &/or precipitated.

(93.8%) reported a specific number of cases. 1 respondent failed to give a specific number when reporting; "a couple a year". Therefore this response

was disregarded in the statistical analysis. These 15 Ophthalmologists supplied a total number of 1,130 cases they would see in a year of potential and/or precipitated narrow angles. The average figure 75.3 , is the number of patients PER Ophthalmologist responding,that would be seen a year with potential and/or precipitated narrow angles.

Question 5. From your use of topically applied pharmaceutical agents have you seen other side effects? (excluding narrow angle closure glaucoma)

(100%) of the respondents replied yes to this question.

Question 6. In conjunction with question #5, can you supply what pharmaceutical agents (mydriatics,cycloplegics, miotics and anesthetics either generic or brand name) have induced these side effects in some of your patients?
Please estimate by number or if able specify how many reactions have been induced by the said pharmaceutical agents in your practice for the year 1978.

Compilation of the data revealed 13 (81.3%) respondents citing reactions in the parasympathomimetic family. Of the cycloplegics used atropine and cyclogyl appeared to be the worst offenders for inducing reactions. 8 (50%) of the Ophthalmologists reported from their use of atropine such reactions as: "hypersensitivity","poisoning","confusion", "cardiac arrest","rash & fever","convulsions", and "hypertension". 9 (56.3%) of the Ophthalmologists cited reactions from the use of cyclogyl as: "sedation","aloofness","convulsions","hallucinations", "seizures","synocope" and "central nervous system reactions".

9 (56.3%) of the respondents reported reactions with the use of the agents in the sympathomimetic family. Neo-Synephrine (phenylephrine HCL) produced problems for 7 (43.8%) Ophthalmologists' patients. These were indicated as: "hypersensitivity reactions", "conjunctivitis","toxic keratitis","cysts", and "heart dis-rythmia". Euphoria had been induced in the adult patients of one Ophthalmologist from the use of 4% cocaine.

5 (31.3%) of the Ophthalmologists cited reactions induced from the miotics. These were reported as: "conjunctivitis","retinal detachments" and "hypersensitivity reactions".

From the use of anesthetics 11 (68.8%) cited allergic reactions from the use of ophthaine (proparacaine).

3 (18.8%) of the responding Ophthalmologists stipulated they had seen many side effects from the use of pharmaceutical agents but did not report on these reactions nor state from what agents these side effects were induced from.

Question 7. In your practice up to date, being as accurate as possible how many patients are legally blind?

325 legally blind cases were supplied from 11 (68.8%) of the respondents.One Ophthalmologist reported "several cases" in his practice. This response was not calculated in the statistical figures. Three respondents (18.8%) stated such information was not availab'e. One Ophthalmologist declared that 10% of his practice involved legally blind individuals.

SUMMARY and CRITIQUE

This survey had been initiated due to the current legislative situaion in Alaska. The introduction of the so-called "drug bill", (use of pharmaceutical agents:anesthetics,cycloplegics,miotics, and mydriatics by the Optometric profession) has been in deliberation within the state house HESS committee. The subject in deliberation became of interest so much so that conducting this survey was of utmost importance to determine any established relevancy, primarily through the use and experience of dilating drops. These deliberations provided the impetus to undertake this survey.

It is a known fact among the Ophthalmologists and few others that the Native Alaskan is predisposed to narrow angle closure glaucoma. With this in mind and the awareness that dilating drops have the potential to induce and precipitate such an attack of glaucoma; questions two & four were directed at seeking a

determinacy of this precarious situation. It would be fair to say predicated from the responses to these two questions that narrow angle closure glaucoma is quite a significant matter in Alaska and cannot be denied.

Examination of all responses lends additional support that medical supervision or personnel medically trained perform dilation in order to deal with the aforementioned and unmentioned side effects that may arise. Most all respondents in this survey had indicated that they could report and list more side effects from the use of ophthalmic pharmaceutical agents. However, they declined from the arduous task of listing the vast array of side effects.

The results of this survey were forwarded to these twenty three Alaskan respondents.

Maureen Rocke
3701 Richmond #16
Anch., AK 99504

Juneau MEDICAL SOCIETY

P. O. BOX 3-3000 • JUNEAU, ALASKA 99802 • TELEPHONE (907) 586-2611

March 9, 1979

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

HB 79 - AN ACT RELATING TO OPTOMETRY

The Juneau Medical Society at its regular meeting on Tuesday, March 6, 1979 unanimously went on record as being opposed to the above captioned legislation as it would allow the practice of medicine by unqualified persons.

Jon C Reiswig M D

JON REISWIG, M. D.
PRESIDENT

HB 79

Peter E. Cannava, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669

TELEPHONE 262-4482

March 13, 1979

Representative Hugh Malone
Pouch V
Juneau, Alaska 99811

RE: HB 79

Dear Hugh:

There seems to be some confusion as to which drugs the optometrists are asking to use. That is one of the problems ophthalmologists see with the bill; it does not be specific as to drug but simply authorizes them to use broad classes of drugs. (anesthetics, mydriatics, cycloplegics) this of course will leave room for them to expand as they see fit rather than be limited to specific drugs as approved by the legislature.

Enclosed please find resolution from University of Alabama the optometrists claim that this institution qualifies them to use drugs on people. the resolution speaks for itself.

Sincerely,

Peter E. Cannava, M.D.
President Alaska State Ophthalmologists

PEC/bc

cc: Pat O'Conner
Margaret Branson
Joyce Munson
Charles Parr
Bill Miles
Nels Anderson
Vernon Hurlbert

of the
University of Alabama School of Medicine Physicians Advisory Board
Adopted - 10/18/78

WHEREAS, physicians from many states have expressed appropriate concern for the fact that the existence of certain courses in the University of Alabama School of Optometry may be described by political opportunists as qualifying Optometry School graduates to attempt to safely perform medical functions; and,

WHEREAS, this Board recognizes that occasional lectures on medical subjects to optometry students are intended only to enable them to more accurately detect eye diseases and refer to physicians; and,

WHEREAS, this Board also recognizes the inherent dangers in optometry graduates believing that such cursory briefings might equip them to attempt the practice of medicine; and,

WHEREAS, Dr. Henry B. Peters has publically stated that the practice of medicine is an "inappropriate goal for optometry",

NOW Therefore be it resolved,

The University of Alabama School of Medicine Physicians Advisory Board recommends that the following public statement be issued and released to the physicians who have expressed concern:

"The education of optometrists ('specialists in the art or profession of examining the eye for defects and faults of refraction and prescribing correctional lenses or exercises but not drugs or surgery')[1] at the University of Alabama in Birmingham is designed to teach optometry principles and to enlighten optometry students in the detection of disease so as to encourage appropriate referral to physicians. This education in no way prepares these graduates with the knowledge to prescribe or use drugs to treat eye disease. This training should not be viewed as a medical credential."

J. Richard Moore, M.D., Chairman

J. Kendall Black, M.D.

E. E. Hale, Jr., M.D.

S. F. Crabtree, M.D.

Ronald E. Henderson, M.D.

[1] Webster's Seventh New Collegiate Dictionary

HB79

Peter E. Cannava, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669

TELEPHONE 262-4462

(see previous letters re HB 79)

March 13, 1979

Representative Hugh Malone
Pouch V
Juneau, Alaska 99811

RE: HB 79

Dear Hugh:

There seems to be some confusion as to which drugs the optometrists are asking to use. That is one of the problems ophthalmologists see with the bill; it does not be specific as to drug but simply authorizes them to use broad classes of drugs. (anesthetics, mydriatics, cycloplegics) this of course will leave room for them to expand as they see fit rather than be limited to specific drugs as approved by the legislature.

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Peter E. Cannava, M.D.

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President Alaska State Ophthalmologists

PEC/bc

cc: Pat O'Conner
Margaret Branson
Joyce Munson
Charles Parr
Bill Miles
Nels Anderson
Vernon Hurlbert

DR. M. C. FALCONER
DR. J. C. FALCONER
DR. G. L. HALL
DR. T. F. HARBOUR
DR. B. L. WALKER
DR. W. D. FAULKNER
OPTOMETRISTS

ANCHORAGE EYE AND CONTACT LENS CENTER
1345 W. NINTH AVE. PHONE: 272-2557
ANCHORAGE, ALASKA 99501

HB79

April 20, 1979

Rep. Thelma Buchholdt
Pouch V
Juneau, Alaska 99801

Dear Thelma,

Here is a little follow-up information in regard to our conversation of Friday, April 20.

South Dakota passed an Optometric Drug Bill into law early in March. The House supported the bill by a 64 to 2 vote and the Senate by a 22 to 11 vote.

March 21 saw Utah's drug bill become law, with a 50 to 12 vote in the House and 20 to 4 vote in the Senate.

North Dakota's Optometric Drug Bill became law on March 22 (House support of 41 to 7 and Senate support of 85 to 10).

The wide margin of support in these states indicates the great need for the Optometric usage of diagnostic pharmaceutical agents.

As I'm sure you are aware, our bill passed the House by an overwhelming margin last year, indicative of the faith in the Optometric community in this State.

I would greatly appreciate your help in expediting our bill through your committee this session. Thank you.

Yours truly,

Bill Faulkner

William D. Faulkner, O. D.

WDF/aeb

Municipality of Anchorage

POUCH 6-650
ANCHORAGE, ALASKA 99502
(907) 274-2525

GEORGE M. SULLIVAN, MAYOR

MUNICIPAL HEALTH COMMISSION

March 27, 1979

Thelma Buchholt, Chairman
Senate Health, Education &
Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholt:

The Municipal Health Commission has reviewed and made a recommendation on House Bill 79 that is presently in your committee.

The Municipal Health Commission is a 33 member, community based group of concerned citizens. The Commission reviews community health issues, grants, problems and legislation and makes recommendations to the Municipal, State and Federal governments and legislative bodies, the general public, and the Regional Health Systems Agency. The Commission membership must meet rigid legal requirements that assure broad demographic and occupational representation as well as a consumer majority.

Attached is the review and recommendation on House Bill 79 as approved by the Legislative Committee on March 7, 1979. We hope that your committee will consider our review and recommendation before making a decision on this bill.

Thank you very much.

Sincerely,

Charles Rigden, Chairman
Municipal Health Commission

Attachment

Primary Legislative Contact: _____
(907)

LEGISLATIVE REVIEW

BILL NUMBER AND TOPIC: House Bill 79

BRIEF SUMMARY: An Act relating to the practice of optometry. This bill defines the term "optometry" and defines what is included in the practice. The bill also outlines the use of drugs for diagnosis.

BILL STATUS: House Bill 79 was introduced by Representatives Martin, McKinnon, Meekins, Miller, and Parr, and was referred to Health, Education and Social Services and Judiciary Committees.

The series of questions below are presented to assist persons responsible for reviewing proposed legislation. Answering each question will help the reader to better understand the intent or meaning of a specific bill. Question #12 asks the Legislative Advisory Committee to formulate a recommendation, which will then be forwarded to legislators, lobbyists, other review bodies, etc., as appropriate. Action taken by this committee automatically sends the bill and comments through 1) Municipal Legal Department, 2) Municipal Administration, and 3) Municipal Health Commission, time permitting.

1. What is the time frame for influencing the bill's outcome by this committee or Commission? This legislative session

2. What does the bill do? Allows optometrists to utilize certain classes of diagnostic drugs in their offices.

3. Who does it affect? Approximately 2/3 of the residents of Alaska who seek eye care.

4. How much does it cost? Will make no cost differences to the consumer.

5. Is it directed to a specific geographic area? No
What area? _____

6. How would enactment of this bill effect Anchorage? Enable the thirteen Anchorage area optometrists to utilize the diagnostic drugs.

September 6, 1979

_____ Individual Committee Members of the following Committees

_____

_____

_____

_____

_____ State Health Coordinating Council
_____ Governor
_____ Bill Sponsor
_____ Other: list

Committee procedure automatically sends the bill through:

1. Municipal Legal Department
2. Municipal Administration
3. Municipal Health Commission, if timely

American Optometric Association™

NEWS

Vol. 18, No. 5
March 1, 1979

Nebraska okays DPA usage

LINCOLN, NB — A signature by Gov. Charles Thone makes Nebraska the 17th state in the nation which has enacted legislation specifically authorizing optometrists to utilize diagnostic pharmaceutical agents (DPAs).

Gov. Thone, a former member of the U.S. House of Representatives, signed into law Legislative Bill No. 9 on February 13, the same day the state's one-house legislature passed the bill by a 33 to eight vote.

The legislation redefines and revises the 1943 state statues relating to the practice of optometry and changes state license requirements, in addition to authorizing the usage of DPAs in Nebraska.

The legislation specifies that no optometrist presently licensed in Nebraska "shall use pharmaceutical agents in the practice of optometry unless such person submits to the Board of Examiners in Optometry evidence of satisfactory

Continued on page 14

Carter proclaims 52nd SYVW

WASHINGTON, DC — To focus the attention of all Americans on the importance of good vision and the need for the public to take care of its eyes, President Jimmy Carter has proclaimed the week of March 4-10 as Save Your Vision Week (SYVW), the 52nd annual celebration of the national event.

"Good eyesight, like so many of life's blessings, is too often taken for granted," the President stated in an official proclamation. "Today, millions of Americans must cope with the burden of impaired vision. In many of

Continued on page 11

Nebraska governor signs DPA legislation

Striking a formal pose following the signing of Nebraska's diagnostic pharmaceutical agent (DPA) law are, from left, James L. Nedrow, O.D., of Beatrice, NB, past president of the Nebraska Optometric Association (NOA); Bernard G. Mullen, O.D. of McCook, NB, NOA president; Gov. Charles Thone; Sen. Bob Clark, the introducer of the bill; and David Kunz, NOA executive assistant.

Nebraska okays DPA usage

Continued from page 1

completion of all educational requirements as adopted by the (state health) department upon the recommendation of the Board of Examiners in Optometry, and has been certified by the department upon the recommendation of the Board of Examiners in Optometry as qualified to use pharmaceutical agents for diagnostic purposes."

With Nebraska's legislative action last month, there are 17 states with legislation authorizing optometrists to use DPAs, in addition to nine other states which do not statutorily prohibit the use of pharmaceutical agents.

According to Attorney D. John Pecorino, manager of Aetna's Marketing Department, Casualty & Surety Division. "We do not differentiate between states which have pharmaceutical agents and those which do not."

Currently, there are 16 states with legislation which specifically authorizes optometrists to utilize pharmaceutical agents. In addition, there are nine other states which do not statutorily prohibit the use of pharmaceutical agents.

According to Virgil L. Rhodes, O.D., of Manchester, TN, chairman of the AOA Advisory Committee on Statutory Definition, the recent Aetna reduction in malpractice coverage is important information for state legislators who are confronted by ophthalmological misinformation concerning DPA legislation.

Aetna reduces annual premium for insured AOA members

By RANDY L. WALLICK

HARTFORD, CT — More than two years of efforts between the AOA and the Aetna Life & Casualty Co. have prompted the Hartford based insurance firm to reduce professional liability rates for AOA members by 18 percent.

About two-thirds of all AOA optometrists insured for professional liability by Aetna will realize a premium reduction of $30 off the current annual primary professional liability premium of $168.

Aetna representatives state the rate reduction combines with several other improvements in the insurance program which are designed to provide AOA members with greater membership services and to make the insurance package more flexible and more competitive.

Coupled with the 18 percent reduction is the removal of surcharges for AOA optometrists. The routine 20 percent surcharge made for partnerships and/or professional corporations and the 25 percent surcharge made for employed optometrists have been removed by Aetna.

Effective February 1st, the program changes and the $30 premium reduction will be implemented upon renewal by the more than 6,000 AOA members currently enrolled in the Aetna program.

According to Ronald D. Solomon, O.D., of Colorado Springs, CO, chairman of the AOA Committee on Insurance, Aetna has agreed to provide special rates for property coverages written on a multiple account basis. "This can mean a possible 25 to 40 percent deviation from the normal price AOA members currently pay for protection," Dr. Solomon said.

According to Roger Detrich, Aetna's account executive for the improved AOA program, "Although we will seek these new rates on a nationwide basis, it is possible that in certain states our existing rates, because of the restrictions of state insurance regulations, are now below the new rates.

"Our insured optometrists in these states will realize no change or a slight increase," Detrich said. He added, however, "This will affect only a minority," he said.

Called one of the best benefit services in recent years, the new Aetna program stems from more than two years of efforts by the Committee on Insurance to gain lower rates for AOA optometrists.

Aetna, which has insured AOA members since 1970, attributes the new

Continued on page 18

NOTE: Page 19 not included in file.

ALASKA STATE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811

REGIONAL INFORMATION OFFICE
1024 West 6th Avenue
Anchorage, Alaska
99501
(907) 278-3668

June 19, 1979

Dear Rep. Buchholdt:

The enclosed material is being forwarded to you as HB 79 is currently in the House HESS committee.

Carol Dickason

LAA 11
(1-26-79 M)

SPECIAL TIMOTHY STEELE ISSUE

THE PEN...

PRO BONO PUBLICO

Published in the Public Interest by Ophthalmology

VOL. 3, No. 1 DEC. 15, 1978 - JAN. 1, 1979

FEDERAL JUDGE RULES AGAINST U.S.

Optometric "Primary Care" Results In Loss of Eye For Four-Year-Old Boy

In a landmark decision that could cause the army to re-examine its policy permitting optometrists to provide initial eye care treatment, Judge James M. Fitzgerald, United States District Judge for the District of Alaska, ruled that Timothy Steele, now an eight-year-old dependent of a soldier in the U. S. Army, was entitled to recover for the loss of his right eye.

> **"I conclude that the plaintiff is entitled to recover in this action from the United States for the loss of Timothy's right eye."** *JAMES M. FITZGERALD U.S. District Court*

Judge Fitzgerald's decision was rendered on October 20, 1978, in the case of Timothy R. Steele and Robert K. Steele, plaintiffs, vs. The United States of America, defendant. In his opinion, Judge Fitzgerald stated, "An optometrist's responsibility is to observe during his eye examinations any manifestation of disease visible in the eye. Upon detecting disease in the eye, it is then his obligation and duty to the patient to make known what the optometrist has observed. In such cases, he may not undertake to diagnose the disease, but should inform his patient that the matter is beyond his competence and advise the patient to seek a qualified medical doctor."

The litigation stemmed from a claim brought on Timothy Steele's behalf by his father against the United States for the loss of Timothy's right eye. Timothy Steele, as a four-year-old boy, was treated by John Shank, O.D., an optometrist in charge of the Eye Clinic at Bassett Army Hospital, Fort Wainwright, Alaska.

According to testimony in the case, it was in October and November of 1973 that Timothy's mother first noticed that his eyes were crossing. On December 19, 1973, she took him to Bassett Eye Clinic where he was seen by Dr. Shank.

During his examination, Dr. Shank measured Timothy's vision and found it to be normal. He then used drops to dilate the pupil and looked inside the eye. He diagnosed Timothy's eye condition as accommodative esotropia, which is correctable by eyeglasses. He wrote a prescription for eyeglasses and made an appointment for Timothy to return to the clinic on January 29, 1974, for a checkup.

On January 29, 1974, Timothy reported to Dr. Shank as requested. The optometrist wrote a different prescription for eyeglasses and instructed Mrs. Steele to make another appointment for Timothy four months after he would begin wearing the new glasses.

The testimony further reveals that in early May, Mrs. Steele noticed that Timothy frequently removed his glasses, saying sometimes he could not see well with them.

On June 10, 1974, Timothy was again examined by Dr. Shank and it was then that he discovered that the vision in Timothy's right eye was limited to light perception. At this point, Dr. Shank made an appointment for Timothy with ophthalmologist Bruce Wolf, M.D., of Fairbanks.

When Dr. Wolf, a medical doctor, examined Timothy on June 17, 1974, he found Timothy's visual acuity in the right eye limited to hand motions and capable of perceiving light. Essentially, his right eye was blind.

Recognizing the seriousness of the case, Dr. Wolf called in William Kinn, M.D., as a consultant. On July 9, 1974, Dr. Wolf and Dr. Kinn observed a retinal detachment of the right eye with a subretinal mass. Their diagnosis was possible retinoblastoma, but toxocara canis was also to be considered. Concluding that specific tests were necessary to identify the disease, Timothy was flown to Letterman Army Medical Center where he was examined on July 12, 1974.

At Letterman, it was determined that, because the danger of retinoblastoma, a fast-spreading, life-threatening malignancy, Timothy's eye should be removed. With parental consent, the surgery was performed by Major Bradley C. Black, M.D.

When the pathological report ruled out retinoblastoma, Timothy was returned to surgery and an implant was placed in the socket. Although recovery appeared to be good, Timothy continued to suffer from periodic socket inflammation.

In September of 1974, Timothy returned to Letterman Medical Center where a prosthesis was inserted in the socket. Testimony revealed that since the prosthesis could not be inserted immediately following the operation, it is unlikely that it will ever appear similar to a natural eye. ●

WHY "THE PEN?"

The files of state and national medical associations, all learned societies concerned with the public health, overflow with a preponderance of evidence that the quality of health care is threatened by the precedent of Government encouraging the lowering of professional standards by allowing medical functions to practitioners with no medical education. Medicine accepts the responsibility to respond to epidemics. Death and trauma are resulting, and Doctors of Medicine can do no less than warn potential victims through the continuous presentation of this evidence. The public press of America, given the facts, is supporting this cause, and concerned physicians throughout the nation are pooling their knowledge and resources to package and present the truth through the PHYSICIANS EDUCATION NETWORK.

A SAD SUMMARY:

- **When Timothy was four, his mother noticed his eyes crossing.**
- **A military dependent, he was taken to an army hospital where he was seen by an optometrist, instead of an M.D. (Current standard U.S. military procedure).**
- **The optometrist disregarded disease, infection or malignancy as causes and prescribed eyeglasses. Despite three visits, two pairs of eyeglasses and advancing blindness, Timothy was not referred to an M.D. ophthalmologist for six months, until after his right eye was blind.**
- **Ophthalmologists immediately recognized the probability of either retinoblastoma (malignancy) or toxocara canis (a parasitic worm infection), either of which is treatable in the early stages.**
- **The doctors recommended to Timothy's parents that the right eye be removed, because of the danger of an advanced life-threatening malignancy, as well as a hopelessly blind eye.**

THIS CHRISTMAS:

- **Timothy, 8, has an artificial eye which will never appear similar to a natural eye.**
- **YOU — The U.S. taxpayers have been found liable for the loss of Timothy's right eye. Who should provide primary care?**
- **Tell your legislators.**

DR. ALLEN'S

DIAGNOSES

James H. Allen, M.D.; founding president, New Orleans Academy of Ophthalmology; professor of ophthalmology, Univ. of Iowa and Tulane Univ. for 30 years; Senior Surgeon, Tulane Univ.; awarded the prized Gold Medal of the Ophthalmology Section of AMA, 1976.

TIMOTHY — WE'RE SORRY — WE'RE TRYING

In spite of the loss of his right eye, and the attendant loss of visual field and depth perception, perhaps the young Alaskan victim will grow up to have more "vision" than many U.S. officials. Nearsighted policy supported by these leaders guarantees that disasters like that which befell young Timothy Steele will continue to happen to our servicemen and women, their dependents, as well as our veterans.

The Timothy Steele case, while tragic, had a relatively happy outcome. The alternative probability — retinoblastoma — might well have resulted in death for the youngster because of the delay resulting from what optometry has designated "primary care."

The optometrist should not judged harshly. It is provable that his education did not equip him to attempt to cope with the problem Timothy presented.

The dean of the Pacific University College of Optometry, a government witness, displayed an identical ignorance of the medical facts and identified Timothy's treatment as proper medical care. It is ignorance and over-confidence at the upper level of optometric education that produces large numbers of sincere optometrists, convinced that they know much more about eye disease than they in fact do.

It would be wrong to blame the Eye Clinic, Bassett Army Hospital, or even the Medical Army leadership at Fort Wainwright. The fact that Timothy was seen first by a person with the right to use dangerous drugs to open his eye to look for what he had no training to see is the fault of the defendant — *THE UNITED STATES OF AMERICA.*

And that, dear reader, means that a Federal Court has ruled that Timothy's right eye was wasted by you . . . and me.

We have thus far failed to communicate simple logic, i.e., that a non-medical measuring scientist cannot be substituted for an M.D., no matter how critical the M.D. military manpower shortage may be.

If it takes a "Doctor Draft," so be it. The current policy of both the Military establishment and the Veteran's Administration in allowing optometrists to experiment with their own invention called "primary care" makes a travesty of Abraham Lincoln's determination "to care for him who shall have borne the battle, and for his widow, and his orphan."

Judge Fitzgerald handed down his landmark decision on October 24, 1978. During the same week, the Chairman of the U.S. House of Representatives Committee on Armed Services, Congressman Melvin Price of Illinois, was responding to concerned M.D.s across the land, as follows: *"We are also told that all military optometrists are bound by principles of acceptable and safe medical practice."*

Respectfully, Congressman Price, in the light of Judge Fitzgerald's opinion, and the disaster which has befallen Timothy, who is t lling you such nonsense?

Again respectfully, Mr. Chairman, would you really expect Robert K. Steele, as the "Natural father and next friend of Timothy R. Steele" to accept and/or respect the credibility of your informants?

Judge Fitzgerald has placed the responsibility on the American people, who look to you for leadership in this matter. We acknowledge that medicine has failed in the past to get the message to your military affairs committee, but perhaps the sad fate of Timothy Steele will at least serve the purpose of opening the eyes of your committee members to the grave danger which exists.

At this writing, a dollar value has not been placed on the loss of Timothy's right eye, but that monetary assessment, plus inevitable subsequent judgments resulting from the present policy of allowing optometrists to render medical services for which they are untrained, would serve to fund proper ophthalmologic care in the military, and provide some safeguards for the Timothys of tomorrow.

JHA

THE PEN....

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Author Provides Basic Information On Crossed Eyes

JOHN EDEN, M.D.
"The Eye Book"

A medical examination would have revealed the cause of Timothy's crossed eyes. No ophthalmologist would have depended on eyeglasses alone without further "medical detective work" in a case which presented crossed eyes starting at four years of age.

In **The Eye Book** *(Viking Penguin, Inc.) author John Eden, M.D. has provided basic information on crossed eyes as follows:*

Strabismus, or crossed eyes, is the second of the common childhood onset eye problems. Like amblyopia, it can seriously impair the visual learning process if uncorrected before age six. Strabismus describes two eyes that are not perfectly parallel when viewing an object. This does not mean that the eyes have to be straight ahead; they simply must be parallel to each other whichever way they are turned. But like lazy eye, "crossed eyes" is a misnomer. Although it is possible in one type of strabismus for the lines of sight (visual axes) to cross, they are not always crossed and certainly at no time do the eyes themselves cross. Some other common names for strabismus are "a cast to the eye" and "wall eyes," but these terms are even less correct than "crossed eyes."

Although strabismus is often very obvious, it is frequently impossible to spot with the naked eye. All the same, it is no more possible to be a little bit cross-eyed than it is to be a little bit pregnant. Any degree of strabismus will have the same visual effect; whether it is a slight or major deviation, the damage done to vision is the same. A particularly unfortunate bit of misinformation that contributes to the number of children who are seriously and permanently handicapped by strabismus is the notion that they will grow out of a tendency to cross their eyes. Although it is true that a certain amount of random divergence or convergence is common in infants, children past the age of one or one and a half should be able to hold both eyes in alignment. Crossed eyes after that age is not normal and cannot be left to improve on their own.

By the same token, you cannot give yourself strabismus. The often-heard warning that rolling your eyes or crossing them in play might make you permanently cross-eyed is completely fanciful. Your external eye muscles are meant to be used, and they are designed to move your eyes in all directions, as well as to hold them parallel to one another. You cannot misuse or overuse these muscles.

Like amblyopia, strabismus is damaging because the brain is constantly given an unacceptable visual message and that interferes with the development of visual skills. Use of the two eyes together is impossible since they are viewing different things. Never having had the chance to receive two similar messages, the brain is unable to learn to assemble a three-dimensional image. Without this learned skill, the individual will never have normal depth perception. And, of course, the deviant eye can become amblyopic.

There are several possible causes of strabismus, some better understood than others. And in some instances we cannot identify the cause at all. The most obvious one — that the eye muscles themselves are too weak to hold the eye in alignment — happens to be relatively uncommon. There is no question that there is a hereditary influence; children whose families have a history of strabismus will have a greater tendency to develop it. Another possible cause is a malfunction of the nerve connection to the external eye muscles. A

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"TIME HAD RUN OUT"

Full Text of Federal Judge Fitzgerald's Decision

LONG BUT IMPORTANT

Judge Fitzgerald's opinion is lengthy, but you will find it interesting reading. State legislators will find it incontrovertible evidence that optometrists, who have no medical education, should *not* be allowed to experiment with eye drops and attempt to diagnose disease. U.S. SENATE AND HOUSE Military Affairs Committee members will find it MUST READING in terms of evaluating the use of optometrists in the military to provide "PRIMARY EYE CARE."

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ALASKA

ROBERT K. STEELE, as the Natural father and next friend of TIMOTHY R. STEELE, and ROBERT K. STEELE, individually,
Plaintiffs,
v.
UNITED STATES OF AMERICA,
Defendant.

NO. F 75-27 Civil

OPINION

Timothy Steele is an eight year old boy whose father is a soldier in the United States Army. Timothy received medical care as a medical dependent at the Eye Clinic, Bassett Army Hospital, Fort Wainwright, Alaska, in 1973 and 1974. This litigation stems from a claim brought on Timothy's behalf by his father against the United States for loss of Timothy's right eye. The Federal Tort Claims Act[1] furnishes the required jurisdiction.

In October and November of 1973, Timothy's mother noticed Timothy's eyes crossing. On December 19, 1973, she took Timothy to the Eye Clinic, Bassett Army Hospital. There Timothy saw Dr. John Shank, an optometrist in charge of the clinic.

Dr. Shank made an extended examination and diagnosed Timothy's eye condition as an accomodative esotropia correctable by eyeglasses. Following his examination of Timothy, Dr. Shank wrote Mrs. Steele a prescription for eyeglasses and made an appointment for her to return Timothy to the clinic January 29, 1974, for a checkup.

During the January visit to the clinic Timothy's mother reported to Dr. Shank that she thought the eyeglasses were helping since Timothy's right eye was not crossing as frequently. However, Dr. Shank's clinical record noted "no good reflex" in Timothy's right eye. The optometrist wrote a different prescription for eyeglasses and instructed Mrs. Steele to make a follow-up appointment for Timothy four months after Timothy would begin wearing the new eyeglasses.

By early May, Mrs. Steele noticed that Timothy frequently removed his eyeglasses. When questioned, Timothy told her that sometimes he wasn't able to see well. An appointment at the eye clinic was scheduled for Timothy on June 10. When Dr. Shank examined Timothy on that date he found vision in Timothy's right eye limited to light perception. At this point Dr. Shank made an appointment for Timothy with ophthalmologist Dr. Bruce Wolf, close by in Fairbanks.

When Dr. Wolf examined Timothy on June 17th he found Timothy's visual acuity in the right eye limited to hand motion although capable of perceiving light. Essentially, Timothy's right eye was blind. The doctor diagnosed leucocoria, right eye, with right esotropia. In his medical opinion the inflammatory cause was a vitreous hemorrhage with possible involvement of toxocara canis or retinoblastoma. Since either disease was extremely serious, Dr. Wolf ordered a complete workup by a pediatrician hoping to rule out one or both. The pediatric workup proved negative and Dr. Wolf then arranged for ophthalmologist Dr. William Kinn, as consultant. Dr. Kinn, a highly qualified ophthalmologist, before opening a practice in ophthalmology at Fairbanks, spent ten years as a military medical officer. His last three years of military service were spent at Fort Wainwright where he was chief of ophthalmology and supervised the optometrists assigned to Bassett Army Hospital.

On examination of Timothy July 9th, Dr. Wolf and Dr. Kinn observed a retinal detachment of the right eye with a subretinal tumor. "Tumor" in this context was defined as a mass rather than a malignancy. Their diagnosis was possible retinoblastoma, but toxocara canis was also to be considered. The doctors concluded specific tests were necessary so that the precise identity of the disease might be known.

Arrangements were made to airevac Timothy from Fairbanks to Letterman Army Medical Center at the Presidio in San Francisco. At Letterman, Timothy was examined July 12 by a team of medical doctors, including Dr. Michael Hogan who was internationally recognized in the field of ophthalmologic pathology.

(Life-threatening Malignancy)

On examination, the medical team observed a retinal detachment involving a grayish yellow tumor. The doctors diagnosed the cause of the tumor as possibly retinoblastoma or toxocara canis. Eye condition at that point in time made it impossible to differentiate between either disease. Because of the danger of retinoblastoma, a particularly fast-spreading and life-threatening malignancy, the doctors recommended to Timothy's parents that his right eye be removed. Timothy's parents immediately consented to the operation and Major Bradley C. Black, a resident assigned to the ophthalmology unit at Letterman, performed the surgery.

After the eye was enucleated it was sent to the ophthalmologic pathology laboratory at the University of California, Berkeley, California, for examination. The laboratory report revealed total retinal detachment of the eye with giant reaction and massive disorganization of the retina. The pathological examination ruled out a retinoblastoma but concluded the cause of the disease to be granulomatous retinitis,[2] etiology unknown. Unlike as in most eye removals, an implant was not inserted into the socket of Timothy's right eye immediately following surgery as there was a substantial possibility that the pathology report might confirm retinoblastoma. The malignancy would necessarily require radiation treatment and a follow-up examination not possible with an implant. When the pathological report ruled out retinoblastoma Timothy was returned to surgery and an implant was placed in the socket.

Dr. Black continued to treat Timothy following the second operation until Timothy returned to Fairbanks. After Timothy returned to Fairbanks he was treated by Dr. Wolf who noted that Timothy's recovery was excellent with the exception of periodic socket inflammation.

Timothy returned in September to Letterman where a prosthesis was inserted into the eye socket with good cosmetic result. Probably the prosthesis will never appear similar to a natural eye since it could not be inserted immediately following the operation.

("Failed to provide adequate care")

It is claimed in this litigation that the optometrist, Dr. Shank, failed to provide adequate care required of an optometrist when he treated Tim-

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TIMOTHY STEELE
. . . during infancy

Steeles Warn Other Parents

In an exclusive telephone interview with Timothy's parents who now live in Hawaii, where Army Sergeant Robert Steele is stationed at Schofield Barracks, PEN learned more of an unfolding tragedy.

Saying the subject was "extremely painful" to them, Sgt. and Mrs. Steele agreed to discuss the case because they wanted to warn other parents against relying on optometrists for "primary care."

Sergeant Steele told PEN that, confronted with a life-threatening alternate possibility, the family welcomed the diagnosis of toxocara canis, but he added, "We were pretty well under for about a week after they took out our boy's eye." The tragedy, Steele said, caused Timothy's mother great emotional stress that required medical treatment.

Confirming the words of attorney Nelson Parrish, Steele advised PEN that up until the time of this incident, Timothy had been a bright, well-adjusted youngster who could look forward to a promising future. Today, at nine years of age, Steele said Timothy is working hard to overcome his handicap and engage in normal activities, but despite his determination, he is encountering difficulties.

Timothy is ashamed of his condition, Steele said, and still suffers physically and psychologically. Mrs. Steele told PEN, "Timothy gets very upset if he finds out that other kids know he has an artificial eye — kids can be unkind."

While after five years, monetary damages have yet to be assessed, Mrs. Steele told PEN, "But nothing can replace Tim's eye." ●

From: Transactions of the American Ophthalmological Society — Vol. 67, 1969.

"It is well to consider that any child with strabismus (crossed eyes), and especially any child with strabismus and a poorly fixating eye, has retinoblastoma until proven otherwise."

Robert N. Ellsworth, M.D.
Director, Eye Tumor Clinic of
Edward S. Harkness Eye Institute
Columbia Presbyterian Hospital

JUDGE'S DECISION

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othy in December of 1973 and January of 1974.

OPTOMETRIC RESPONSIBILITY

Dr. Shank graduated with a degree in optometry from Pacific University at Forest Grove, Oregon, in 1971. He was commissioned in the United States Army as a Captain in the medical services and during the summer of 1973 was assigned to Fort Wainwright, Alaska. In November of 1974 he left the Army and now is in the practice of optometry at Kodiak, Alaska.

When Dr. Shank made his first examination of Timothy's eyes on December 17, 1973, he recorded a brief history:

Past six weeks mother thinks patient is cross-eyed. Father amblyopic. Age 4. Negative medical history. Rubs eyes after playing up close. Notices no real problem with depth. No allergies.

In addition he also tested Timothy's unaided vision using a standard AO chart (pictures) for children. The best possible visual acuity when measured with an AO chart is 20/30. Dr. Shank recorded Timothy's visual acuity 20/30 OD and OS (both eyes). After dilating Timothy's eyes he made an internal examination and noted:

Preliminary scoping shows opacity in right eye. Dilated with 10 percent Neo at 1430. Vitreous lesion in right eye caused from hemorrhage.

Upon completing the examination, Dr. Shank concluded that Timothy's eye problem was caused by an accomodative esotropia[3] correctable by a prescription for eyeglasses. He did not think it necessary to refer Timothy to an ophthalmologist.

Dr. Willard Bleything, Dean of the College of Optometry, Pacific University, Forest Grove, Oregon, who was called as a government witness at trial, agrees with Dr. Shank. According to Dr. Bleything, the findings of Dr. Shank's December examination are entirely consistent with an accomodative esotropia, hence, there was no need to send Timothy to a medical doctor.

In his testimony Dr. Bleything touched on the scope of training provided in a school of optometry. A significant part of optometric training is given over to recognition of diseases in the eye. In this case no one questions the principle requiring optometrists to refer their patients to medical doctors once disease is detected in the eye.

(Vitreous Hemorrhage)

In Timothy's case, however, Dr. Bleything would distinguish between an active vitreous hemorrhage and an inactive vitreous hemorrhage. He classifies an inactive vitreous hemorrhage as a scar and suggests referral to a medical doctor is indicated only in the event that an active vitreous hemorrhage were detected. It is implicit by this reasoning that to Dr. Bleything a scar is not an indication of existing disease. Scar tissue, according to Dr. Bleything's opinion, when old or inactive, is typically black. This is consistent with Dr. Shank's testimony that the vitreous hemorrhage detected in his December examination was old because it appeared black or dark.

Actually a black or dark color in a vitreous hemorrhage has nothing at all to do with its age, but rather is a result of its magnitude or extent. The black or dark color indicates a lack of reflected light from the retina behind the hemorrhage. Blood in a vitreous hemorrhage is not black; it is only the shadow that appears black. Indeed, as Dr. Black states in his deposition, an old vitreous hemorrhage would appear as white strands in the vitreous and settle to the lower part of the vitreous. And Dr. Kinn testified that he had personally observed hemorrhages in the vitreous more than a year old which were red in color. He explained that a hemorrhage would appear to be black because it was sufficiently thick with blood to absorb all the light reflecting off the retina during an examination, not because of an innate darkness of color.

The interrelationship between optometric and medical responsibility is discussed in considerable depth in the scientific text referred to at trial, "The Optometric Profession," by Hirsch & Wick. The text notes that responsibility for recognizing eye disease has not always been a part of optometry, nor indeed is it now a part of optometric services in parts of the world outside of the United States and English speaking countries. In some European countries an optometrist is expressly forbidden to examine the eye to determine whether it is healthy or not.[4]

Some of the diseases which may be discovered by examination of the eye are brain tumors, diabetes, kidney disorders, hypertension, as well as some diseases caused by microorganisms such as tuberculosis. Optometrists study about these and other diseases in order to recognize eye manifestations of diseases. An optometrist should not attempt to complete a definitive diagnosis but recognize this responsibility is part of the practice of medicine. This principle is clearly stated in "The Optometric Profession."

JUDGE JAMES M. FITZGERALD
U.S. District Judge - Alaska

"The difference between optometric and medical responsibility to the patient may be clarified by example. If an optometrist observes a hemorrhage in the fundus, he recognizes that it may be due to any of the diseases already enumerated. It also may have resulted from a vascular accident or from undue capillary fragility. The important consideration for the optometrist, however, is that he see and identify the hemorrhage. It is his responsibility to refer the patient to the appropriate medical practitioner for diagnosis and treatment of the disorder. The optometrist's understanding about disease is sufficient to recognize the various diseases that can cause hemorrhage. He does not attempt to differentiate between them. Medical technology has advanced so greatly in the past few decades that there are now many laboratory tests the physician can use in making the correct diagnosis. Disease is diagnosed by many procedures. The appearance of the eyeground is only one of them." *The Optometric Profession.*

I am not persuaded with Dr. Bleything's reasoning that referral to a medical doctor ought to depend on whether the optometrist has diagnosed a vitreous hemorrhage as active or inactive. The authors, Hirsch & Wick, suggest in their text that the important consideration is that the optometrist be able to see and identify the hemorrhage. It then becomes his responsibility to refer the patient to a medical doctor for diagnosis and treatment. Since Dr. Shank detected the vitreous hemorrhage of the right eye during his December examination, it was his immediate responsibility to promptly refer Timothy to a medical doctor. In point of fact, ophthalmological services were then readily available to military personnel at Fort Wainwright and to their dependents under a federal contract with Dr. Wolf.

Dr. Shank was aware of symptoms other than vitreous hemorrhage which are of significance to an optometrist. Esotropia in a child of four, Timothy's age in 1973, is a serious matter. Dr. Black states that esotropia in a four year old child is very rare. Most cases of congenital esotropia caused by muscle imbalance develop before age two. This condition is correctable by an operation on the muscles of the eye. Accomodative esotropia, such as diagnosed by Dr. Shank in December, 1973, develops in most cases at age two to two and a half, although it occasionally develops as late as age four or five. This condition is correctable by eyeglasses and the esotropia usually corrects itself after eyeglasses are worn. But esotropia may also indicate some type of retinal or vitreous pathology in the visual axis. This will often involve a disease in the macula, the central part of the retina. This condition reduces visual acuity in the eye and as a result the eye turns inward. In Dr. Black's opinion the most important thing to rule out when a child does present an esotropia is retinal or vitreous pathology. But even more, when a vitreous hemorrhage is observed in a child, it is very important that retinoblastoma be immediately considered until that disease can be completely ruled out.

Dr. Wolf, who treated Timothy at Fairbanks before and after his hospitalization at Letterman, agrees with Dr. Black that Dr. Shank should have referred Timothy to an ophthalmologist in December. Dr. Wolf believes that referral to a medical doctor ought to have been made immediately when Dr. Shank learned of the esotropia from Timothy's mother. Dr. Kinn, who consulted with Dr. Wolf, also agrees that referral was indicated in December. Indeed, Dr. Zimmerman, an eminent ophthalmic pathologist, who testified for the government at trial, concurs that further investigation should have been undertaken at the time the lesion was observed in Timothy's right eye.

(Credible Opinion Cited)

I am persuaded from credible, convincing medical opinion, as well as the scientific publication referred to, that Dr. Shank failed to meet the standards required of his profession when he examined Timothy in December of 1973. He knew that Timothy presented an esotropia and in the course of his examination he observed a vitreous hemorrhage in the right eye. An optometrist's responsibility is to observe during his eye examinations any manifestation of disease visible in the eye. Upon detecting disease in the eye, it is then his obligation and duty to the patient to make known what the optometrist has observed. In such cases he may not undertake to diagnose the disease, but should inform his patient that the matter is beyond his competence and advise the patient to seek a qualified medical doctor. Certainly in January when Dr. Shank detected the poor reflex in Timothy's right eye, he should have sent Timothy to a medical doctor. Instead, he delayed making a referral to an ophthalmologist until after his last examination in June, 1974. By that time Timothy was essentially blind in his right eye, and by then the retina had pulled away from the rear of Timothy's right eye. As it was to turn out, nothing thereafter could be done to save the vision or to save the eye. Time had run out.

Several questions arise at this juncture. Was the disease which ultimately caused the eye to be removed present when Dr. Shank made his examination in December, 1973? What was the nature of the malady and could it have been diagnosed? Could the disease have been treated had it been timely discovered?

There is general agreement in the testimony of the physicians that the disease which brought about the removal of Timothy's right eye was present when Dr. Shank made his initial examination.

When Dr. Wolf examined Timothy in June, 1974, he diagnosed a vitreous hemorrhage with the possibility of either retinoblastoma or toxocara canis. The team of medical doctors who examined Timothy at Letterman Hospital in July considered four possibilities. The first was persistent hyper-

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JUDGE'S DECISION

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plastic primary vitreous, a congenital defect of the eye present at birth and generally noticed shortly after birth. With such a condition as persistent hyperplastic primary vitreous, the eye is usually a bit smaller. The front part of the eye is ordinarily not normal so there are distinguishing factors for that disease. The medical doctors at Letterman were able to rule out this possibility. They were also able to rule out a vitreous hemorrhage as a cause since the vitreous of the eye was fairly clear when the doctors made their examination. The two remaining considerations related to some type of inflammatory response, most probably either toxocara canis or retinoblastoma.

(A Dangerous Malignancy)

Retinoblastoma is an extremely dangerous malignancy sometimes found in the eyes of young children. When diagnosed, retinoblastoma requires removal of the diseased eye to prevent the malignancy from escaping outside the eye, possibly through the optic nerve into the brain.

Retinoblastoma was ruled out in the University of California pathological report following examination of the eye after the operation. A negative finding of retinoblastoma eliminated any need for radiation treatment. In Dr. Black's medical opinion the cause of the inflammation of Timothy's eye was probably toxocara canis. Dr. Black observed that although the larva was never found in the new sectionings of the eye, it is known that the larva may disintegrate or completely disappear in the eye.

Toxocara canis is a parasitic round worm frequently found in dogs. The eggs of the parasite may be ingested by children playing in dirt and the eggs hatch in the intestines of the child into a larva. The larva bores through the intestinal wall and enters the blood stream and is disseminated to different parts of the body. In every instance, with possible rare exception, the parasite is not able to complete its life cycle in a human host and the larva dies without developing into an adult worm. The most common locations where it has been found are in the liver or the lungs. Inflammation of the eye by toxocara is fairly rare. But when it does appear it tends to result in a massive inflammation which usually involves the retina and sometimes may intrude into other structures inside the eye. The presence of toxocara in the body often leads to visceral larva migrans syndrome. The child can have a fever and may have some type of lung disorder, his liver may be enlarged and tender and there may be some abnormalies in certain blood tests. However, an ocular toxocara inflammation frequently occurs without a visceral larva migrans syndrome occurring and some studies suggest that in only three or four percent of ocular toxocara inflammation is the syndrome present. With ocular toxocara, so long as the larva remains alive, there is usually not much effect on the eye. There may be a local inflammation in the retina or a small whitish elevated lesion in the retina at the site of the larva or where it penetrated the retina, but the stage at which the parasite usually becomes very damaging is when the larva dies and decomposes. This leads to an extensive lesion in the eye eventually resulting in a massive scar. If the larva is able to work itself into the vitreous cavity of the eye, it brings about an even more severe inflammatory process.

(Dr. Krupp's Testimony)

Dr. Iris Krupp of Tulane University in New Orleans, Louisiana, is a widely renowned expert in the field of parasitology. She began her work on toxocara as a graduate student in 1954. Since then, she, in association with several ophthalmologists, has done extensive work in the detection and treatment of toxocara. She developed a reliable serologic test for the detection of toxocara which was announced in an article[5] published in the "American Journal of Tropical Medicine" in May, 1974.[6] After examining the medical records, including the pathology report, in Dr. Krupp's opinion the probability was 90 percent that the disease in Timothy's right eye was toxocara.

Ophthalmic pathologist Dr. Lorenz Zimmerman was a principal government witness at trial. He agreed that the University of California pathological report required that retinoblastoma be ruled out as a cause. However, he noted Dr. Helenor Foerster, a widely known ophthalmic pathologist, also performed a pathological examination on Timothy's eye. Dr. Foerster has published a number of important scientific papers, one of which presented the initial description of toxocara infection of the eye. Dr. Foerster prepared a pathological report in connection with a paper which she presented to the Western Ophthalmic Club. In her report, Dr. Foerster observed many pigment-laden macrophages and giant cells in the retina. Dr. Zimmerman believed this was significant since it implied substantial bleeding into the eye, or alternatively, that a foreign body containing iron might have been introduced into the eye. He postulated that bleeding may have been brought about by several causes, including persistent hyperplastic primary vitreous. In addition, Dr. Zimmerman suggested another possibility of the cause of the inflammation might be a low grade bacterial infection. He did not, however, conclusively rule out toxocara as a possible cause but noted that the larva was not found in either pathological examination. Also, in Dr. Zimmerman's opinion the iron pigment described by Dr. Foerster in her pathological report would not be characteristic of toxocara infection. For these reasons he discounted toxocara as the cause.

Dr. Zimmerman concluded that in this instance it is unlikely that the cause of Timothy's eye inflammation can ever be reliably known, hence the doctor's final diagnosis was chronic sclerosing endophthalmitis, cause undetermined.

It is true that the larva was not found during pathological examination. But as Dr. Black explained, the larva may decompose and disintegrate. The University of California pathological report following examination of the eye was prepared by Dr. Joseph Elinson, an ophthalmologist. In his deposition testimony, Dr. Elinson stated the pathological diagnosis was granulomatous [illegible], etiology unknown. As stated above, this is a general inflammation involving the retina. Toxocara canis characteristically causes this type of inflammation although other causes are possible.

In the course of the pathological examination, a technician prepared 30 to 40 sections from the eye. A section is less than a tenth of a millimeter and unless the entire eye is sectioned it is possible to miss the larva. In Dr. Krupp's opinion, insufficient sections of the eye were examined to exclude the possibility that the larva was in the eye. Other possibilities suggested by Dr. Zimmerman that bleeding into the vitreous was caused by persistent hyperplastic primary vitreous were ruled out during the medical examination in July at Letterman, nor is there anything to suggest the possibility of a foreign metallic object as the cause of the inflammation.

I find on the basis of the testimony of the treating physicians, including Dr. Wolf, Dr. Kinn and Dr. Black, that toxocara canis was the probable cause of the inflammation in Timothy's right eye. The opinions of the treating doctors are substantially similar to the opinion of Dr. Krupp whose qualifications in this field are outstanding. I find in all probability the larva entered the eye through the retina prior to the time Dr. Shank made his examination in December of 1973. Probably the vitreous hemorrhage observed by Dr. Shank was caused by underlying lesion in the retina of the eye.

(Ophthalmic Procedure)

While it cannot be known with absolute certainty what an ophthalmologist would have done or been able to do if Timothy had been seen in December, 1973, Dr. Kinn testified that the ophthalmologist would have been immediately concerned with making a diagnosis. At that time the physician might have had some indication of a retinal lesion which would cause him to suspect either a granulomatous reaction or a retinoblas-

Continued on page 6

IRIS KRUPP, M.D.
Tulane University Professor

M.D. Expert Witness Comments...

Iris Krupp, M.D., of New Orleans, an authority on parasitology who testified as an expert witness in the Steele case, has issued a warning to PEN readers to seek an early medical eye examination if symptoms similar to Timothy's are noticed. Delay, as in Timothy's case, can result in blindness.

In a letter to the editor of PEN, Dr. Krupp, a Tulane University professor, indicates that early treatment with steroids and thiabendazole (an anti-parasitic drug) and/or the laser could save the eye of a patient with visceral larva migrans, which afflicted Timothy Steele.

Dr. Krupp also said that man is not a natural host for the roundworm of the dog (toxocara canis), but may affect children who have eaten dirt or food contaminated by fecal material of a dog containing the eggs of the parasite.

Once ingested, the eggs hatch and the larvae pass from the intestines into the blood stream and may settle in any organ of the child's body. Symptoms may include coughing and wheezing, excessive weariness, loss of appetite, seizures and changes in the ability to see.

Diagnosis can be made by studies of the blood and examination of the sites at which the larvae may be deposited.

Finally, Dr. Krupp emphasized that "It is extremely important that persons with ocular lesions be seen early by a physician experienced in the diagnosis and treatment of this infection, as delay may result in blindness." ●

A medical educator comments:

"In every patient with a misdirected eye and/or an abnormality in the eye, the possibility of a malignant tumor must be excluded."

Moss L. Antony, M.D.
Department of Ophthalmology
School of Medicine
Tulane University

Conclusion: Judge Fitzgerald's Ruling

Continued from page 5

toma. The ophthalmologist would have been able to examine the microscopic details with specific instruments and, if inflammatory cells were observed, the doctor could have concluded that an inflammatory reaction was present. In such circumstances a diagnosis of toxocara would be likely. Dr. Kinn explained that since the eye was functioning in December it would not have been prudent to remove the eye even if retinoblastoma was suspected. Rather, Dr. Kinn would recommend a therapeutic trial of steroids be undertaken and if the response would be favorable, then the eye not be removed. But if the mass continued to grow despite the treatment and if retinoblastoma could not be ruled out, it would be necessary to enucleate the eye.

Although in Dr. Zimmerman's opinion there is no recognized treatment for toxocara canis, in fact according to Dr. Krupp, the use of steroids in treating toxocara appeared in the medical literature as long ago as 1961.[7] And since that time, Dr. Krupp maintains there have been numerous reports in the literature on the use of steroids. In her own right, Dr. Krupp has participated in treating approximately 20 cases involving ophthalmic toxocara. Her treatment for toxocara includes thiobendazole and steroids, generally used in combination. Thiabendozle is an antihelmintic medicine which kills the larva. The steroid is an anti-inflammatory agent which reduces the mass of inflammation generally associated with toxocara. In each of the cases in which Dr. Krupp participated, treatment was able to arrest the loss of vision at the stage it was when the patient was first seen. Results of treatment can usually be observed within three to four weeks. In the event a patient does not respond to treatment, retinoblastoma may be indicated.

Dr. Black was also aware of several cases where inflammation of the eye was treated with steroids, and in isolated cases steroid treatment has decreased the inflammation, resulting in minimal scarring. But in Dr. Black's opinion, in most instances toxocara is not seen by the ophthalmologist until it has been quite destructive. However, assuming that visual acuity in Timothy's right eye was 20/30 in December of 1973 and treatment with steroids was instituted, some vision might have been salvaged.

In Dr. Wolf's opinion, if Timothy had been seen by an ophthalmologist in 1973, very possibly the eye could have been saved. Since a granulomatous inflammation is a cellular reaction to a foreign object, treatment would be taken to block the reaction. Steroids are a recognized form of treatment for granulomatous inflammation.

I find it probable that an ophthalmologist examining Timothy's right eye in December, 1973, would have diagnosed possible granulomatous reaction, toxocara canis or retinoblastoma. Although there was a lesion in the eye that to some extent impaired Timothy's vision, his visual acuity in the eye was 20/30, the best that could be measured on Dr. Shank's eye chart. The ophthalmologist under such circumstances would almost certainly institute a course of treatment involving steroids in order to reduce the inflammation. The treatment would have prevented further loss of vision and toxocara inflammation would have caused minimal scarring. The eye would have been saved.

Since the jurisdiction of the court is found under the Torts Claims Act, Alaska tort law controls. *Richards v. U.S.*, 369 U.S. 1; *U.S. v. English*, 521 F.2d 63 (9th Cir. 1975). The concept of liability arising out of negligence has been recently stated by the Alaska Supreme Court to be:[8]

> It is elemental that in order for liability to be imposed in a negligence action, the plaintiff must establish a duty of due care owed him by the would-be defendant, a breach of that duty, and finally, that the injury was proximately caused by the breach of duty. Generally speaking, the duty of due care or ordinary care is the duty to act with that amount of care which a reasonably prudent person would use under the same or similar circumstances.
>
> *Leigh v. Lindquist*, 540 P.2d 492, 494 (1975).

Dr. Shank's failure to promptly inform Mr. and Mrs. Steele of the vitreous hemorrhage in their child's eye and his accompanying failure to refer Timothy to an ophthalmologist was a breach of the standard of care owed to Timothy Steele and his parents. I find Dr. Kinn's testimony as the duty owed to be especially persuasive. Not only is he a board certified ophthalmologist who continually deals with optometric referrals, but Dr. Kinn was previously chief of the eye clinic at Bassett Army Hospital for three years. During those years, he was in charge of the optometrists at the eye clinic and had overall responsibility for all medical and optometric care at the clinic. Additional evidence of the breach of the standard of care is found in the established text "The Optometric Profession." That authoritative work explicitly states that an optometrist is bound not to try to differentiate between pathologies such as hemorrhages. Instead, an optometrist must refer the patient to a medical practitioner for prompt examination.

(Judge's Conclusion)

I conclude that competent optometric practice required that Timothy's parents be notified and that the child be referred. The failure to inform and refer was not a "judgment call" but a violation of the governing principles of professional standards.

Optometrists are trained to recognize symptoms of many diseases which may be discovered by eye examination. They are not permitted under recognized optometric standards to undertake a definite diagnosis but recognize this as the responsibility of a medical doctor.[9] Obviously, it is foreseeable that failure to refer to a qualified medical practitioner, when required to do so, will result in delay of diagnosis and the institution of treatment; so it proved to be in Timothy's case. At the time the referral was finally made to an ophthalmologist, it was too late. Time had run out, and the only thing that could be done was to remove the eye.

I conclude that the plaintiff is entitled to recover in this action from the United States for the loss of Timothy's right eye.

DATED at Anchorage, Alaska, this 20th day of October, 1978.

ss: James M. Fitzgerald
United States District Judge

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1 28 U.S.C. 1346(b). Plaintiff's original complaint founded jurisdiction on the Federal Torts Claims Act but mistakenly cited the section as 1366(b).

2 Rethitis is an inflammation which chiefly involves the retina. "Granulomatous" is a type of inflammation. Thus, the pathology conclusion was that of a general retinal inflammation of unknown origin.

3 Esotropia, meaning pointing inward.

4 **The Optometric Profession** by Monroe J. Hirsch and Ralph E. Wick, (1968 edition) Chilton Book Co. at page 17.

5 Hemoglutination Test for the Detection of Antibodies Specific for Ascaris and Toxocara Antigens in Patients with Suspected Visceral Larva Migrans.

6 Since the article did not appear until May, 1974, the physicians who treated or examined Timothy were probably not aware of Dr. Krupp's serological test.

7 By Schneider at the Oxnard Clinic.

8 The standard of care required of medical doctors, osteopaths, and dentists is found at AS 09.55.540. Optometrists were not included. In 1976 the statute was broadened to include all health care providers. 31 Ch. 102 SLA 1976. The amendment was limited, however, to actions filed after the effective date, May 29, 1976. Since Steele v. U.S. was filed August 20, 1976, the amendment is not applicable.

9 The Optometric Profession, pp 6, 17.

EDEN: CROSSED EYES

Continued from page 2

common, more readily explainable cause is an uncorrected high degree of farsightedness. Remember that young people can correct farsightedness by using their near-focusing ability. This involuntary action plays a part in strabismus because when near-focusing muscles are used the eyes automatically converge to take in the near object. Notice that when you shift from looking at a far object

Strabismus.

to looking at a near one your eyes turn in a bit. This is a natural and normal reflex, but when a farsighted child uses the near-focusing muscles to view far objects clearly, his or her eyes may converge. The reflex is stronger in some than in others, so it does not mean that all children with uncorrected farsightedness will develop strabismus, but it is a possibility.

A disease that causes poor vision in one eye is another possible cause. If one eye sees quite badly, there is not much visual benefit to be gained from using it. The brain will not tell the nerves to tell the external muscles to hold the eyes parallel, and the defective eye may simply turn in or out because there is little reason for it to hold itself parallel to the other eye.

What difference does all this make? Is strabismus more than just a cosmetic problem, a matter of looking a bit odd because the eyes are crossed? Indeed it is. Binocular use is not a skill mechanically achieved; it must be learned in that ever-important period before age six. If strabismus is uncorrected during that time, the child will never be able to learn to use both eyes together. Correction after age six will improve appearance, but it cannot provide a second chance to learn binocularity. Likewise, if the strabismus has caused the deviant eye to become amblyopic, correction of the deviance after age six will not cure the ambiyopia.

Epicanthus.

Extremely misaligned eyes can be spotted by a parent or anyone looking at the child, but strabismus is often not that pronounced. An eye doctor, however, can readily discover strabismus during the routine eye examination and can determine how it should be treated.

A condition called *epicanthus* often causes parents of young children to suspect strabismus. At birth, a wide nose bridge normal to all babies is combined with an unusual eyelid fold that often makes it seem that one eye is turned in too far when the baby looks slightly to one side. In fact a large portion of the sclera is hidden by the *epicanthal fold*, but the eye is not turned in more than normal. This is an anatomical feature that is not at all related to strabismus, and it does not interfere with learning to see. The child may look abnormal, but he or she does not see abnormally. And in most cases, the epicanthus recedes as the child's nose narrows. ●

FOUNDER SALUTED BY AMA NEWS — PART II

Ochsner: "Treat The Whole Patient"

The accomplishments of Alton Ochsner, M.D., PEN's International Advisory Board Chairman, are legend in the annals of American medicine. Terming PEN, "The most potent communications effort I have ever observed in medicine," Dr. Ochsner has said, "Ophthalmology — medicine's protectors of one of God's greatest gifts — eyesight — finds itself in the trenches, doing grim battle against a potential epidemic of ineptitude foisted on the American public by some legislators who have heard only the exaggerations and half truths of the optometric side of a non-argument."

Free-lance author Nancy Yanes Hoffman, in an article titled "Alton Ochsner: 82 and Still Going Strong," which appeared in the AMA Journal on August 25, 1978, Vol. 240, No. 8, has captured the essence of this man's greatness. PEN wishes to express its appreciation to Ms. Hoffman and to the JAMA for permission granted to present this material in a series of articles.

"Alton Ochsner: 82 and Still Going Strong," Part II:

The trend in American medicine, as in American life, toward trying to get by with mere competence while not striving for excellence, worries Ochsner. "The other thing that worries me is that physicians rely too heavily on laboratory findings. I fear we are developing a group of competent technicians, treating disease but not treating the whole patient. I stress to our young people that they must sit down with a patient, take a complete history, do a careful examination, then evaluate the findings and arrive at a working diagnosis. After that, they should order laboratory tests. If the laboratory work confirms the clinical diagnosis, accept it. If it doesn't, disregard the laboratory findings and keep on looking. Sounds like heresy, I know, but it's true."

Ochsner remembers a South American woman (the Ochsner Medical Institutions draw many Latin American patients) who had been diagnosed as a hypochondriac with severe psychiatric problems. Although Ochsner protested, "I don't know anything about psychiatry," he saw the patient, became convinced that she had no more psychiatric difficulties than the rest of us, examined her and diagnosed her case as amebiasis. The laboratory test disagreed — as did the gastroenterologists. Ochsner insisted on instituting anti-amebiasis therapy. "Three days later she walked into my office and said, 'Doctor, I'm well for the first time in years.' What convinced me? Such things as tenderness over the appendix and the liver and listening carefully to the chronology of her symptoms: 'I wake up in the morning and I could whip my weight in anything. By ten o'clock, I can't drag one foot after the other.' This complete asthenia is characteristic of amebiasis. Doctors must listen to the patient, discard their hidebound preconceptions, track down every clue, have the courage of their convictions even when their peers oppose them. I can't emphasize this enough to students."

As Ochsner looks back at his diverse medical career, he believes that his most valuable contribution to medicine has been his teaching. "I'd like to be remembered as a teacher. As Tulane's professor of surgery, I've gotten my greatest satisfactions from teaching more than 3,600 medical students and from teaching our resident fellows here at the Ochsner Foundation Hospital." No student will ever forget those harrowing sessions in the "bull pen" with Alton Ochsner. At one of these "Why Clinics," as Ochsner dubs them, he was barraging a student with questions. "Why? Why? Why?" demanded Ochsner, forcing the student to analyze and defend every assumption that was not thought through. In a classic fight-or-flight response, the student fainted. When he was revived, Ochsner interrogated him just as vehemently — with one additional question: "Why did you faint?"

Who was his best student? "Mike DeBakey. Remarkable, brilliant." Ochsner considers DeBakey "indefatigable." As for himself: "I don't know if

ALTON OCHSNER, M.D.
PEN'S International Advisory Board Chairman

I have such prodigious energy. My friends say I work too hard. That's ridiculous. I love what I do. I have fun from the time I get up in the morning until I go to bed at night. I don't work hard; I put in long hours. I think that I'm basically lazy, but I'd be miserable if I didn't work." Ochsner insists that his fabled vigor comes from not wasting energy on disappointment or regret for the road not taken. "Then, too, I've never smoked. Tobacco is the most malevolent aging factor present today. Everybody gets older, but nobody has to get old. Chronological age is irrelevant to physical and mental age. Start with a good machine, take care of it, and it will last a long time.

How to age as well as Ochsner — or, at least, to try? "Three factors accelerate aging: tobacco, our modern sedentary life (people must exercise strenuously daily, until they're out of breath, huffing and puffing), and obesity." Ochsner himself eats sparingly, usually skips lunch, and never has permitted his trim body to lose the battle of the bulge. "If I ate what I wanted," he says, "I'd weigh 300 pounds."

What was Ochsner's most interesting case? An impossible question. Separating Siamese twins; the first successful resection of a saccular aneurysm of the aorta; a thyroidectomy on Tomas Gabriel Duque, then former President of Panama, in 1942, at Cordell Hull's request; surgery on the late jazz trumpeter Muggsy Spanier, who thanked him by writing the song, "Oh, Dr. Ochsner"; or treating Ben Hogan after an automobile accident. Six weeks after the accident, ready to be discharged from an El Paso Hospital, Hogan had suffered a pulmonary embolus, had received anticoagulation therapy, then had had a massive embolus five days later.

It was Mardi Gras time. After attending the Queen's supper, Ochsner had gotten to bed at 4 A.M., arisen at 5 A.M. and had worked all day until ten in the evening. He had finally fallen into bed, "dog-tired," when the phone rang. Could he fly to El Paso? Hogan was cyanotic and comatose. As soon as Ochsner saw Hogan he said, "He's got to have his cava tied — immediately" Ochsner remembers: "Hogan was bleeding profusely. His blood was absolutely incoagulable. His prothrombin time was 0. At noon, I began giving him protamine sulfate and vitamin K and blood transfusions. By midnight, his pro-time was 30%, but we couldn't wait any longer because he was sinking fast. I operated."

Ochsner flew home, got in at 8 A.M., went directly to the foundation hospital, and started work. Hogan got well and won touraments after that.

Ochsner postscripts: "People are reluctant to tie off the vena cava, because it seems like such a horrible procedure, but it's not. It can be a life-saving act." Why? "Most patients don't develop a fatal infarction after a nonfatal pulmonary infarct, so surgeons and internists both gamble that every patient won't have a fatal embolus. But every patient who's had a pulmonary embolus is a candidate for another one. He may be lucky and not have one, but it's dicey." Again, Ochsner repeats George Dock's dictum: the importance of being careful. "Many doctors will say wait until a patient has had two or three emboli, then ligate. In my opinion, that's playing Russian roulette. **All medicine is judgment. I can bring anybody in off the street and teach him how to cut and sew in three months. It's knowing when to operate and when not to operate."**

After teaching, Ochsner considers his most important contribution to medicine his work toward the establishment of a causal link between smoking and lung cancer and, subsequently, between smoking and its deleterious effects on the vascular system. "When I was a medical student in 1919, we admitted a patient with lung cancer to Barnes. As usual, the patient died, because the mortality was almost 100%. Dr. Dock had us witness the autopsy because he said that the condition was so rare that we'd never see another case as long as we lived. I didn't see another case for 17 years — until 1936. Then there were nine cases in six months. An epidemic. There had to be a cause. They were all men, all smoked cigarettes heavily, all began smoking in the first world war. When I researched the history of smoking, I found that very few cigarettes had been consumed prior to World War I.

"In 1936, I had the temerity to state — not suggest — that cigarettes caused this new plague." He sighs. "Not that anybody believed me or listened to me. Even in 1950, when I was president of the American Cancer Society, I used to have knock-down-drag-out fights with E. Cuyler Hammond [ScD], their chief biostatistician. [Dr. Hammond, vice-president for epidemiology and statistics, now agrees with Ochsner.] It took the American Heart Association even longer to take up the cudgels against cigarettes, though they are just as noxious to the vascular system as the respiratory system."

Part III of "Alton Ochsner: 82 and Still Going Strong" will appear in the next edition of THE PEN. ●

N.C. REPEAL RESOLUTION

The resolution of the Section on Ophthalmology of the North Carolina Medical Society, was inadvertently omitted in the December 1 issue of THE PEN. The complete text follows:

RESOLUTION:

WHEREAS, the medical doctors who are members of the North Carolina Ophthalmology Section of the North Carolina Medical Society are increasingly concerned about the jeopardy to the public health inherent in the 1977 law which allows the use of drugs with their inherent dangers by medically untrained optometrists; and,

WHEREAS, such drugs are unnecessary to the practice of optometry; and,

WHEREAS, AMA medical ethics Principle 10 mandates that physicians provide their efforts, resources and expertise to the benefit of the public welfare,

NOW THEREFORE BE IT RESOLVED, that the North Carolina Society of Ophthalmology in cooperation with the North Carolina Medical Society will have legislation introduced in the North Carolina Legislature for the purpose of repealing the 1977 optometric drug use law, and will publicly campaign for repeal, maintaining this action until such time as the mission is accomplished and the protection of the people of North Carolina is assured.

Passed May 5, 1978
Pinehurst, North Carolina

H. Maxwell Morrison, M.D.
President, Section Ophthalmology, NCMS
David B. Sloan, Jr., Secretary
Section Ophthalmology, NCMS

Steele's Attorney Comments On Case

O. Nelson Parrish of Fairbanks, Alaska, attorney for the plaintiffs Robert K. Steele and Timothy R. Steele, provided PEN with his reaction to the decision as rendered by Judge James M. Fitzgerald.

"I think," Nelson Parrish said, "that the essence of the court's decision is that optometrists, and schools of optometry (compared to ophthalmology) will not be allowed to set their own standards as to what they can and cannot do. The court's decision recognized that optometrists are not sufficiently trained to make the same kinds of decisions that ophthalmologist M.D.s can, and should make, in situations similar to that presented in Timothy's case."

Continuing, Parrish stated, "The U.S. Government was, in fact, contending throughout this trial that since we (the plaintiffs) did not present an optometrist to say that what the optometrist treating Timothy did was wrong, our case ought to be dismissed. The Government, in fact, moved for a 'directed verdict' (to throw our case out of court) on the grounds that only an optometrist can say what is or is not wrong about what another optometrist does."

When questioned by PEN as to the judge's reaction to this line of reasoning, attorney Parrish replied, "The judge rejected it by saying, in effect that since an optometrist is not fully trained to recognize dangerous situations, such as presented in this case, he could not then say what he did or did not do is right or wrong. Having arrived at that point, the court then in effect said it was going to accept the position of all the medical doctors who testified, including the government's doctor, that the boy should have been referred."

In concluding his comments, Nelson Parrish told PEN that this case had convinced him that, "optometrists, with no medical education, are attempting to pull themselves up by their own bootstraps, into an invulnerable position of unaccountability."

Mail to: James H. Allen, M.D., 9104 Quince St.
New Orleans, LA 70118

PEN MEMBER APPLICATION

"PEN MUST SURVIVE AND GROW . . . IT IS ALREADY THE MOST VIABLE, POTENT, AND ACTIVE COMMUNICATIONS FORCE IN MEDICINE — IT'S A MUST DO - CAN DO - AND WILL DO ORGANIZATION."
Alton Ochsner, M.D.

STATEMENT OF INTENT

I intend to be an active member of PEN and I endorse and support the STATEMENT OF PURPOSE.

In providing my resources I am assuring that PEN will continue to block efforts to invade medicine at the expense of the public health. I am subsidizing the ever-expanding promulgation of **truth**, the circulation of THE PEN and other publications to an ever-expanding audience. I am assuring the availability of resource materials, mass communications, legislative, and other expertise relating to this issue to all who support medicine in this cause.

I DESIRE TO INFORM AND BE INFORMED AND HEREBY PLEDGE DUES IN THE AMOUNT OF $250 ANNUALLY. (Subject to reduction as PEN grows)

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Ophthalmologist?_____ Other specialty_____

Profession, other than M.D.?_____

Check enclosed ($250)_____ Please bill me_____

☐ Resident Dues $25.00
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THE PEN FORUM

Public Service by Alabama M.D.s Draws National Praise

As reported in the December 1 issue of THE PEN, the Medical Advisory Board to the University of Alabama has passed a resolution which declares that University Optometry School graduates are not trained to attempt to practice medicine. This action, to protect the public, is being saluted by M.D.s throughout the nation.

Dear Dr. Hale:

I want to thank you for the public service rendered by the Medical Advisory Board to the University of Alabama for publicly defining the limited role of optometrists. Their efforts over the past several years have been to mislead the public into the scope of services that they provide. It is important to make every effort to protect the medical well-being of the public.

Please be assured of my best wishes.

Robert A. Wiznia, M.D.
New Haven, Connecticut

Dear Dr. Moore:

Let me express my appreciation to you and the other physician members of the Medical Advisory Board of the University of Alabama. Your courage in opposing the attempts by non-practitioners (optometrists) to get into the practice of medicine is commendable. Defining the role of optometry is a public service and the actions taken by the Medical Advisory Board will be of great help in our fight to protect the high quality of medical care in this country.

Joe H. Woody, M.D.
Charlotte, North Carolina

Dear Dr. Henderson:

I found it most gratifying to see that wisdom has prevailed in the resolution to define the limited role of optometry in medicine through your efforts and convictions. The valuable limited services of optometrists has been recognized by medicine and by ophthalmology alike. False claims and false advertising, as well as impersonating physicians by optometrists is totally alien to the medical arts. Your clear perception of the problem, and your action deserves many thank-yous from all physicians, patients, and the public at large.

Georges Birenbaum, M.D.
Lexington, Kentucky

Dear Dr. Pittman:

I congratulate you, as a member of the University of Alabama Medical Advisory Board, for speaking out forthrightly regarding optometric education at your University. The public and legislators around the country need to know that optometrists are not trained to assume a medical role. Your resolution is a godsend.

The American people owes you a debt of gratitude.

Charles B. Bobo, M.D.
Greenwood, South Carolina

Dear Dr. Henderson:

As a practicing ophthalmologist and a citizen I wish to congratulate you for the role you have played and the service you have rendered to the public in defining the limited role of optometry We all know at times it takes courage to stand up on your hind legs for what is right. But remember there is only one truth and all the local political and social pressures cannot alter that.

You have helped to open the eyes of the public as to the only proper role of optometry in vision care.

Walter C. Bullington, M.D
Charlotte, North Carolina

Dear Dr. Moore:

Today I received a copy of the resolution of the University of Alabama School of Medicine Physician Advisory Board concerning the education of optometrists at that institution.

It gives me a feeling of relief and appreciation that there are fellow medical doctors in this country who have the insight and understanding that is necessary to protect our lay population from the zealous political ambitions of those people who place ego and economics above personal ability in matters of the health care of this nation.

Please accept my thanks and appreciation for your efforts in this matter.

Jerome L. Byers, M.D., P.A.
Dallas, Texas

Dear Doctor Moore:

Congratulations to you for your great effort in defining the status of optometric education with regard to the practice of medicine in the resolution passed by the Medical Advisory Committee, at the University of Alabama School of Medicine.

It was a great public service to all of the people of our country.

James W. Clower, M.D.
Daytona Beach, Florida

Aloha, Doctor Pittman!

By publicly defining the limited role of optometrists, you and your colleagues on the University of Alabama Medical Advisory Board have done your patients a real service.

Thanks . . . or as we say in Hawaii,
Mahalo!

John M. Corboy, M.D.
Wahiawa, Hawaii

Dear Dr. Pittman:

Thanks for a job well done. Your recommendation in that we issue a public statement concerning the education of Optometrists is welcomed by all of us who understand the problems related to the eye. The resolution itself is a work of art, and describes optometric education exactly as it should be described.

Please know that your efforts are greatly appreciated.

R. H. Monahan, M.D.
St. Paul, Minnesota

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UNITED STATES PHYSICIANS EDUCATION NETWORK

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.
- 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.

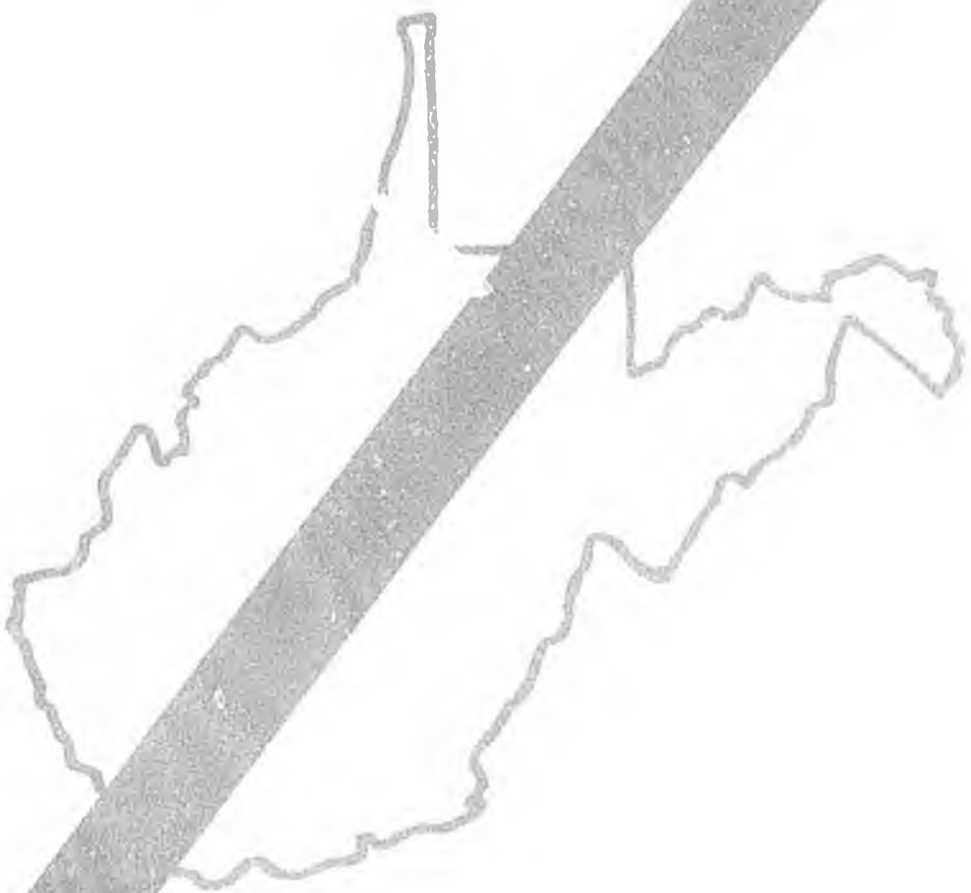
2/28/79

Name	Organization	Address	Bill N
DON HOSTAK	DIV OF OCC. LICENSING		HB 79
SAM A. MCCONKEY, M.D.	—	1919 LATHROP, FBKS, AK	HB 79
Marvin Grendahl M.D	—	3500 LaTouche Alaska AK.	HB 79
ROBERT PAGE M.D.	—	RR3 Box 3051 JNU	HB 79
Nelson Arvisl	—	536 1/2 4th Ave Fairbanks.	
Ron Tuban MD	—	PO Box 6636 Ketchikan	
Ray a. Box OD	alaska optometric assn.	611 W. 7th Anchorage	
BOYD L. WALKER, O.D	ALASKA OPTOMETRIC ASS'N.	1345 W 9th Anchorage AK	
AHARON STERNBERG, O.D.	~~1016 W. 6th Ave, A~~ "	→ 1016 W. 6th Ave. Anch. 99501	

OPTOMETRY

1980

A Post Facto Report on
Enr. H.B. 1005 (1976)



Developed and Presented by

The West Virginia
Optometric Association

OFFICE OF THE
PRESIDENT
Freda J. Slaymaker, O.D.
P.O. Box 663
Charleston, West Virginia 25323
(304)342-3536

January 22, 1980

Dear Legislator:

This letter is an integral part of a report to you concerning the functioning of the 1976 updating of the West Virginia Optometry Law through H.B. 1005 which among other changes included diagnostic and therapeutic drug use by qualified optometrists.

To those of you who are "seasoned" legislators some of this is material of which you will perhaps be well aware. To those of you who have been recently elected, I will endeavor to provide you with as much pertinent material as possible without undue composition.

This law (H.B. 1005) has now been in effect since 1976 and has been functioning in the satisfactory manner as was intended by the legislature.

Optometrists have for over three and a half years been providing diagnosis and treatment to the many patients who live in the smaller towns in rural areas where no other eye care practioners are available except the local optometrist. He, along with his colleagues, has administered drugs to Thirty Thousand Six Hundred Forty-Nine (30,649) patients with a savings of Four Hundred Fifty Thousand (450,000) miles (greater details enclosed for the term involved in this report).

Educational courses are being made available to the optometrists of West Virginia on a continuing basis providing them with newer diagnostic and therapeutic methods of treatment as they occur.

The inclusion of the use of drugs by optometrists is still a major bone of contention by a number of ophthalmologists who, through their efforts and financing, have been sending what has been referred to as a "poisonous pen" letter (prepared by a public relations firm) to legislators of which you no doubt will be a recipient.

The enclosed letter from Dr. Butterfield contains results of the most recent survey conducted by the West Virginia Board of Optometry of those optometrists currently certified to use pharmaceuticals. This will provide you with greater details of the functioning of the law from the standpoint of drugs used and treatment instituted with far less travel time of which many indigent patients would not have the means and, thus, could not otherwise have received proper

treatment.

In submitting this report to you on behalf of the optometrists of the State of West Virginia we hope it will provide you with a better understanding of the results of your labor by supplying a means whereas the people of West Virginia are delivered an improved system of health care services.

Respectfully yours,

Freda J. Slaymaker

Freda J. Slaymaker, O.D.
President
West Virginia Optometric Association

FJS/scp

WEST VIRGINIA BOARD OF OPTOMETRY

J. GORDON BUTTERFIELD, O.D.
SECRETARY-TREASURER
WEST VIRGINIA BOARD OF OPTOMETRY
111 BROOKS STREET
CHARLESTON, WEST VIRGINIA 25301

January 22, 1980

The Honorable W. T. Brotherton, Jr.
President, Senate of West Virginia
State Capitol Building
Charleston, West Virginia 25305

The Honorable Clyde M. See, Jr.
Speaker, West Virginia House of Delegates
State Capitol Building
Charleston, West Virginia 25305

RE: Report on Enrolled H.B. 1005 of 1976

Dear President Brotherton and Speaker See:

The purpose of this letter is to report to each of you and your respective bodies on the Enrolled H.B. 1005 enacted on February 20, 1976 by the Sixty-Second Session of the West Virginia legislature. As you may recall, this law expanded the statutory definition of "optometry" to include, among other things, the limited use of drugs prescribable for the human eye for both diagnosis and treatment, under carefully prescribed certification authority delegated to the West Virginia Board of Optometry. This Board has endeavored continuously and faithfully to both certify and monitor the use of drugs by optometrists practicing under the registration of this Board.

Recent information compiled from the one hundred seventeen (117) West Virginia registered optometrists now certified by this Board for drug usage is as follows:

a. A total of sixty-three (63) different drugs prescribable for the human eye have been employed by these West Virginia certified optometrists since the law was enacted.

b. Thirty Thousand Six Hundred Forty-Nine (30,649) individual patients have been seen by these optometrists and conditions such as infectious or allergic conjunctivitis, corneal abrasions and blepharitis (granulated eye lids) have been treated by those certified in the compilation.

c. The distance those patients who otherwise would have had to travel to geographical locations other than those of the treating optometrists for treatment by ophthalmologists or appropriate medical specialists to whom they formally were referred would have required that over 450,000 aggregate miles be traveled by the 30,649 patients.

d. Forty-six (46) different pathological conditions have been diagnosed and treated by these West Virginia certified optometrists.

Those 117 West Virginia optometrists who have been certified are widely dispersed throughout our state and are now faithfully and well providing expanded eye health care benefits to the people of West Virginia. IT SHOULD BE ADDITIONALLY NOTED THAT THERE HAS BEEN NO REPORT TO THIS BOARD OF ANY ADVERSE REACTION IN THE DIAGNOSIS AND TREATMENT RENDERED TO PATIENTS INVOLVED BY ANY WEST VIRGINIA CERTIFIED OPTOMETRIST.

There have been reports in the newspapers during the past few months of adverse reactions allegedly caused by optometrists. These alleged reports have all been made by one oththalmologist.

Registered letters sent to him by this Board seeking his cooperation in helping to identify and fulfill this Board's responsibility have been met with only silence. This Board, therefore, considers his alleged complaints to be just that.

Please be advised that this Board is quite aware of the full responsibility placed upon it by the legislature in the enactment of this law Enrolled H.B. 1005. This data was compiled in a continuing effort to support the trust which has been reposed in it. Each of you is encouraged to call upon this Board for any additional information which may be helpful.

Sincerely yours,

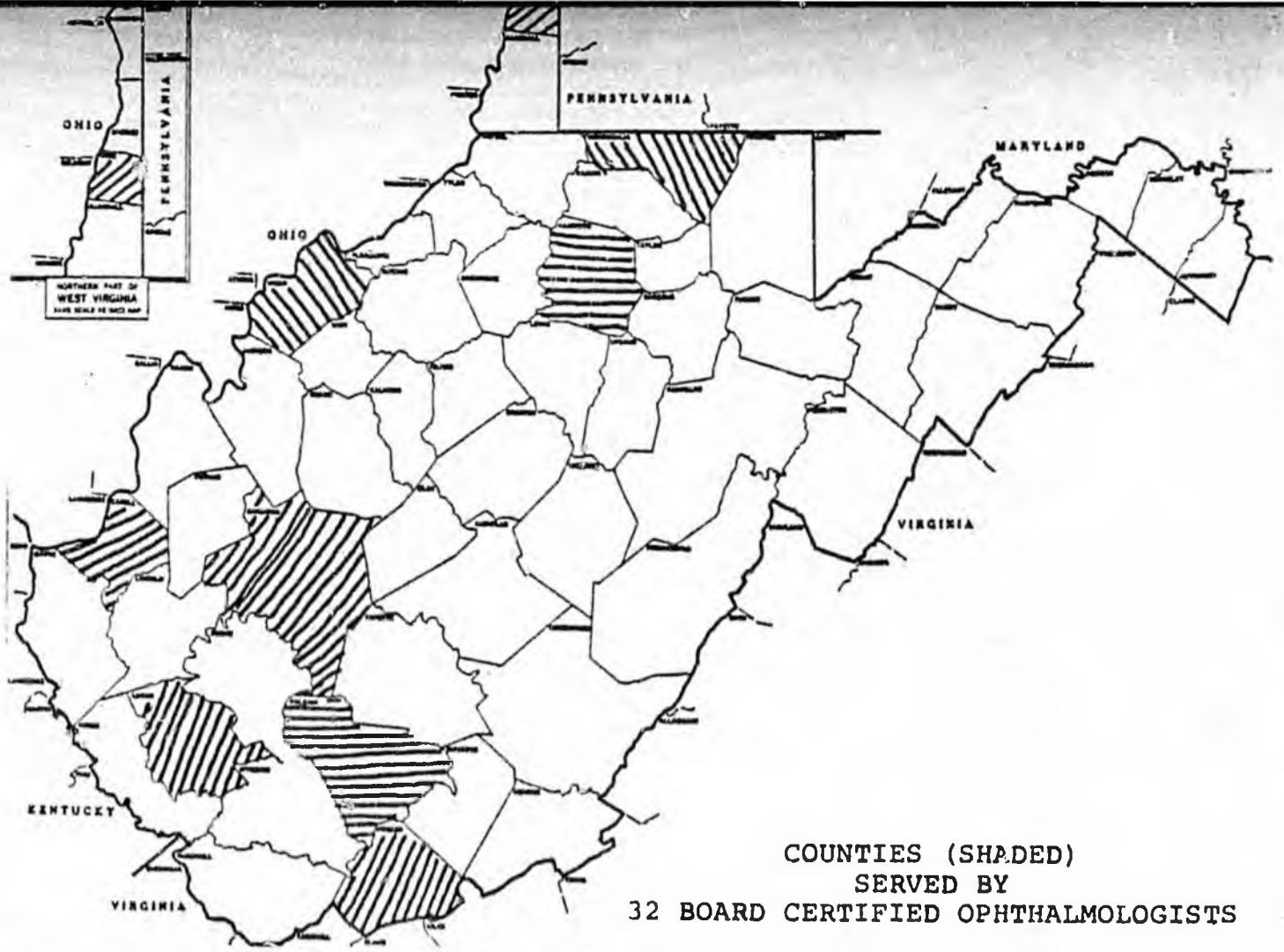
J. Gordon Butterfield, O.D.
Secretary-Treasurer

JGB/scp

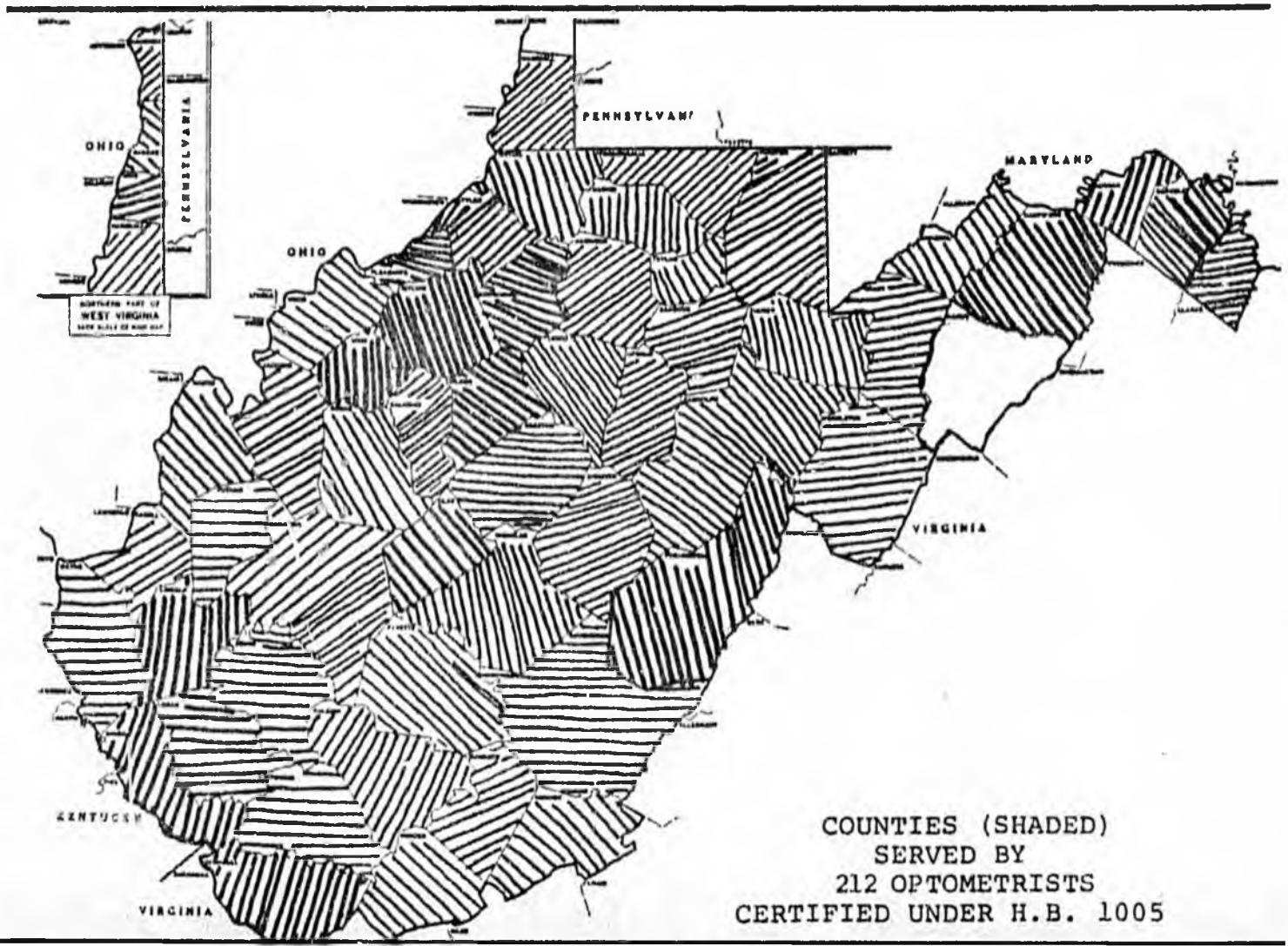
COMPARATIVE PHARMACOLOGICAL INSTRUCTION FOR

HEALTH CARE PROFESSIONS

PROFESSION	SCHOOL	PHARMACOLOGY HOURS OF INSTRUCTION	REFERENCE	RESTRICTION ON DRUG USE IN WEST VIRGINIA
Optometry	Southern College of Optometry	Total = 204 Lecture = 156 hours (Ocular & Systemic) Lab = 48 hours Plus 696 hours Clinical use of FDA Classified Drugs. Plus 180 hours of Elective Seminars attended by 80% of students.	Catalog of Southern College of Optometry 1979-80	Topically applied Ophthalmic Drugs as permitted in Enrolled H.B. 1005 March 1976
Dentistry	University of Tennessee Center for Health Sciences/ Memphis	Total = 70 hours Lecture = 40 hours Lab = 30 hours Plus Clinical use of drugs	General Catalog The University of Tennessee Center for Health Sciences/ Memphis 1978-79	NONE
Medicine	University of Tennessee Medical Units/ Memphis	Total = 187 hours Lecture = 88 hours Lab = 99 hours Plus Clinical use of drugs for 17 months *Clinical use of ocular drugs probably less than 25 of other drugs since Ophthalmology represents only 1.1% of total curriculum	General Catalog The University of Tennessee Medical Units/ Memphis 1973-74	NONE
Podiatry	Pennsylvania College of Podiatric Medicine	Total = 176 hours	Pennsylvania College of Podiatric Medicine 1977-79	NONE
Osteopathy	Philadelphia College of Osteopathic Medicine	Total = 156	Bulletin of Philadelphia College of Osteopathic Medicine 1978-79	NONE



COUNTIES (SHADED)
SERVED BY
32 BOARD CERTIFIED OPHTHALMOLOGISTS



COUNTIES (SHADED)
SERVED BY
212 OPTOMETRISTS
CERTIFIED UNDER H.B. 1005

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

SENATE BILL NO. 75
(Companion to House Bill No. 79)

"An Act relating to the practice of optometry."

This bill would permit the use of selected drugs including topical anesthetics, mydriatics, cycloplegics and miotics by optometrists and as such would delete from the definition of optometry the restriction against the use of drugs. All eight of these are drugs which are instilled directly into the eye. Mydriatics are drugs which cause the pupil to open widely while miotics cause the pupil to close down. Cycloplegics cause temporary paralysis of the muscles which control the shape of the lens.

Approximately 31 states now allow optometrists to use diagnostic topical drugs, either through specific enabling legislation or through the lack of specific prohibition. The issue of use of such drugs by optometrists has been controversial and in recent years certain states have given permission while it has been denied in other states. Those in favor of the use of drugs by optometrists argue that optometric services are more widely distributed than ophthalmologic services and that the optometrist serves as an entry point for primary eye care. The use of diagnostic drugs is said to expand the ability of the optometrist to recongize eye abnormalities and to increase medical referral for diagnosis and treatment. The optometric group also states that the drugs which are proposed rarely have adverse effects.

On the other hand, the medical group argues that the use of drugs would not materially improve the capacity of optometrists to recognize abnormalities. Optometrists are not expected to diagnose diseases of the eye, and if a departure from normal is noted, the patient is expected to be referred to a physician for diagnosis. If empowered to use diagnostic drugs, the concern on the part of the medical community is that the optometrists would be making diagnostic judgments which the physicians do not believe them qualified to make. Moreover, the medical community notes that adverse reactions, while admittedly rare for certain of the drugs, can have extremely serious consequences when they do occur. For example, they cite a higher rate of predisposition to a certain type of glaucoma in Alaska Natives and the possibility of precipitating an attack through use of mydriatics.

In some states which have permitted the use of diagnostic drugs, the permissive legislation has contained certain limitations, none of which appear in the current draft of the Alaska bill. For example, Rhode Island permits the use of mydriatics, miotics and topical anesthetics while Maine permits only the use of topical anesthetics and mydriatics. A bill which may still be under consideration in the Ohio legislature specifically prohibits use of pilocarpine (a drug which constricts the pupil), atropine and homatropine (drugs which dilate the pupil and temporarily paralyze accommodation of the lens) and 10% phenylephrine (a strong mydriatic). In Oregon, the Board of Optometry

is empowered to designate the diagnostic pharmaceutical agents for topical use, but provides that the designation shall be with the advice and guidance of the Board of Medical Examiners for the State of Oregon.

Some states define the type of training in pharmacology which would be required before an optometrist would be permitted to use diagnostic drugs. For example, Pennsylvania requires that the course given by an institution be accredited by a regional or professional accreditation organization recognized or approved by the Council on Postsecondary Accreditation or the United States Office of Education.

If the Legislature chooses to authorize use of certain drugs by optometrists, the Department of Health and Social Services suggests that definitions and restrictions similar to those in use in other states may be advisable, and that the professional opinion of the medical and optometric communities should be sought to insure the health and safety of the general public.

Approved by: _____
Helen D. Beirne
Commissioner

Date: March 20, 1980

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB No. 79, SB No. 75
Title "An Act relating to optometry."
Requested by Commissioner's Office Date 3/18/80

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health/Division of Public Health
BRU, Program, or Subprogram(s) Affected
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES	0	0	0	0	0	0
200	TRAVEL	0	0	0	0	0	0
300	CONTRACTUAL	0	0	0	0	0	0
400	COMMODITIES	0	0	0	0	0	0
500	EQUIPMENT	0	0	0	0	0	0
600	LAND & STRUCTURES	0	0	0	0	0	0
700	GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
	TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Fund Source)	0	0	0	0	0	0

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: M. Deaver Date: 3/18/80
Division/Office: P.H. Admin. PH:
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: Date: 3/20/80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Assuming the Department will fund five similar contracts on an annual basis, projected costs are as follows:

181,000 x 5 = $905,000
Adjusted for inflation, 10%/year x 2 years
Total program costs = $1,095,000

Administrative costs required by the Department are as follows:

Personnel Services			$94,300
Grants Administrator R 17		29,460	
Field Representative R 15		25,620	
PT Clerk Typist III		8,915	
PT Accounting Clerk III		10,010	
	Sub total	74,005	
	Benefits	20,311	
Travel			$16,000
Contract negotiation, monitoring and technical assistance			
Contractual			$22,300
Phones		5,000	
Rents		5,600	
Printing and Advertising		10,000	
Copier services		1,000	
Postage		600	
Repairs and Maintenance		10,000	
		22,300	
Commodities			$ 1,500
Equipment			$ 3,800
1 typing desk		459.80	
1 typing chair		136.02	
2 executive desks		1,311.00	
3 executive swivel chairs		619.00	
1 correcting selectric typewriter		902.48	
1 5-drawer file cabinet		231.48	
1 bookcase		112.49	
		3,772.29	

Department staff, a Grants Administrator and a Project Field Representative, will be responsible for negotiating and executing contracts; monitoring and providing technical assistance; and providing statewide coordination.

(End Fiscal Note Analysis)

SECTIONAL ANALYSIS OF HOUSE BILL NO. 86

Section 1. Adds a new chapter to AS 08 (Business and Professions) entitled "Veterinary Practice Act." Each section of this new chapter will be analyzed separately.

ARTICLE 1. BOARD OF VETERINARY MEDICINE

Sec. 08.95.010. CREATION AND MEMBERSHIP OF BOARD. Creates a Board of Veterinary Medicine, composed of four veterinarian members and one public member, to replace the current Board of Veterinary Examiners.

Sec. 08.95.030. SOURCE OF APPOINTMENTS FOR VETERINARIAN MEMBERS. Directs the governor to appoint each veterinarian member of the board from a list of at least three candidates recommended by the Alaska State Veterinary Medical Association.

Sec. 08.95.040. BOARD MEETINGS. Requires the board to hold a regular annual meeting and permits the chairman to call other meetings.

Sec. 08.95.050. OFFICERS. Directs the board to elect a chairman, subject to the governor's approval, and a secretary to serve one-year terms.

Sec. 08.95.060. REPORT REQUIRED. Requires the chairman and secretary to submit a report on the actions of the board to the Department of Commerce and Economic Development at the end of each examining period.

Sec. 08.95.070. MEETING OF NATIONAL VETERINARY STATE BOARD OF EXAMINERS. Authorizes the board to send one of its members to the annual meeting of the National Veterinary State Board of Examiners at state expense.

Sec. 08.95.080. POWERS AND DUTIES OF THE BOARD. Directs the board to regulate the "practice of veterinary medicine" (as defined) in accordance with the Act, to adopt regulations implementing the Act, and to authorize the issuance, renewal, or reinstatement of a license, permit, or certificate of registration to any person entitled to it. Authorizes the board to adopt regulations interpreting, clarifying, and making specific the provisions of the Act. Directs that the powers granted to the board under the Act be liberally construed.

ARTICLE 2. LICENSING.

Sec. 08.95.200. LICENSE REQUIRED. Prohibits anyone but a licensed veterinarian from practicing veterinary medicine except

(1) a veterinarian licensed in another state consulting with a licensed veterinarian in this state;

(2) the holder of a temporary permit, acting under the direction of a licensed veterinarian, who has applied to take the veterinarian's examination;
(3) a veterinarian licensed in another state who holds a temporary permit to conduct the practice of a licensed veterinarian during his absence;
(4) a person performing tasks within his competence, other than diagnosis, prescription, or initiation of treatment, under the "general supervision" (as defined) of a licensed veterinarian and in accordance with board regulations;
(5) a person performing artificial insemination of animals, who holds a permit to do so;
(6) a person giving advice on livestock management or engaging in accepted livestock management practices in accordance with board regulations;
(7) a faculty member of a "veterinary school" (as defined) engaging in his official duties;
(8) a person lecturing, giving instructions, or performing demonstrations with the approval of the board, at a veterinary school, or in connection with a continuing education course or seminar sponsored by a veterinary school or approved by the board;
(9) a veterinary student performing duties or actions assigned by his instructors;
(10) a veterinary student acting under the general supervision of a licensed veterinarian;
(11) a person engaging in scientific research that reasonably requires experiments with animals;
(12) a person gratuitously giving emergency aid to animals;
(13) the owner of an animal and his regular, full-time employees caring for and treating the animal, unless ownership of the animal was transferred to avoid application of the Act or the employees were hired primarily to treat animals;
(14) a merchant or manufacturer selling at his regular place of business products used in the prevention or treatment of animal diseases;
(15) a person selling or applying a pesticide or herbicide;
(16) a governmental employee engaging in his official duties.

Sec. 08.95.220. QUALIFICATION FOR EXAMINATION. Sets out the qualifications for taking an examination to become a licensed veterinarian. These qualifications are substantially the same as under existing law except for a new provision allowing a person who was not graduated from a veterinary school to take the examination if he has passed the Education Commission for Foreign Veterinary Graduates examination in veterinary medicine.

Sec. 08.95.230. EXAMINATION FEE. Directs the Department of Commerce and Economic Development to establish a fee to accompany applications for licensing as a veterinarian, refundable if the applicant is found unqualified to take the examination.

Sec. 08.95.240. CONTENT OF EXAMINATION. Requires that the examination be in two parts, a national examination selected by the board and a state examination prepared by the board. Requires the examination to cover subjects and techniques commonly taught in veterinary schools and permits the board to require a practical demonstration of skills.

Sec. 08.95.250. EXEMPTION FROM NATIONAL EXAMINATION. Permits the board to exempt an applicant from the national examination who meets specified criteria involving years of practice as a veterinarian in another state and recent passing of a national examination.

Sec. 08.95.260. REEXAMINATION. Allows a person failing an examination to take a subsequent examination upon payment of the examination fee.

Sec. 08.95.265. INITIAL LICENSE AND RENEWAL FEES. Directs the Department of Commerce and Economic Development to establish a fee for issuance of a veterinarian's license and a fee for biennial renewal.

Sec. 08.95.270. TEMPORARY PERMIT TO PRACTICE WITH LICENSED VETERINARIAN. Permits a qualified applicant for a veterinarian's license who has not failed a veterinarian's examination to obtain a temporary permit to practice veterinary medicine under the direction of a licensed veterinarian, pending examination. Comment. The permit holder is required to be under the "direction" of a licensed veterinarian rather than his "general supervision." "General supervision" is defined in the Act but "direction" is not. The difference between these terms is not clear but might be made so by board regulation.

Sec. 08.95.280. TEMPORARY PERMIT TO TAKE OVER PRACTICE OF LICENSED VETERINARIAN. Allows a veterinarian licensed in another state, who would be qualified to take the veterinarian's examination in this state, to obtain a temporary permit, for no longer than 60 days, to conduct the practice of a licensed veterinarian during his absence. Directs the Department of Commerce and Economic Development to establish a fee for these temporary permits and any renewals that may be permitted by the board.

Sec. 08.95.290. REINSTATEMENT OF LAPSED LICENSE. Allows a veterinarian whose license has lapsed to have it reinstated without examination within three years of its lapsing.

ARTICLE 3. REGULATION OF PRACTICE OF VETERINARY MEDICINE.

Sec. 08.95.400. DISCIPLINE OF LICENSED VETERINARIANS. Authorizes the board to revoke or suspend the license of a licensed veterinarian or otherwise discipline a licensed veterinarian for specified reasons, including unprofessional conduct as defined in board regulations.

Sec. 08.95.410. REVOCATION AND SUSPENSION OF TEMPORARY PERMITS. Authorizes the board to revoke or suspend a temporary permit for a violation of the Act or a regulation adopted under it, whether committed by the permit holder or the licensed veterinarian with whom he is associated.

Sec. 08.95.420. ARTIFICIAL INSEMINATION OF ANIMALS. Directs the board to adopt regulations providing for issuance of permits to perform artificial insemination of animals. Authorizes the board to revoke or suspend such a permit for a violation of the Act or a regulation adopted under it.

Sec. 08.95.430. REGISTRATION OF VETERINARY TECHNICIANS. Directs the board to adopt regulations providing for the registration of "veterinary technicians" (as defined). Directs that these regulations require, for registration, the completion of college programs approved by the board, but permits the board to register veterinary technicians before July 1, 1981 who have been graduated from high school and completed two years of satisfactory work experience in lieu of college programs. Sets a fee of $25 for registration and biennial renewal. Authorizes the board to revoke or suspend a certificate of registration for a violation of the Act or a regulation adopted under it. Emphasizes that a veterinary technician must be under the general supervision of a licensed veterinarian. Provides that this section does not require a veterinary technician to become registered, but authorizes the board to impose such a requirement by regulation.

Sec. 08.95.440. STANDARDS OF PRACTICE. Authorizes the board to establish standards of practice, including continuing education requirements, for (1) licensed veterinarians and holders of temporary permits; (2) holders of permits to perform artificial insemination of animals; (3) persons giving advice on livestock management or engaging in livestock management; and (4) persons acting under the general supervision of licensed veterinarians. Authorizes the board to

(1) classify persons acting under the general supervision of licensed veterinarians; (2) limit or qualify the duties which may be performed by members of a class; (3) permit or require members of a class to be registered or licensed; (4) establish qualifications for registration or licensing of members of a class; (5) provide for renewal, revocation, and suspension of certificates or licenses of members of a class; and (6) set fees for issuing and renewing certificates or licenses of members of a class.

Sec. 08.95.460. RESPONSIBILITY OF LICENSED VETERINARIAN. Requires employees of a licensed veterinarian to be under his general supervision. Makes the licensed veterinarian responsible for the performance of any person required to be under his direction or general supervision.

ARTICLE 4. ENFORCEMENT.

Sec. 08.95.600. UNLAWFUL PRACTICE OF VETERINARY MEDICINE. Makes the unlawful practice of veterinary medicine a misdemeanor punishable by a fine of not less than $50 or more than $500 or imprisonment for not more than 90 days. Makes each day of unlawful practice a separate offense.

Sec. 08.95.610. NO RIGHT TO COMPENSATION FOR SERVICES UNLAWFULLY RENDERED. Provides that a person is not entitled to compensation for services constituting the practice of veterinary medicine that are unlawfully rendered.

Sec. 08.95.620. INJUNCTION. Authorizes the board to seek an injunction to restrain a person from practicing veterinary medicine unlawfully.

Sec. 08.95.630. REMEDIES CUMULATIVE. Declares that remedies for enforcing the Act are cumulative and independent.

Sec. 08.95.640. INVESTIGATIONS. Authorizes the board to conduct investigations to determine whether violations of the Act or regulations adopted under it have occurred.

ARTICLE 5. ABANDONMENT OF ANIMALS.

Sec. 08.95.800. Authorizes a licensed veterinarian or temporary permit holder to dispose of an animal, by sale or otherwise, left in his custody and abandoned. Provides that abandonment is considered to have occurred if the animal is unclaimed within 10 days after notice is sent to the owner or his agent.

ARTICLE 6. GENERAL PROVISIONS.

Sec. 08.95.900. DEFINITIONS. Defines principal terms used in the Act, including "animal," "general supervision," "practice of veterinary medicine," and "veterinary technician."

Sec. 08.95.910. SHORT TITLE. Designates AS 08.95 as the Veterinary Practices Act.

Section 2. Makes the Board of Veterinary Medicine subject to the centralized licensing law.

Section 3. Directs the Department of Commerce and Economic Development to provide investigative services to the Board of Veterinary Medicine to assist it in matters of professional discipline.

Section 4. Gives the Board of Veterinary Medicine a termination date of June 30, 1985 for purposes of the sunset law.

Section 5. Reenacts a portion of the sunset law as a new section in the Alaska Statutes. This reenactment has no substantive effect. It is necessitated by the inclusion of the Board of Veterinary Medicine in the sunset law.

Section 6. Provides for a lien on an animal for veterinary services.

Section 7. Makes the Board of Veterinary Medicine subject to the administrative adjudication provisions of the Administrative Procedure Act.

Section 8. Repeals the current laws relating to the practice of veterinary medicine and a portion of the sunset law. The repeal of a portion of the sunset law is of no effect, other than to eliminate a reference to the Board of Veterinary Examiners, because its reenactment as a new section is provided for in Sec. 5.

Section 9. Provides for the validity of a temporary license to practice veterinary medicine issued under law that is being repealed.

Section 10. Provides for the validity of a license to practice veterinary medicine issued under law that is being repealed.

Section 11. Authorizes the reinstatement of a lapsed license to practice veterinary medicine, within five years of its lapsing, which was issued under law that is being repealed.

Section 12. Directs that the members of the Board of Veterinary Examiners automatically become veterinarian members of the Board of Veterinary Medicine and serve until their terms on the former board would have expired.

Section 13. Directs that the title "Board of Veterinary Examiners" in the laws of the state be read as "Board of Veterinary Medicine." Provides for continuation of proceedings begun, orders issued, and regulations adopted under law that is being repealed. Directs that property of the Board of Veterinary Examiners be transferred to the Board of Veterinary Medicine.

Section 14. Makes this Act effective July 1, 1979.

BILL ANALYSIS

ASSIGNMENT DATE_____

UNASSIGNED_____

DEPARTMENT	SPONSOR (PRINCIPAL)	BILL NO.
Commerce & Economic Development	Miles, Martin, Barnes, Buchholdt, Cotten, Phillips & Hayes	HB 86

DEPARTMENT POSITION

Opposed as noted below.

DIVISION DIRECTOR	DATE	COMMISSIONER	DATE
Occupational Licensing	February 2, 1979		

GOVERNOR'S OFFICE USE

☐ POSITION NOTED ☐ POSITION APPROVED ☐ POSITION DISAPPROVED

BY: DATE:

SUMMARY

(1) RELATED BILLS (SIMILAR OR CONFLICTING)
(2) OTHER AGENCIES AFFECTED BY BILL

(2) a. ORGANIZATIONAL SUPPORT FOR BILL	(2) b. ORGANIZATIONAL OPPOSITION TO BILL
Alaska Veterinary Society	Unknown

(3) PROGRAM EFFECTS OF BILL

Some major changes to existing practice act (AS 08.98) and increased costs in implementation.

(4) FISCAL IMPACT: ☐ NONE ☒ FISCAL ANALYSIS ATTACHED

(5) AMENDMENTS PROPOSED:

(6) COMMENTS:

The Division of Occupational Licensing opposes Secs. 1 through 14 of HB 86, "An Act relating to the practice of veterinary medicine; and providing for an effective date." Provisions in the Act for additional members, annual National meeting attendance, specialty permits (Sec. 420), and registration of technicians would entail substantial additional costs for regulation and administrative overhead. Many other aspects of the proposed Act are objectionable from the standpoint of standard statutory authority. These include, but are not limited to, (1) a requirement that board members be appointed only from a list submitted by the State association, (2) limits on voting power of public members,

(See reverse)

(3) a requirement that those applying for temporary permits may work only under supervision of a licensee, (4) that the board itself may conduct investigations, and (5) inappropriate revisions to AS 08.03 (Termination, Continuation and Reestablishment of Regulatory Boards).

We believe that the present practice act is workable but needs amendments. Appropriate recommendations have been made as a result of the Sunset review process that should be considered in increasing board efficiency. We do not believe, however, that the proposed new act would accomplish this nor would it be in the best overall interests of the public.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB 86

Title An act relating to the practice of veterinary medicine; and providin

Requested by for an effective date Date 2/15/79

Miles, Martin, Barnes, Buchholdt, Cotten, Phillips and Hayes

II. FISCAL DETAIL

Agency Affected Commerce and Economic Development

Program Category Affected Public Protection

Budget Request Unit(s) Affected Regulation and Licensing of Professions

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES	-0-	-0-	-0-	-0-	-0-	-0-
200 TRAVEL	-0-	1.8	1.9	2.0	2.1	2.2
300 CONTRACTUAL	-0-	3.0	3.1	3.4	3.6	3.8
400 COMMODITIES	-0-	-0-	-0-	-0-	-0-	-0-
500 EQUIPMENT	-0-	-0-	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES	-0-	-0-	-0-	-0-	-0-	-0-
700 GRANTS, CLAIMS, ETC.	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL	-0-	4.8	5.0	5.4	5.7	6.0

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	4.8	5.0	5.4	5.7	6.0
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

FY 80 travel includes funding for two additional board members transportation and per diem to attend presently budgeted board meetings of two a year. There will be one person making one out-of state trip per year to national organization. Contractual expense includes costs for a hearing per year. This includes costs for a hearing office and court reporters preparation, recording, and reporting of the hearings before and after organization. Inflation is computer @ 6% per year. A detailed analysis of expenditures is attached.

IV. DATE 2/15/79 PREPARED BY Don Bostak

AGENCY Occupational Licensing

PHONE 465-2534

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

Travel

1 trip	Out-of-State Trans.	550
6 days	Out-of-State Per Diem	300
		850

Boards, Commissions and Legislators

2 trips for 2 additional members	In State Trans.	478
8 days	In State Per Diem	440
		918

Total Travel FY 80 1,768

Contractual

Cost for 8 hour hearing. This includes the cost for a hearing officer and court reporter's before and after preparation, recording, and reporting of the hearings activities. 3,000

Total Contractual FY 80 3,000

February 10,1979

Dear Sally,

A pleasure to hear from you! Thanks for sending along the Veterinary Prctice Act. I have been wondering where it stood these days. I reviewed it and discussed it at length with two Veterinarians, and have one suggestion and a question. The Vets agreed with my suggestion, but declined to write and represent themselves...sigh.

The suggestion: Page 3, Art. 2, Sec. 08.95.200 ...(15) now reads:

> "No person may practice veterinary medicine in this state who is not a licensed veterinarian except...(15) a person selling or applying a pesticide or herbicide."

I thought seriously of dropping out of school to start selling pesticides and doing sprays on the side! I think the intent is better reflected in this wording from the original draft of the act:

> "No person may practice veterinary medicine in this state who is not a licensed veterinarian. THIS ACT SHALL NOT BE CONTRUED TO PROHIBIT: ... (15) a person selling..."

My question concerns the "one public member" of the board (page 1,Art. 1, Sec.08.95.010), and also page 2, Sec.08.95.030. The bill states that the governor shall appoint each veterinarian member, etc. It does not, at this time, say who appoints nor who nominates the public member. I assume the governor appoints, but should it be specified? Hopefully the appointee would have some relevant experience and interest in the profession. I wouldn't object to the position myself!

Take care,

Tom

Tom & Joan Welsh
P.O. Box 81067
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99708