SB

735

D.A.B.F.P.)

Introduced 1-26-79
Logged 1-26-79
Referrals Judiciary
Comm. Meeting
" Action

NOTIFY: · DR BOX 6-2501
· Dr. T.F. Harbour
1345 W. 9th
Anch. Ak 99501
272-2557
· Sen. Sumner 3791

Notify Sen. Sumner's office when scheduled for comm. meeting
" Dr. Tom Harbour
1345 West 9 St
Anch 99501
Carolyn Cannava - 262-4340 (Sold tax)

Vadd Nowak
SR Box 70746-C
Fairbanks Alaska
99701

FAIRBANKS, AK
MAR 12
1-PM
1980
99701

Honorable Clem Hackney
Alaska State Senate
Pouch V
Juneau, Ak
99811

Dear Mr. Hackney

I would like you to support Senate Bill 75. I believe this bill promote better "eye" care by granting optometrist the use of diagnostic eye drops.

Thank You.

Robert Bowen

File

VILLAGE DRUG REFERENCE

Prepared by

Joseph C. Whitaker, R. Ph.

Community Health Aide Program
Alaska Area Native Health Service
Box 7-741
Anchorage, Alaska 99510

June, 1977

VILLAGE DRUG REFERENCE

TABLE OF CONTENTS

OFFICIAL AND TRADE NAME

INDEX

Script Type = (Acetaminophen) = Official Name
Regular type = (Tylenol) = Brand Name, Synonyms, Abbreviations

Rev. 6/77

I

K

L

M

N

O

P

R

S

T

V

WXYZ

ISOPROPYL ALCOHOL RUBBING COMPOUND N.F. — ISOPROPANOL 70%

DESCRIPTION AND USES

* Isopropyl alcohol is used to clean the skin prior to giving an injection or obtaining a blood sample.

* Isopropyl alcohol is used to disinfect instruments and thermometers. Leave them in contact with the solution for at least 20 minutes.

* Isopropyl alcohol can be used as a soothing rub or to toughen the skin.

WARNINGS

* Isopropyl alcohol is not the same as drinking alcohol. It will make a person sick if it is taken by mouth. It may even be fatal.

* Isopropyl alcohol will sting if it comes in contact with cuts and abrasions. Avoid using it near injuries.

* Isopropyl alcohol will burn.

STORAGE DIRECTIONS

* Store it at room temperature with the other external liquids. It will not be damaged by accidental freezing.
* Leave the lid on tight to prevent evaporation.
* Isopropyl alcohol is a non-prescription drug.

AMPHYL DISINFECTANT SOLUTION:

* Amphyl is a cleaning and disinfecting solution for instruments and equipment. It is not used on the skin.

* Store this chemical at room temperature with other external liquids. It will not be ruined by accidental freezing.

POVIDONE IODINE SOLUTION: BETADINE

DESCRIPTION AND USES

* Betadine is used as an antiseptic on abrasions, cuts, burns and other injuries. It can also be used to disinfect instruments. It is as effective as iodine tincture, but it is less irritating.

WARNINGS

* Some patients are allergic to iodine. Do not use Betadine if the patient has an iodine allergy.

STORAGE DIRECTIONS

* Store Betadine at room temperature with the other external liquids.
* Betadine may be damaged by freezing.
* Betadine does not have an expiration date.
* Betadine is a non-prescription drug.

HYDROGEN PEROXIDE SOLUTION U.S.P. H_2O_2

DESCRIPTION AND USES

* Hydrogen peroxide solution releases oxygen when it comes in contact with skin or pus. The oxygen bubbles help clean out pus, dirt and other material from wounds or infected areas. The oxygen is also weakly antiseptic. If it is used to clean the ears, it should be sucked out or removed with a piece of twisted tissue.

* Hydrogen peroxide is occasionally used as a mouth wash or gargle. It should be mixed with an equal amount of water before being used in this manner.

STORAGE DIRECTION

* Store hydrogen peroxide at room temperature with the other external liquids.
* Do not use it if it has been frozen. Freezing may cause it to lose its oxygen bubbles.
* Protect the drug from excessive heat and direct sunlight.
* Hydrogen peroxide is a non-prescription drug.

AMPICILLIN:
250MG CAPSULES
250MG/5ML OR 125MG/5ML SUSPENSION

PRINICIPEN^R POLYCILLIN^R
OMNIPEN^R PENBRITEN^R
AMCILL^R TOTOCILLIN^R

DESCRIPTION AND USES

* Ampicillin is a form of penicillin. It kills some types of bacteria that are not killed by other types of penicillin. It is often used for urinary tract infections and for ear infections that do not respond to penicillin VK.

Usual Dose	Urinary Tract Infection	Gonorrhea
Children under 3 take 125mg 4 times daily for 7-10 days. Adults and older children take 250mg 4 times daily for 7-10 days.	Adults take 500mg (2 capsules) 4 times daily for 7-14 days.	Adults take 3500mg (14 capsules) with 2 tablets of probenecid all at one time as a single dose.

WARNINGS

* Ask the patient if he is allergic to penicillin before you give him ampicillin. Penicillin allergies are common and may be serious. If the patient is allergic to ampicillin he may have one of the following types of reactions if he takes the drug:
  - * Hives, skin rash, itching.
  - * Edema, swelling of the eyelids.
  - * Fever, generalized aching.
  - * Shock, difficulty breathing.
* Patients often have minor gastrointestinal problems when they take the drug. Tell them to continue taking the drug if they can tolerate the symptoms. If the symptoms are bad, contact the physician or switch to another antibiotic. Common complaints are:
  - * Nausea.
  - * Vomiting.
  - * Diarrhea.
  - * Stomach gas.
  - * Stomach distress.
  - * Inflammation of the tongue.
  - * Black hairy tongue.
  - * Mild rash in children.
* Do not use ampicillin if the patient is allergic to penicillin. Use erythromycin.

STORAGE AND DISPENSING DIRECTIONS

* Store this drug at room temperature with the oral tablets. It will not be harmed by accidental freezing.
* Check the expiration date before giving it to the patient.
* This drug is a prescription drug.
* Tell the patient to take the medicine a half hour before meals and at bedtime until it is all gone.
* Special instructions for the pediatric liquid:
  - * Mix the powder with the correct amount of clean water just before dispensing.
  - * Tell the mother to keep the medicine cool but to protect it from freezing.
  - * Tell the mother to shake it well before using.
  - * Tell her to throw it away after 2 weeks if there is any left.

BENZATHINE PENICILLIN INJECTION 1,200,000 UNITS

BICILLIN LA

DESCRIPTION AND USES

* Bicillin LA is a type of penicillin. Its main advantage is its length of action. After it is injected into the muscle, it dissolves very slowly. The effect lasts for several weeks, but it is fairly weak. It will only work against bacteria, such as streptococci, which are very sensitive to penicillin.

* Its major use is to treat sore throats caused by streptococci. The medicine is given <u>once</u> as a single dose.

    * Children under 4 receive 300,000 units IM.
    * Children between 4 and 12 receive 600,000 units IM.
    * Adults and older children receive 1,200,000 units IM.

* It can be used to treat impetigo using the above dosage.

* It can be used to prevent streptococcal infection in patients with a history of rheumatic fever. The patient is given 1,200,000 units every 30 days.

* Bicillin LA is also used to treat syphilis.

WARNINGS

* Ask the patient if he is allergic to penicillin before you give him a Bicillin LA injection. Penicillin reactions are common and may be serious. If the patient is allergic to penicillin, he may have one of the following types of reactions. The reaction may occur 8 to 15 days <u>after</u> the injection was given.

    * Skin rash, hives or itching.
    * Edema, swelling or eyelids.
    * Fever, generalized aching.
    * Shock, difficulty breathing (rarely).

STORAGE AND ADMINISTRATION

* Store Bicillin LA in the refrigerator. Do not use it if it has been frozen, even if it looks good.
* Check the expiration date before you use it.
* Bicillin LA is a prescription drug.
* Warm the tubex in your hands and shake it well before injecting. Inject it at a slow steady rate so that you do not block the needle. Use good I.M. technique.

POTASSIUM PHENOXYMETHYL PENICILLIN
250MG TABLETS
250MG/5ML SUSPENSION

PENICILLIN VK
LEDERCILLIN^R
PENTIDS^R

V-CILLIN K^R
PENVEE^R
COMP CILLIN^R

DESCRIPTION AND USES

* Penicillin VK is a form of penicillin that works well when taken by mouth. It is not quite as effective as procaine penicillin however. The medicine leaves the body rapidly in the urine, so the dose must be repeated every 6 to 8 hours.

* Penicillin VK can be used for many infections including strep throat, otitis media, and skin infections. Penicillin VK is effective against "strep throat", but Bicillin LA injection is preferred. Patients often forget to take Penicillin VK.

* Give the patient the following dose 4 times daily for 10 days.

    * Children under 3 125mg (1/2 teaspoonful).
    * Patients 3 and older: 250mg (1 tablet).

    * Larger doses may be required for some infections.

WARNINGS

* Ask the patient if he is allergic to penicillin before you give him any. Penicillin allergies are common and may be serious. If the patient is allergic to penicillin he may have one of the following types of reactions if he takes the drug.

    * Hives, skin rashes, itching.
    * Edema, swelling of the eyelids.
    * Fever generalized aching.
    * Shock, difficulty breathing.

* Do not use penicillin VK if:

    * The patient is allergic to penicillin. Use erythromycin.
    * The patient is unreliable or likely to forget to use the drug. Use procaine penicillin or Bicillin LA.
    * The patient has a serious infection like pneumonia. Use procaine penicillin.

STORAGE AND DISPENSING DIRECTIONS

* Store this drug at room temperature with the other oral tablets. It will not be harmed by accidental freezing.
* Check the expiration date before giving it to the patient.
* This drug is a prescription drug.
* Tell the patient to take the drug a half hour before meals and at bedtime until it is all gone.
* Special instructions for the pediatric liquid:

    * Mix the powder with the correct amount of clean water just before dispensing.
    * Tell the mother to keep the medicine cool but to protect it from freezing.
    * Tell the mother to shake it well before using.
    * Tell her to throw it away after 2 weeks if there is any left.

PROCAINE PENICILLIN G INJECTION
300,000 UNITS, 600,000 UNITS
2.4 MILLION UNITS

WYCILLIN®

DESCRIPTION AND USES

* Procaine penicillin G injection is the most effective penicillin in the village. It is used for many infections such as:

  * Pneumonia.
  * Strep Throat.
  * Otitis media.
  * Skin infections.
  * Gonorrhea.

* It is useful for serious infections that require high doses. It is also useful if the patient is unable to take medicine by mouth or likely to forget to take the medicine.

* For most infections give the patient the following dose once or twice a day for 7 to 10 days:

Children under 2	Children between 2 and 12	Older patients
300,000 units IM	300,000-600,000 units IM	600,000-1,200,000 units IM

* For gonorrhea, follow these directions:

  * Give the patient 2 tablets of Probenecid (Benemid) by mouth. The Probenecid makes the penicillin act longer.

  * Wait a half hour, then give the patient 4.8 million units of Procaine penicillin IM. Use 2.4 million units in each buttocks.

WARNINGS

* Ask the patient if he is allergic to penicillin before you give him any. Penicillin allergies are common and may be serious. Do not give the patient penicillin if he thinks he may be allergic to it. Check with your physician if you are in doubt.
* If the patient is allergic to penicillin, he may have one of the following types of reactions when he receives the drug.

  * Hives, skin rashes, itching.
  * Edema, swelling of the eyelids.
  * Fever, generalized aching.
  * Shock, difficulty breathing.

STORAGE DIRECTIONS

* Store this drug in the refrigerator.
* Freezing will ruin this drug. Do not use it after it has been frozen, even if it looks good.
* Check the expiration date before using it.
* This drug is a prescription drug.
* The 2.4 million unit injection does not fit into the metal tubex syringe. Remove the ribbed plastic cylinder from the needle hub. Screw it into the blue stopper and use it as the plunger.

ERYTHROMYCIN
250MG TABLETS
200MG CHEWABLE TABLETS
125MG/5ML SUSPENSION

ILOSONE®
ERYTHROCIN®
ILOTYCN®

DESCRIPTION AND USES

* Erythromycin is an antibiotic. It kills many of the same bacteria as penicillin. If the patient is allergic to penicillin, erythromycin is often used in its place.

* The dosage is much the same as for penicillin VK. The following dosage is recommended for streptococcal throat infections, ear infections, and impetigo. infections.

  * Adults and older children: 250mg (1 tablet) 4 times daily for 10 days.
  * Children betwen 1 and 6: 125mg (1 teaspoonful) 4 times daily for 10 days.
  * Children under 1 year of age: 62.5mg (1/2 teaspoonful) 4 times daily.

WARNINGS

* Allergic reactions such as skin rashes occur in a very few patients.
* Jaundicemay appear following the use of some types of erythromycin. If it does, stop the drug and contact your referral physician.
* A few patients may have nausea, vomiting, diarrhea or similar gastrointestinal complaints. Tell the patient to continue to take the drug if he can tolerate the effects. Contact your referral physician if the effects are bad.
* Do not use erythromycin if:

  * Penicillin is effective and the person does not have a penicillin allergy.
  * The patient is allergic to erythromycin.
  * The patient has jaundice or liver disease.

STORAGE AND DISPENSING DIRECTIONS

* Store erythromycin at room temperature with the other oral tablets and liquids. It will not be harmed by accidental freezing.
* Check the expiration date before givin the drug to the patient.
* This drug is a prescription drug.
* Tell the patient to take the medicine a half hour before meals and at bedtime until it is all gone.
* Special instructions for the pediatric liquid:

  * Mix the powder with the correct amount of clean water just be dispensing.
  * Tell the mother that she can keep the erythromycin at room temperature or in the refrigerator. Do not let it freeze.
  * Shake the medicine well before giving a dose.
  * Throw away any medicine that is left after it has been mixed for 2 weeks.

* The chewable tablets are for children who are too small to swallow adult type tablets. They should be chewed up well.

NYSTATIN ORAL SUSPENSION 100,000 UNITS/CC

MYCOSTATIN[R]
NILSTAT[R]

DESCRIPTION AND USES

* Nystatin is an antibiotic that is effective against the fungus monilia (candida albicans). Since it is not absorbed from the g.i. tract, it will treat infections in the mouth and g.i. tract only. It has few side effects for the same reason.

* It is used to treat thrush in infants.

    * Place 2cc in the mouth 4 times daily for 10 days. The medicine should be held in the mouth for a few minutes before swallowing.

WARNINGS

* There are few side effects since the drug is not absorbed into the body. A few patients may have nausea, vomiting, g.i. distress or diarrhea.

* Do not give nystatin to a patient who is allergic to it. Allergies are rare.

STORAGE AND DISPENSING DIRECTIONS

* Store this drug at room temperature with the other oral tablets or liquids. Do not use the drug if it has been frozen, even if the bottle is not broken. Freezing may ruin it.
* Check the expiration date before giving the drug to the patient.
* Nystatin is a prescription drug.
* Shake the bottle before filling the dropper.
* Tell the mother to give the medicine to the child every 6 hours until all is gone (about 6 days).
* Explain to her that the drug acts in the mouth.
* Place 1cc in each side of the mouth (2cc total). Have the child hold the medicine in his mouth before swallowing. It helps to rub the medicine directly on the sores in the mouth.

TETRACYCLINE U.S.P.
250MG CAPSULES OR TABLETS

ACHROMYCIN V® TETRACYN®
PANMYCIN® TETRACHEL®

DESCRIPTION AND USES

* Tetracycline will stop the growth of many types of bacteria that are not affected by penicillin. Unlike penicillin, tetracycline will not kill the bacteria, only slow their growth. Tetracycline is useful if the patient is allergic to penicillin or if penicillin is not effective.

* Tetracycline is used to treat urinary tract infections, bronchitis, and other infections in adults. The usual dose is 250-500mg (1-2 capsules) 4 times daily for 10-14 days.

* It is also used to treat gonorrhea if the patient is allergic to penicillin. The dose is 1500mg (6 capsules) as a single dose, followed by 500mg (2 capsules) 4 times daily for 4 days.

WARNINGS

* Tetracycline may cause many minor irritating side effects such as:
  * Loss of appetite.
  * Stomach discomfort.
  * Nausea and vomiting.
  * Bulky loose stools.
  * Diarrhea.
  * Inflammations of the mouth, skin, rectum, etc.

* It may occasionally cause more serious rections such as:
  * Skin rashes, hives, itching, shock and other allergic reactions.
  * Severe yeast or fungi infections of the gastrointestinal tract.
  * Rashes on skin areas exposed to sunlight (photosensitivity).

* Do not give tetracycline to:
  * Patients who are allergic to it.
  * Pregnant women or children under the age of 12. Tetracycline may cause discoloration of the teeth or slow bone growth in the fetus or child.
  * Patients who have kidney or liver problems.

STORAGE AND DISPENSING DIRECTIONS

* Store this drug at room temperature with the other oral tablets. It will not be damaged by accidental freezing.
* Check the expiration date before giving the drug to the patient.
* This is a prescription drug.
* Tell the patient to take tetracycline a half hour before meals and at bed time. If it upsets his stomach, tell him to take it with a light snack or with meals.
* Calcium, aluminum, magnesium and iron salts interfere with the absorption of tetracycline. Tell the patient not to take antacids or milk within one hour of the time he takes the tetracycline. Tell him not to take iron (ferrous sulfate, vitamins with iron, geritol etc) for the entire 10 days that he is taking tetracycline.

SULFISOXAZOLE (GANTRISIN)R

TRISULFAPYRIMIDINES (TRIPLE SULFA)
500MG TABLETS
500MG/5ML SUSPENSION

DESCRIPTION AND USES

* Sulfisoxazole and trisulfaprimidines are not identical. Their actions are so similar that they will be discussed together. Both are "sulfa" drugs that are effective against many types of bacteria. They were once used for many infections, but are now used mainly for urinary tract infections. Occasionally they are used for ear infections in combination with penicillin.
* The medicine is taken 4 times daily for 10-14 days.
  * Children between 2 and 6 take 1 teaspoonful.
  * Adults and older children take 2 tablets.
    * The physician may often ask the patient to take a large dose (8 tablets) for the first dose only.
  * The patient should take a large glass of water with each dose.

WARNINGS

* Sulfa drugs may cause a number of serious allergic reactions including:

  * Hives, rashes, itching.
  * Inflammation of the mouth, eyelids, nose, urethra, penis.
  * High fever, severe headache.
  * Fever and joint pain.
  * Shock or difficulty breathing.

* Sore throat, fever, pallor, jaundice, weakness, and bruising may be signs of a serious blood disorder. Stop the drug and contact your referral physician.
* Some patients may develop a skin rash on areas exposed to the sun (photosensitivity). Nausea or vomiting occur frequently, they do not indicate a serious problem.
* Do not give sulfa drugs to:
  * Patients who are allergic to sulfa or chemically similar drugs (hydrochlorothiazide, acetazolamide, tolbutamide).
  * Patients who are not producing urine adequately. The drug will come out of the urine and form crystals in the kidneys if the urine is too concentrated.
  * Infants under 2 months of age, women who are breast feeding infants, or women near term (ready to deliver). Infants develop jaundice if they receive sulfa.

STORAGE AND DISPENSING DIRECTIONS

* Store the tablets and liquid at room temperature with the other oral tablets and liquids. The tablets will not be harmed by accidental freezing but the suspension will be ruined. Do not use it even if the bottle is not broken.
* The suspension should be shaken well before using.
* This is a prescription drug.
* Tell the patient to take the medicine every 6 hours (before meals and at bedtime) with a large glass of water. The patient should drink lots of fluids so he will make lots of dilute urine.

HYDROCORTISONE - NEOMYCIN - POLYMIXIN B EARDROPS

CORTISPORIN[R]

DESCRIPTION AND USES

* Cortisporin is a combination of two antibiotics and a drug to reduce inflammation. Polymixin B and Neomycin are effective against many bacteria that cause ear infections. Hydrocortisone helps reduce the inflammation and itching that may result from these infections.

* The infected ear should be cleaned and dried first. Any pus or drainage should be removed.

    * The patient should tilt his head to one side.
    * Place 3 or 4 drops into the ear. Repeat the process 3 or 4 times daily. Use the drops 5 to 7 days or as needed.

WARNINGS

* The patient may become allergic or sensitive to the drug.

* Do not use the drug if:

    * The patient is allergic to neomycin, polymixin B or hydrocortisone.
    * The patient's ear appears to be irritated by the drug.
    * The patient has a viral infection such as chicken pox, small pox vaccination or herpes simplex.

STORAGE AND DISPENSING DIRECTIONS

* Store this drug at room temperature with other ear drops. Cortisporin will probably be ruined if it is accidentally frozen. Do not use it if it has been frozen.
* Check the expiration date before giving the drug to the patient. Cortisporin has a very short expiration date.
* Cortisporin is a prescription drug.
* Special instructions:

    * Tell the patient to warm the bottle in his hands before using the drops.
    * Shake the bottle well before using it.
    * Demonstrate the correct way to use the ear drops to the patient.
    * Tell the patient to avoid touching the dropper to the ear or with his fingers.

POLYMIXIN B, BACITRACIN, NEOMYCIN OPHTHALMIC OINTMENT — NEOSPORIN®
POLYMIXIN B, GRAMICIDIN, NEOMYCIN OPHTHALMIC SOLUTION — NEOSPORIN®

DESCRIPTION AND USES

* Neosporin is a brand name used by the Burroughs Wellcome Company for several different combinations of antibiotics. These two products meet high standards of purity and sterility and are intended to treat minor bacterial infections of the eye.

* Do not confuse the small 3.5Gm tube of ophthalmic ointment with the large 15Gm tube of polymixin B, bacitracin and neomycin topical ointment. The large tube is not sterile and should be used on the skin only.

* Neosporin is used to treat a variety of minor bacterial infections of the eye. Place a small amount of the ointment or 1 or 2 drops inside the lower eyelid every 3 or 4 hours. Neosporin may also be used to prevent infection if an eye has been injured.

WARNINGS

* Patients may become allergic to one of the 3 antibiotics, usually neomycin. Stop using the drug if the patient's eye becomes red or irritated.

* Do not use neosporin if the patient is allergic to neomycin, polymixin B, or bacitracin.

* Do not use the ointment form if the patient has a deep laceration of the cornea or the sclera. The ointment might enter the inside of the eyeball and be difficult to remove.

STORAGE AND DISPENSING DIRECTIONS

* Store Neosporin at room temperature with the other eye drops.
* Neosporin drops may be damaged by freezing. Check carefully to see if the dropper or the bottle is broken. If it is not broken and the drops look normal, it is probably safe to use them.
* Check the expiration date before giving the medicine to the patient.
* This is a prescription drug.

* Special instructions.:
  * Teach the patient the correct way to use eye ointments or drops.
  * Tell the patient to place the ointment or drops in the space between the lower eyelid and the eyeball.
  * Tell the patient to avoid touching the tip of the tube or the dropper with the fingers or to the eye.

Rev 6/77

PREDNISOLONE - SULFACETAMIDE OPHTHALMIC OINTMENT AND SOLUTION METIMYD®

DESCRIPTION AND USES

* Metimyd contains two drugs, prednisolone and sulfacetamide. Prednisolone is a drug that reduces inflammation and redness from infection, irritation or allergy. Sulfacetamide is a sulfonamide ("Sulfa") that stops the growth of bacteria.

* Metimyd is effective in treating a variety of problems including:

  * Allergies of the eyelids.
  * Conjunctivits due to hay fever.
  * Chemical irritations.
  * Heat burns.
  * Iritis.
  * PKC.

* The ointment or drops are applied to the inside of the lower eyelid every 4 to 8 hours. The ointment lasts longer so it is preferred for bedtime use.

WARNINGS

* Inflammation is a normal defense used by the body to prevent the spread of infection. If prednisone stops the inflammation, and sulfacetamide does not kill the germ, the infection may spread.

* Prednisolone may increase the pressure within the eyeball.

* Some people are allergic to sulfa drugs. Stop the drug if the eye becomes more red or swollen.

* Do not use metimyd if:

  * The patient is allergic to "sulfa" drugs like sulfisoxozole (Gantrisin) or trisulfapyrimidines (triple sulfa).
  * The patient has an eye infection due to a virus such as small pox vaccination, chicken pox or herpes simplex. Metimyd will cause the infection to spread.
  * The patient has an eye infection caused by fungi.
  * The patient has an eye infection caused by tuberculosis.
  * The patient has an eye infection that is producing a lot of pus.

STORAGE AND DISPENSING DIRECTIONS.

* Store metimyd at room temperature with the other eye drops. The eye drops will be ruined by accidental freezing. Do not use them even if they look normal. The ointment will probably not be harmed by accidental freezing.
* Check the expiration date before using.
* This is a prescription drug.
* Special instructions:

  * Teach the patient the correct way to use eye ointments or drops.
  * Tell the patient to place the ointment or drops in the space between the lower eyelid and the eyeball.
  * Tell the patient to avoid touching the tip of the tube or the dropper with the fingers or to the eye.
  * Shake the drops well before using them.

SULFACETAMIDE SODIUM OPHTHALMIC OINTMENT/DROPS — SODIUM SULAMYD[R]

DESCRIPTION AND USES

* Sulfacetamide is an antibacterial drug of the sulfonamide or "sulfa" type. It is used in the treatment of minor bacterial infections of the eye and eyelid. It is the best drug to use for infants with eye infections.

* Place a small amount of the ointment or a few drops of the solution inside the lower eyelid 3 or 4 times a day. The ointment lasts longer so it is the preferred form at bedtime.

WARNINGS:

* Sulfacetamide, like other "sulfas", may cause allergic reactions. Stop using the drug if the patient's eye becomes red, swollen or irritated because of the drug.

* Do not use sulfacetamide if the patient is allergic to sulfacetamide, sulfisoxazole (Gantrisin[R]), Trisulfapyrimidines (Triple Sulfa) or other sulfa drugs.

* Do not use the ointment foam if the patient has a deep laceration of the cornea or the sclera. The ointment might enter the inside of the eye ball and be difficult to remove.

STORAGE AND DISPENSING DIRECTIONS

* Storage sulfacetamide at room temperature with the other eye drops and ointments. It will probably not be harmed by accidental freezing, unless the container is broken by the freezing.
* Check the expiration date before using the drug.
* This is a prescription drug.
* Special instructions:

  * Teach the patient the correct way to use eye ointments or drops.
  * Tell the patient to place the ointment or drops in the space between the lower eyelid and the eyeball.
  * Tell the patient to avoid touching the tip of the tube or the dropper with the fingers or the eye.

SILVER NITRATE 1% OPHTHALMIC SOLUTION IN WAX AMPULS

DESCRIPTION AND USES

* Silver nitrate is an antibacterial. The drops are used to prevent ophthalmia neonatorum, an eye infection of newborn infants that causes blindness. Ophthalmia neonatorum is caused by the same bacteria that causes gonorrhea.

* The state law requires that all infants be treated with silver nitrate eye drops immediately after birth.

    * Stick a pin into the tip of the wax ampul.
    * Squeeze the other end to force out a drop.
    * Place one drop in each eye. Do not touch the eye with the wax ampul.
    * It is best to leave the drop in the eye and let the tears wash it out. Do not rinse it out.
    * Throw away the opened wax ampul.

WARNINGS

* Silver nitrate is an irritating drug. Only the silver nitrate that comes in the wax ampuls should be used in the eye. The drug will cause the baby's eyes to be red and irritated.

* Do not use the drops if they appear to be dark or discolored.

STORAGE DIRECTIONS

* Store this drug at room temperature with the eye drops or your OB supplies. Freezing will probably not ruin the drug, but high temperatures may melt the wax ampul.
* Silver nitrate is light sensitive. Store it in a dark place.
* Silver nitrate is a prescription drug.
* Special instructions:

    * Do not use the silver nitrate if it is discolored, or black.
    * The wax will make the liquid inside seem slightly colored. If there is any questions, return the drug to the pharmacy for a fresh supply.
    * At the time of use, examine the drop as it comes from the wax ampul. The solution should be clear and colorless.

BACITRACIN OINTMENT

BACITRACIN, NEOMYCIN AND POLYMIXIN B TOPICAL OINTMENT

"3 ANTIBIOTIC OINTMENT"
"TRIPLE ANTIBIOTIC",
NEOSPORIN^{R}, MYCITRACIN^{R}

DESCRIPTION AND USES

* Bacitracin is an antibiotic that inhibits the growth of streptococci, staphylococci and other common bacteria. It is often used in ointments by itself or combined with neomycin and polymixin B. Neomycin and Polymixin B are antibiotics that are effective against additional bacteria.

* Bacitracin and 3 antibiotic ointment are used on minor infections such as impetigo or infected rashes. It is usually applied to the area 3 or 4 times daily after washing. The ointment will be of little value in serious infections.

WARNINGS

* Bacitracin has few harmful effects but neomycin may cause local allergic reactions such as inflammation or redness.

* Do not use these ointments on:

    * Patients who are allergic to them.
    * Large wounds that will require suturing.
    * Eye infections (use the ophthalmic ointment form).

STORAGE AND DISPENSING DIRECTIONS

* Store these drugs at room temperature with the external liquids or ointments. The ointments will probably not be damaged by accidental freezing.
* Check the expiration date before dispensing.
* This drug does not require a prescription.
* If the ointment is being used for impetigo, tell the patient to wash the sores to remove the crusts before applying additional ointment.

MAFENIDE CREAM SULFAMYLON[R]

DESCRIPTION AND USES

* Mafenide (sulfamylon) retards the growth of bacteria on the skin. Its main use is to prevent severe bacterial infection following 2nd or 3rd degree burns. It has no soothing or pain relieving effects.

* After the patient has been treated for shock and pain, clean the burn area and remove dead tissue. Apply sulfamylon cream to the burn using a sterile gloved hand. Apply the cream to a thickness of 1/16".

* Remove the cream daily by bathing. Replace the cream when needed to keep the burned area covered with cream at all times.

WARNINGS

* Sulfamylon often causes pain or a burning sensation when it is applied. This is normal but unpleasant.

* Some patients may develop an allergic reaction (rash, hives, itching, swelling, redness, etc.) after they have been using the drug for 10-14 days. Do not confuse the allergy symptoms with the normal side effects.

* The medicine upsets the normal acid-base balance of the body. Most patients adjust to this easily. Patients with lung disease may develop acidosis.

* Do not use sulfamylon on minor burns. It is of no value and may cause discomfort.

STORAGE AND DISPENSING DIRECTIONS

* Store this drug at room temperature with the other ointments. It will probably be ruined by freezing. Do not use it if it has been frozen.
* This is a prescription drug.
* Do not give the drug to the patient as a general rule. Apply it yourself using the correct sterile technique. Apply it about 1/16" thick.

FURAZOLIDONE AND NIFUROXIME VAGINAL SUPPOSITORIES — TRICOFURANR

DESCRIPTION AND USES

* Furazolidone and Nifuroxime will kill the bacteria trichomonis and the yeast candida albicans. These two organisms are responsible for many vaginal infections. Tricofuran is not effective against gonorrhea.

* Tricofuran is used to treat trichomonas vaginitis or vaginal moniliases as follows:

    * One suppository is placed in the vagina (birth canal) in the morning and at bedtime for 1 week.
    * After one week, the medicine is used at bedtime only.
    * If the woman has her menstrual period, she should continue to use the medicine.
    * The treatment will need to last at least 2 weeks and perhaps an entire menstrual cycle.

WARNINGS

* The patient may become allergic to the drug. She should stop using it if irritation, burning, itching, or redness occur. Douching may help to remove the irritating drug.

* The medicine will leak out of the birth canal. This can be kept to a minimum by inserting the suppository properly.

STORAGE AND DISPENSING DIRECTIONS

* Store the suppositories at room temperature with the external liquids and ointments. They will not be damaged by accidental freezing.
* If the suppositories become soft, store them in the refrigerator or hold the suppository under cool water for 2 minutes.
* This is a prescription drug.
* Special instructions:

    * This medicine is a little inconvenient to use. Go over the directions carefully encourage the patient to follow them.
    * Review the directions that come with the package. Tell the patient to lie down for a full 10-15 minutes after inserting the suppository.
    * A man can catch the infection from the woman. He may have no symptoms, but he may reinfect the women.
    * The patient's husband should not have sex with her or he should wear a condom (rubber) to prevent him from becoming infected.

SURGICAL DETERGENT — PHISOHEX®

DESCRIPTION AND USES

* Phisohex is a detergent solution containing 3% hexachlorophene. After each use, a small amount of hexachlorophene is left on the skin. The hexachlorophere will slow the growth of common skin bacteria. It is effective only when used repeatedly. It has no advantage over other soaps for cleaning wounds or other occasional use.

* Phisohex is used by medical personnel to clean their hands. It is also used to clean the skin of a patient who has impetigo. Ordinary soap and water is probably as effective for the latter use.

* Phisohex is used much like ordinary soap. Wet the area to be washed. Add a small amount of phisohex. Rub to produce suds. Add more water to produce more suds. Rinse the area thoroughly, then dry it.

WARNINGS

* Hexachlorophene can be absorbed through the skin and mucous membrane (mouth, vagina, etc). It is absorbed more readily through the skin of babies or if the skin is burned or irritated. Phisohex should always be rinsed off well to prevent absorption.

* If it is absorbed, hexachlorophene can damage the brain or nervous system. The effects include irritability, stimulation, and possibly convulsions. The harmful effects can be fatal.

* Do not use phisohex:

    * If the patient is a small baby.
    * If the skin is red, inflamed, burned or irritated.
    * As a dressing or like a lotion.
    * On a mucous membrane or in the vagina.

STORAGE AND DISPENSING DIRECTIONS

* Store phisohex at room temperature with the external liquids. It may be ruined by freezing. If it becomes frozen, unthaw it and shake it well. If it looks normal, go ahead and use it.
* Phisohex is a prescription drug.
* Explain to the patient that it must be used like soap. Tell him to rinse it off well. Warn him that it is dangerous if swallowed and must be kept out of the reach of children.

WHITE PETROLATUM — PETROLEUM JELLY, VASELINE[R]

AQUAPHOR

VITAMIN A AND D OINTMENT

DESCRIPTION AND USES

* The above 3 products are somewhat similar and have similar uses. White petrolatum is a semi-solid product obtained from oil. It will not absorb water. Aquaphor contains white petrolatum plus other ingredients that help it absorb water. Vitamins A & D ointment contains petrolatum, ingredients that help it absorb water, and vitamins A & D. The two vitamins are supposed to help skin rashes like diaper rash heal more quickly.

* These products help treat or prevent diaper rash. They form a water proof barrier between the urine in the diaper and the baby's skin. The ointment is applied to the skin as often as needed to keep up the water proof covering.

* These ointments can also be applied to dry skin. They will prevent evaporation of water from the skin and keep it moist and soft.

* These ointments can also be used for other lubricating or protective uses.

WARNINGS

* These products do not contain antibiotics. If the diaper rash is badly infected, the patient may need antibiotics.

STORAGE AND DISPENSING DIRECTIONS

* Store these ointments at room temperature with other external ointments and liquids. They will not be damaged by accidental freezing.
* These drugs do not require a prescription. White petroleum and vitamin A & D may be available in the village store.

HYDROCORTISONE 1% OINTMENT — CORT-DOME® — CORTEF®

TRIAMCINALONE 0.1% CREAM — KENALOG® — ARISTOCORT®

DESCRIPTION AND USES

* Hydrocortisone reduces inflammation, itching, and other discomforts when applied to rashes caused by eczema, allergies, or irritants. The hydrocortisone treats the symptoms but does not remove the underlying cause. Triamcinolone is a similar medication with similar uses and warnings.

* A small amount of the ointment is applied to the rash and rubbed in well. It may need to be applied 2 to 4 times daily.

WARNINGS

* These drugs reduce inflammation and may allow any infection present to spread.

* A few patients may develop an allergy to the drug. Other patients may develop itching, burning, or acne-like skin eruptions. If the patient has problems with the drug, tell him to stop using it.

* Do not use hydrocortisone or triamcinalone on:

    * An infected rash.
    * A skin rash caused by TB, small pox vaccination, chicken pox, or a virus such as herpes simplex.
    * An eyelid or eye inflammation or rash.

STORAGE AND DISPENSING DIRECTIONS

* Store these drugs at room temperature with the external ointments and liquids. Accidental freezing may ruin them. Do not use them if they have been frozen.
* Check the expiration date before using.
* These drugs are prescription drugs.

ACETAMINOPHEN
325 MG TABLETS
60 MG/0.6CC DROPS

TYLENOL R
TEMPRA R
DATRIL R

* Acetaminophen reduces pain and fever much like aspirin. Unlike aspirin, acetaminophen does not reduce inflamation. Acetaminophen has fewer side effects than aspirin and is available in a liquid dosage form for children.

* Acetaminophen is used to treat mild to moderate pain from headacehs, toothaches, headcolds, menstural cramps, muscle aches, etc. The usual adult dose is 2 tablets (650mg) every 4 hours if needed for pain. Larger doses will not relieve severe pain. It can be used to reduce fever in the same dosage.

* Acetaminophen is the best drug to use to reduce fever in children. Give the child the following dose every 4 hours if needed:

    * Children under 6 months of age = 0.3cc
    * Children 6 months to 1 year = 0.6cc
    * Children 1 to 3 years old = 0.6cc to 1.2cc
    * Children 3 to 6 years old = 1.2cc to 2.4cc
    * Children from 6 to 12 years old = 1/2 to 1 adult 325mg tablet.

WARNINGS

* Acetaminophen has few harmful effects if taken correctly. A few patients may have a skin rash or other signs of allergy.

* Acetaminophen is considered to be a relatively safe drug, but an overdose of it can cause illness and even death. A single dose of 20 tablets or more in an adult may lead to serious injury to the liver. Children appear to be less likley to have liver injury than adults, but a full bottle or more of acetaminophen drops may lead to serious livery injury in a 20 lb. child. If a patient takes an overdose of this drug, cause vomiting and follow the other steps normally taken for a medication overdose and contact your referral physician for advice.

* Large doses of acetaminophen taken for several years may also be harmful.

* Do not use acetaminophen if:

    * The patient is allergic to acetaminophen or phenacetin (rare)
    * The patient has arthritis like pain. Use apsirin instead since it will reduce inflamation.

STORAGE AND DISPENSING DIRECTIONS

* Store acetaminophen at room temperature. Acetaminophen will not be damaged by accidental freezing unless the bottle breaks.
* Acetaminophen is a non-prescription drug.
* Show the mother how to measure the dose. Tell her that 1.2cc is 2 dropperfuls, 2.4cc is 4 droppersful, etc.

ASPIRIN
325MG (5 GR.) TABLETS "ADULT ASPIRIN"
75MG (1 1/4 GR.) TABLETS "BABY ASPIRIN

A.S.A.
ACETYLSALICYLIC ACID

DESCRIPTION AND USES

* Aspirin has 3 separate actions on the body. It is an:

  * Analgesic (reduces pain).
  * Antipyretic (reduces fever).
  * Anti-Inflammatory (reduces inflammation and swelling).

* The adult dosage is 2 tablets of the 325mg size every 4 hours if needed for pain or fever. Aspirin will relieve mild to moderate pain from headaches, toothaches, menstrual cramps, muscle aches etc. Larger doses will not give relief of severe pain. Larger doses (3 or 4 tablets every 4 hours) may help reduce inflammation in swollen joints due to rheumatic fever or arthritis.

* The pediatrician's prefer that you use acetaminophen drops for small children, rather than aspirin. If you must use aspirin for fever, follow these dosage recommendations:

  * Children under 3 months - Do not give aspirin.
  * Children 3 to 6 months of age - 1/4 of a 75mg baby aspirin.
  * Children 6 to 12 months - 1/2 of a 75mg baby aspirin.
  * Children 1 year old - 1 baby aspirin.
  * Children 2 years old - 2 baby aspirin.
  * Children 3 years old - 3 baby aspirin.
  * Children 4 years old - 4 baby aspirin.
  * Children 5 to 12 years old - 4 baby aspirin or one adult aspirin.
  * The above dose may be given every 4 hours if needed. Do not give it more often. Do not continue the aspirin for more than 48 hours at the above dose.

WARNINGS

* Aspirin has many side effects, some of which can be serious. Overdosage can be fatal, especially in small children. The harmful effects are more common in children who are feverish and dehydrated. Be certain that children taking aspirin are given plenty of liquids.
* Aspirin in the usual doses can cause:

  * Nausea.
  * Vomiting.
  * Abdominal pain.
  * Small amount of blood loss from the intestines.
  * Worsened gastric bleeding and ulcers.
  * Sweating.

* About 1 in every 500 persons is allergic to aspirin. Patients who have asthma or nasal allergies are more likely to have aspirin allergies. Aspirin allergy symptoms can include:

  * Rashes and hives.
  * Inflammed nose, asthma, nasal polyps.
  * Fainting.
  * Edema of the face, eyelids, lips.
  * Difficulty breathing, asphyxia, and death.

* Aspirin can block or increase the effects of some other drugs.

* If the patient receives a slight over dose, he may have symptoms of salicylism. If this occurs, stop the drug until the symptoms go away. If the drug is still needed, restart the drug at a small dose. Symptoms of salicylism include:

* Ringing ears.	* Dizziness.	* Rapid breathing.
* Headache.	* Dimness of vision.	* Rapid pulse.
* Confusion.	* Sweating.	* Vomiting.
* Drowsiness.	* Fever.	* Diarrhea.

* Do not use aspirin if:
  * The patient is allergic to it.
  * The patient is a child and you have acetaminophen available. Use acetaminophen instead.
  * The patient is taking probenecid (benemid) for gout, or anti-coagulents (warfarin, counmadin).
  * The patient has ulcers or gastrointestinal bleeding.

STORAGE AND DISPENSING DIRECTIONS

* Store aspirin at room temperature with the other tablets. It will not be harmed by accidental freezing.
* Aspirin does not require a prescription.
* Aspirin should be taken with food, milk, at meals or with a large amount of water to prevent stomach irritation. Baby aspirin tablets should be smashed and mixed with a small amount of water.
* Warn the patient that aspirin is the most common cause of death in accidental poisoning of small children. Keep aspirin out of the reach of children, especially flavored baby aspirin!

PROPOXYPHENE
65MG CAPSULES

DARVON[R]

DIRECTIONS AND USES

* Propoxyphene is an analgesic. It will relieve mild to moderate pain, much like aspirin. Unlike aspirin, it will not reduce fever or inflammation. Recent studies have shown propoxyphene to be no more effective than aspirin for the relief of pain.

* Propoxyphene is used to relieve mild to moderate pain caused by headache, toothache, menstrual cramps, muscle aches and injuries. The usual adult dose is one 65mg capsule every 4 hours.

WARNINGS

* Propoxyphene has a number of harmful side effects including:

  * Drowsiness or dizziness.
  * Sedation.
  * Headache.
  * Insomnia.
  * Excitement.
  * Euphoria (feeling of well being).
  * Skin rashes.
  * Nausea and vomiting.
  * Constipation.

* Many people who have taken propoxyphene want to continue to take it because it makes them feel good. They develop a psychological dependance on the drug. Propoxyphene is not as often abused as codeine or morphine, but it must be considered a habit forming drug.
* Patient should not do hazardous work, such as drive a snow machine, while taking propoxyphene because the drug will make them drowsy or dizzy. Alcohol and other sedative drugs will increase the drowsiness.
* Overdose with the drug will cause coma, depressed breathing, shock, edema of the lungs and death. Convulsions may occur.
* Do not give the patient propoxyphene if:

  * The patient is a child.
  * The patient has arthritis. Aspirin is better.
  * The patient is using a lot of this drug or may be abusing it.
  * The patient has not tried aspirin or acetaminophen.
  * The patient drinks a lot of alcohol, operates dangerous equipment or might be harmed by the sedative effects.

STORAGE AND DISPENSING DIRECTIONS

* Store this drug at room temperature with the other oral tablets. Propoxyphene capsules will not be damaged by accidental freezing.
* Check the expiration date before dispensing.
* This is a prescription drug. It is subject to drug abuse by some patients. Use it only with your referral physician's order.
* Warn the patient about the dizziness or drowsiness. Tell him not to drink alcohol, drive a snow machine, or operate dangerous equipment.

SODIUM SALICYLATE
300MG ENTERIC COATED TABLETS

NASAL
SOD. SAL.

DESCRIPTION AND USES

* Sodium salicylate is very similar to aspirin. It has most of the same actions and harmful effects. The enteric coating prevents the tablet from dissolving until it reaches the intestine. This means that the drug causes less stomach irritation, but it also acts more slowly.

* Sodium salicylate is used to reduce the pain and swelling of the joints caused by arthritis. The usual dose is 600 to 900mg (2 or 3 tablets) 4 times daily.

WARNINGS

* Sodium salicylate has the same harmful effects as aspirin including:

  * Salicylism from over dose.
  * Interferring with effects of other drugs.
  * Causing gastrointestinal bleeding.
  * Serious poisoning from accidental over dose.

* Sodium salicylate is less likely to cause stomach upset or allergic reactions than is aspirin.

* Do not use sodium salicylate if the patient:

  * Has a fever or headache. Use aspirin or acetaminophen since sodium salicylate acts to slowly.
  * Is a child. The tablets are too strong for pediatric use.
  * Has an allergy to aspirin or sodium salicylate.
  * Is taking anticoagulants (coumadin, warfarin) or probenecid (Benemid).

STORAGE AND DISPENSING DIRECTIONS

* Store sodium salicylate at room temperature with the other tablets. It will not be damaged by accidental freezing.
* Sodium salicylate does not require a prescription.
* Tell the patient to take the drug with lots of water. Warn him that the drug is dangerous if taken in too large a dose. It can be fatal to small children. The red tablets look like candy. Keep it out of the reach of children!

PENTAZOCINE
50MG TABLETS
30MG/CC AMPUL

TALWIN

DESCRIPTION AND USES

* Pentazocine is a analgesic. Injectable pentazocine is about as effective as morphine or meperidine for severe pain. Oral pentazocine is about as effective as oral codeine. Pentazocine is considered to be less habit forming than narcotics like morphine and codeine. It has less of an abuse problem as well.

* Pentazocine is taken by mouth for mild to moderate pain such as toothaches, severe headaches, injury, etc. The usual adult dose is 50 to 100mg (1 to 2 tablets) by mouth every 4 hours.

* Injectable pentazocine is used to treat severe pain. The usual adult dose is 30 to 60mg IM or subcutaneously.

WARNINGS

* Pentazocine has many side effects. The most common are sedation, nausea and vomiting. Alcohol and other sedative drugs will increase the drowsiness.
* Some of the other main side effects include:

    * Loss of appetite, cramps, diarrhea and consripation.
    * Dry mouth, dizziness, sweating, nasal congestion, tachycardia, flushing and urinary retention.
    * Change in blood pressure, shock.
    * Vision disturbances, weakness, drunken feeling, grogginess, headache, depression, excitement, nightmares.
    * Itching and allergic reactions.

* Pentazocine is not as addicting as morphine or meperidine, but some people may abuse the drug.
* Do not give pentazocine if:

    * Aspirin or acetaminophen will be effective.
    * The patient has low blood pressure or other symptoms of shock.
    * The patient has a head injury or brain damage.
    * The patient is a child.
    * The patient has a breathing difficulty such as asthma, cyanosis, COPD. Pentazocine will further depress his breathing.
    * The cause of the pain is unknown and the patient will be seen by a physician soon. If the pain is relieved, the physician may have trouble finding the cause.

STORAGE AND DISPENSING DIRECTIONS

* Store this drug at room temperature with the tablets or injections. If it is frozen, the ampul will probably break. It it does not, the medicine is probably safe to use.
* Check the expiration date before using.
* This is a prescription drug. It has some abuse potential. Use it only with a physician's order or, in an emergency, as outlined in your manual.
* Warn the patient that the drug will cause dizziness or drowsiness. Tell him to stay in bed.

MEPERIDINE INJECTION 50MG DEMEROL[R]

MORPHINE INJECTION 10MG

DESCRIPTION AND USES

* Morphine and meperidine are analgesics. They are highly effective for severe pain due to injuries, heart attacks, heart failure and other problems. They have been abused by drug addicts and are subject to special legal controls. The actions of morphine, meperidine and pentazocine are similar.

* The usual adult dose of meperidine is 50 to 75mg I.M. This dose is repeated every 3 to 4 hours.

* The usual adult dose of morphine is 10mg subcutaneously every 4 hours. It may also be given I.M.

WARNINGS

* Like all narcotics, morphine and meperidine have many side effects. The ones you should be most concerned with are:

  * Sedation.
  * Nausea and vomiting.
  * Respiratory depression.
  * Circulatory depression.

* The patient may have hallucinations, nightmares, and many other side effects. The drugs affect the mind, respiration, circulation, and the operation of the gastrointestinal tract. The patient should go to bed and stay there. Assist him if he must be transported.
* Morphine and meperidine are addicting to some people. Addiction is not a problem if the patient receives only a few injections to control acute pain.
* Do not use morphine or meperidine if:

  * The patient has minor pain that can be relieved by aspirin or acetaminophen.
  * The patient has low blood pressure or other symptoms of shock.
  * The patient has a head injury or brain damage.
  * The patient has a breathing difficulty due to asthma, COPD, or similar disease. Narcotics will further depress his breathing.
  * The cause of the pain is unknown and the patient will be seen by a physician soon. If the pain is relieved the physician may have trouble finding the cause.
  * The patient must perform dangerous work requiring alertness (such as flying a plane). Narcotics are for patients in bed or on a stretcher.

STORAGE AND DISPENSING DIRECTIONS

* Store morphine at room temperature in a locked cabinet. Only the health aide should have access to the cabinet.
* Accidental freezing may break the glass tubex. If it does not appear to be damaged, the drug is probably all right.
* Check the expiration date before using the drug.
* Morphine and meperidine are controlled drugs as well as prescription drugs. Use it only with a physician's order or, in an emergency, according to your manual. You must keep a record of each dose of the drug you receive and use.
* Do not let the patient stand up or walk about after he has received either of these drugs.

LIDOCAINE INJECTION — XYLOCAINE®

DESCRIPTION AND USES

* Lidocaine is a local anesthetic. It will block the nerves near the area into which it is injected. Lidocaine is used to block the pain in an area that must be sutured, debrided, or otherwise treated painfully.

* Inject a small amount of the solution every 1/4" to 1/2" in the desired area. 3cc to 5cc is enough total solution for a small laceration. Use the smallest amount possible. Aspirate frequently to be certain that you not injecting into a vein.

WARNINGS

* Allergic reactions are rare, but may occur. Reactions have included skin rashes, edema, asthma, shock-like reactions, and death.

* If a large amount of lidocaine is injected into a vein or rapidly absorbed, the patient may have:

    * Anxiety, tremors or other signs of nervous system stimulation.
    * Slow heart beat, low blood pressure, or other signs of cardiovascular depression.

* Do not use liodcaine if:

    * The patient is allergic to it.
    * The area is infected or inflammed.
    * The patient is in shock.

STORAGE AND DISPENSING DIRECTIONS

* Store lidocaine at room temperature with the other injections. If lidocaine is frozen, the vial may break. If it does not break, it is safe to use the drug.
* Check the expiration date before using the bottle. When you first use the vial, write the date on the bottle. Discard the vial 30 days after opening.
* Lidocaine is a prescription drug.

CLOVE OIL

EUGENOL
OIL OF CLOVES

DESCRIPTION AND USES

* Clove oil is a local anethetic. It is used to stop a toothache on a temporary basis. The tooth is still decayed and must be restored or pulled by a dentist.

* The clove oil may be placed on a small piece of cotton. The cotton is then inserted into the cavity of the tooth. The clove oil will have to be replaced periodically as the effect wears off.

* Clove oil is also used as an ingredient in a temporary filling.

WARNINGS

* Clove oil is a temporary measure only. The tooth is still decayed. The patient must see a dentist as soon as possible

STORAGE

* Store clove oil at room temperature with the internal liquids.
* Clove oil will not be damaged if it is accidentally frozen.
* Clove oil is a non-prescription drug. Follow the guidelines in the health-aide manual.
* It is best to apply this drug yourself. Do not give the bottle to the patient.

ALUMINUM HYDROXIDE GEL WITH MAGNESIUM TRISILICATE TABLETS	GELUSIL[R]
ALUMINUM HYDROXIDE - MAGNESIUM HYDROXIDE SUSPENSION	MAALOX[R]
ALUMINUM HYDROXIDE - MAGNESIUM HYDROXIDE WITH SIMETHICONE SUSPENSION	MYLANTA[R]

DESCRIPTION AND USES

* All 3 of these products are antacids containing an aluminum and a magnesium salt. Aluminum salt antacids tend to cause constipation, while magnesium salts cause diarrhea. The combination of the two is less likely to cause either. The simethicone in mylanta reduces "gas" in the stomach.

* Antacids are also used to treat peptic ulcer, acute alcohol gastritis gastritis due to disease or drugs, and other stomach problems caused by too much acid in the stomach. The usual dose is 1 to 2 tablespoonfuls or 1 or 2 tablets every 1-2 hours. The tablets should be chewed well and taken with water.

* A smaller dose (1-2 teaspoonfuls) may relieve indigestion, heartburn, "sour stomach" and similar minor complaints.

WARNINGS

* A few patients may have constipation or diarrhea as a side effect. Serious side effects are rare.

STORAGE AND DISPENSING DIRECTIONS

* Store antacids at room temperature with the other oral tablets or liquids. Accidental freezing will ruin Mylanta or Maalox Suspension. Even if the bottle is not broken, the medicine may be damaged so that it will not shake up properly. Freezing will not hurt the tablets.
* All 3 of the antacids are non-prescription drugs.
* Tell the patient to shake the liquids well before using. Tell him to chew the tablets and swallow them with water.

KAOLIN WITH PECTIN N.F.

KAOPECTATE®
KALPEC

DESCRIPTION AND USES

* Kaolin is a type of clay. Pectin is a carbohydrate obtained from apples and citrus fruit. Irritating chemicals and bacteria are adsorbed onto the surface of these two drugs. Pectin is also a demulcent that soothes the lining of the g.i. tract.

* Kaolin with pectin is used to treat simple diarrhea. Give the patient Kaolin with Pectin 3 or 4 times daily if needed:

    * Adults may have 30ml (2 tablespoonfuls).
    * Children between 6 and 12 may have 15ml (1 tablespoonful).
    * Children between 3 and 6 may have 1-2 teaspoonfuls.
    * Children under the age of 3 may have 1/2 to 1 teaspoonfuls.

WARNINGS

* Do not use Kaolin with Pectin for more than a few days. If the diarrhea lasts longer than this, contact your referral physician.

* Kaolin with Pectin is not very effective alone. It is important that the patient follow the directions regarding fluids and diet.

STORAGE AND DISPENSING DIRECTIONS

* Store Kaolin with Pectin at room temperature with the other oral liquids. Accidental freezing may ruin it. Do not use it if it has been frozen.
* Kaolin with Pectin is a non-prescription drug.
* Shake it well before using.

MILK OF MAGNESIA U.S.P. MAGNESIA MAGMA

DESCRIPTION AND USES

* Milk of Magnesia is a suspension of magnesium hydroxide in water. It acts as an antacid or a laxative depending on the dose. When used as a laxative, it works by retaining water in the intestine. This produces a loose watery stool.

* One or two teaspoonfuls (5-10ml) will act as an antacid. One to two Tablespoonfuls (15-30ml) will act as a laxative and relieve constipation.

WARNINGS

* The use of laxatives can become a habit. Encourage people to excercise, drink plenty of fluids, and eat lots of fruits and vegetables to prevent constipation. It is not necessary to have a "daily" bowel movement to be normal.

* Constipation may be a symptom of appendicitis, bowel obstruction or some other serious problem. The use of milk of magnesia in these situations may be harmful.

* Do not use milk of magnesia if:

    * The patient has poor kidneys. The magnesium will not be excreted and may depress the patient's breathing.
    * The patient has fever, pain in the right lower quadrant, nausea, or other symptoms of appendicitis.
    * The patient is a child under the age of 12, unless you are instructed to do so by a physician.

STORAGE AND DISPENSING DIRECTIONS

* Store milk of magnesia at room temperature. Do not use it if it has been frozen. Even if the bottle is not broken, the suspension may be ruined.
* It is a non-prescription drug.
* Encourage the patient to take plenty of water while taking this drug. Water provides the bulk that stimulates the bowels.

PHENOBARBITAL AND BELLADONNA

PB AND BELLADONNA

DESCRIPTION AND USES

* Phenobarbital is a sedative that relieves nervous tension and anxiety. Belladonna is an antispasmotic that relieves cramps and spasms of the smooth muscle of the intestines and other digestive organs.

* This product is used to treat spasms and cramps of the gastrointestinal tract. It will help relieve the belching, cramps, constipation, and diarrhea that may accompany some gastrointestinal upsets. The usual adult dose is one tablet 3 or 4 times daily.

WARNINGS

* Phenobarbital causes drowsiness. Alcohol and other sedatives drugs will increase the drowsiness.

* Belladonna may cause many minor irritating side effects. Do not stop the drug unless the effects bother the patient a lot. Common effects include dry mouth, blurred vision, difficulty urinating, headache, fast heart beat, dizziness, and nervous system stimulation.

* This drug will cause harmful effects if the patient takes too much. The harmful effects are particularly severe in children.

* Do not give Pb and belladonna to children. Check with a physician before you give it to someone with glaucoma or an obstruction of the stomach, intestine or bladder.

STORAGE AND DISPENSING DIRECTIONS

* Store this drug at room temperature with the other oral tablets. It will not be harmed by accidental freezing.
* This is a prescription drug.
* Warn the patient that he should expect some drowsiness, dry mouth, and possibly blurred vision. Tell him to avoid driving a vehicle, doing dangerous work and drinking alcohol.

TRIMETHOBENZAMIDE HCL 200MG RECTAL SUPPOSITORIES

TIGAN®

DESCRIPTION AND USES

* Trimethobenzamide is an antinauseant. It is effective for nausea caused by infections. It is not generally used for other causes of nausea such as irritating drugs, motion sickness or pregnancy.

* Tigan is used to treat nausea due to acute febrile illnesses or gastroenteritis. It should not be given to children under the age of 1. Adults and older children may have the following dose by the rectum every 8 hours if needed:

    * Children between 1 and 2: 1/4 suppository.
    * Children between 2 and 8: 1/2 suppository.
    * Children over the age of 8 and adults: 1 suppository.

WARNINGS

* Trimethobenzamide causes few side effects. A few patients may have:

    * Skin rashes or other allergic reactions.
    * Shaking or rigidity of the muscles.
    * Dizziness or drowsiness.
    * Other side effects.

* Tigan suppositories also contain the local anesthetic benzocaine. Some patients may be allergic to this drug.

* Do not use trimethobenzamide if:

    * The patient is allergic to trimethobenzamide or benzocaine.
    * The patient is a child under the age of 1 (unless directed to do so by a physician).
    * The nausea is due to pregnancy, motion sickness, or irritating effects of drugs (unless told to do so by a physician).
    * The vomiting will respond to simple measures like bed rest, stopping all solid foods, etc.

STORAGE AND DISPENSING DIRECTIONS

* Tigan may be stored at room temperature or in the refrigerator. It will not be damaged by accidental freezing.
* Check the expiration date before using it.
* This is a prescription drug.
* Show the patient how to cut the suppositories in halves or fourths. Cut them before you remove the foil. Remind the patient to remove the foil before inserting the suppository.

ERGONOVINE MALEATE U.S.P.
0.2MG INJECTION

METHYLERGONOVINE MALEATE U.S.P. METHERGINE®
0.2MG TABLETS

DESCRIPTION AND USES

* Ergonovine and methylergonovine stimulate the muscles of the uterus and makes them contract. This helps reduce or prevent bleeding from the uterus following childbirth.

* Ergonovine is given as a single I.M. injection following the delivery of the placenta. The usual dose is 0.2mg.

* Methylergonovine tablets are started following the delivery of the placenta as well. The mother takes one tablet every 4 hours for a total of 6 tablets.

WARNINGS

* Headaches, dizziness and abdominal cramps may occur. Either drug may cause increased blood pressure or a slow heart rate in some patients.

* Do not give the mother either drug if:

    * She has high blood pressure.
    * The child and placenta have not been delivered.
    * The uterus is infected
    * The mother has a liver or kidney disease.

STORAGE AND DISPENSING DIRECTIONS

* Store methylergonovine tablets at room temperature with the other oral tablets. The tablets will not be harmed by accidental freezing.
* Store ergonovine injection in the refrigerator. Accidental freezing may break the tubex. Replace the drug if it has been frozen and you have any question about its quality.
* Check the expiration date before using either drug.
* They are both prescription drugs.

FERROUS SULFATE
325MG TABLETS
125MG/CC DROPS

FESO4
FEOSOL®
FER-IN-SOL®
IRON DROPS

DESCRIPTION AND USES

* Ferrous sulfate is a source of iron. Iron is an important part of the hemoglobin found in the red blood cell. Hemoglobin enables the red blood cells to carry oxygen from the lungs to the body tissues.
* Iron is usually obtained from foods. Milk is a poor source of iron. For this reason, babies require an iron supplement. Pregnant women also require extra iron because of the rapid increase in their blood supply and that of the fetus. Patients with a blood loss from injuries, ulcers, excessive menstrual flow, or other causes may also require additional iron to help rebuild their blood.
* Children from birth to age 1 may receive 0.6cc of the drops once each day to prevent low hemoglobin. This is not needed if the child is receiving a vitamin that contains iron or is receiving a product like similac with iron.
* The usual dose of iron to treat low hemoglobin is:
    * Children from age 6 months to 1 year = 0.6cc 3 times daily
    * Children from 1 years to 2 years = 1.2cc 2 times daily
    * Children from 2 years to 5 years = 1.2cc 3 times daily
    * Children 5 to 10 years = 1 tablet 2times daily
    * Adults and children over 10 years = 1 tablet 3 times daily
    * The medicine must be taken for 4 months while the body slowly builds new red blood cells.

WARNINGS

* Iron is poisonous if too much is taken. It is hazardous because it looks like candy.
* Iron may cause constipation, stomach irritation, and possible cramps and diarrhea. This is more of a problem with adults than children. If the patient has gastrointestinal complaints, have them take the drug just after a meal. Iron usually causes the patient to have dark colored stools.
* Iron drops may stain the teeth of older children. Place the drops in the back of the mouth or dilute them with liquids. Do not mix the drops with milk or formula.
* Do not give iron tablets or drops to:
    * Patients who are taking tetracycline. Iron will reduce the effectiveness of the antibiotic.
    * Patients with ulcers, regional enteritis or ulcerative colitis. Check with a physician first since iron may irritate the g.i.tract.

STORAGE AND DISPENSING DIRECTIONS

* Store iron tablets and drops at room temperature with the other tablets and oral liquids. Accidental freezing will not harm the tablets or drops, but it may break the bottle holding the drops.
* Ferrous sulfate is a non-prescription drug. Provide it to pregnant women, infants, and patients with low hemoglobin as directed in your manual.
* Tell the patient to take the drug with food if it irritates his stomach. It is more effective if the stomach is empty.

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

PEDIATRIC VITAMINS [illegible]

BABY-VI-FLOR®
ADDED WITH FLUORIDE®

PRESCRIPTION AND USE

* This product [illegible] does not supply iron. A shortage of vitamin [illegible] can cause permanent damage. Fluoride helps to prevent [illegible]

* Children from birth to age [illegible] receive one dropperful daily by mouth. The drops may be placed directly [illegible] or mixed with the baby's food.

WARN

* There are no harmful effects [illegible] receive the correct dose. Warn the parents [illegible] of the reach of children to prevent accidental overdose.

* Do not use this product in the [illegible]:

    * Drinking water from a fluoride [illegible] source.
    * Receiving vitamins from a commercial formula like Similac or Enfamil. [illegible] fluoride tablets instead.
    * Receiving vitamin [illegible] iron drops.

STORAGE [illegible]

* Store this drug [illegible] like other oral liquids. It may be ruined by [illegible]
* Check the expiration date. If [illegible]
* This is a prescription drug. Give [illegible] to all babies under the age of one according to your [illegible] directions or according to the manual.

THE PRECEDING DOCUMENT(S) MAY NOT FILM
LEGIBLY BECAUSE OF POOR QUALITY OF THE
ORIGINAL.

PEDIATRIC VITAMINS WITH IRON — TRI-VI-SOL WITH IRON®

DESCRIPTION AND USES

* This product contains vitamins A, D, and C and a small amount of iron. It does not contain fluoride. A shortage of vitamins can slow a child's growth or cause permanent damage. A shortage of iron can cause low hemoglobin.

* Children from birth to age 1 should receive 1 dropperful daily by mouth to prevent a vitamin or iron shortage. The drops may be placed directly in the mouth or mixed with water, juice, or formula.

WARNINGS

* There are no harmful effects if the child receives the correct dose. Warn the parents to keep the medicine out of the reach of children to prevent accidental overdose.

* Do not use this product if the child is receiving a commercially prepared formula that contains both vitamins and iron (such as similac with iron).

* If you are giving the child Tri-Vi-Sol with iron, he does not need to take iron drops to prevent low hemoglobin.

STORAGE AND DISPENSING DIRECTIONS

* Store this drug at room temperature with the other oral liquids. This drug may be ruined by freezing.
* Tri-Vi-Sol with iron is a non-prescription drug. Give it to babies under the age of 1 as directed in the manual or by your referral physician.

PRENATAL VITAMINS

NATABEC Rx

DESCRIPTION AND USES

* This product contains vitamins, mineral, and iron. Pregnant women have a greater need for folic acid, iron and certain other vitamins and minerals This formula is designed to meet the need of the woman during pregnancy. She should take one capsule daily while she is pregnant. Some physicians recommend that she continue the medication as long as she is breast feeding as well.

WARNINGS

* This product contains 150mg of ferrous sulfate (iron). The iron may cause constipation or stomach irritation in some patients.

* Vitamins with iron can be poisonous if a child takes a lot of them. Warn the mothers to keep them out of the reach of children.

STORAGE AND DISPENSING CONDITIONS

* Store this drug at room temperature with the other oral tablets. It will not be damaged by accidental freezing.
* Check the expiration date before dispensing.
* This is a prescription drug.

SODIUM FLUORIDE 2.2MG TABLETS

DESCRIPTION AND USES

* Fluoride helps prevent tooth decay. It is most effective if it is taken daily in the water. If your village does not have fluoridated water, all the children should receive fluoride daily from tablets or drops. Fluoride is most effective if it is taken while the child is young, while the teeth are still forming.

* Children under the age of 1 should have 1/2 tablet daily. Children over the age of 1 should have a whole tablet daily. The tablet should be chewed and swallowed.

WARNINGS

* Sodium fluoride is a safe drug. It has no harmful effects if it is taken in the correct dosage. Large amounts of fluoride for a long period of time may cause discolored teeth. A single large dose of fluoride can also be harmful to a child. Give the parents only one bottle at a time. Warn them to keep the medicine out of the reach of children.

* Do not use fluoride tablets if:

    * The child receives fluoride from the water.
    * The child is taking vitamins that contain fluoride (Poly-Vi-Flor, ABDEC with fluoride).

STORAGE AND DISPENSING

* Store this drug at room temperature with the other oral tablets. It will not be harmed by accidental freezing.
* Sodium flouride is a prescription drug. Use it according to the manual or your referral physician's directions.

DIPHENHYDRAMINE HCL
25MG CAPSULES
12.5MG/5ML ELIXIR

BENADRYL®

DESCRIPTION AND USES

* Diphenhydramine is an antihistamine. It will relieve itching, skin rashes, hives, and a variety of allergy symptoms.

    * Children from 1 to 5 years of age may receive 1 teaspoonful of the elixir (12.5mg).
    * Children from 6 to 12 may have one 25mg capsule.
    * Adults and other children may have one or two 25mg capsules.
    * The above dose can be given 4 times daily if needed.

* Diphenhydramine is also used as a sedative and to prevent motion sickness. When used as to prevent motion sickness, the adult patient should taken 25 to 50 mg a half hour before the trip starts.

WARNINGS

* Diphenhydramine, and most other antihistamines, causes drowsiness. Alcohol will make the effect worse. The patient should be told not to drink alcohol or operate dangerous equipment. Children may be stimulated rather than depressed. They may act restless or nervous, or be unable to sleep.

* Some patients may be troubled by minor irritating effects such as:

    * Dry mouth.
    * Difficult urination.
    * Dizziness.
    * Blurring vision.
    * Ringing in the ears.
    * Stomach upset.
    * Nausea.
    * Diarrhea.
    * Constipation.

* Any overdose can depress the patient's breathing.

* Do not give diphenhydramine to:

    * Breast feeding mothers since it may appear in the milk or reduce the mother's ability to make milk.
    * Patients who must perform dangerous work requiring mental alertness.
    * Patients with epilepsy or a seizure problem. Check with a physician. The drug may cause some patient's with epilepsy to have a seizure.

STORAGE AND DISPENSING DIRECTIONS

* Store this drug at room temperature with the other oral tablets and liquids. It will not be damaged by accidental freezing.
* This is a prescription drug.
* Remember to tell the patient about the sedative effect of the drug. Warn them not to drink or operate dangerous equipment. Tell them to stop the drug as soon as they feel better.

DIPHENHYDRAMINE EXPECTORANT

BENYLIN[R]
DIPHENHYDRAMINE COMPOUND (
EXPECTORANT
"BENALYN"

DESCRIPTION AND USES

* Benylin[R] contains the antihistamine diphenhydramine and several expectorants that loosen mucous so that it can be coughed up. It is easy to confuse the expectorant with the elixir. Both products contain 12.5mg of diphenhydramine per teaspoonful. The expectorant also contains sodium citrate and ammonium chloride.

* Benylin is used to loosen the mucous in the lungs that causes the coughing. It will also suppress a cough caused by a head cold or allergy.

    * The adult dose is 1-2 teaspoonfuls 4 times daily.
    * Children from 6 to 12 may have 1 teaspoonful.
    * Children from 1 to 6 may have 1/2 teaspoonful.

WARNINGS

* Diphenhydramine causes drowsiness. Alcohol, other antihistamines, and other sedative drugs will make this effect worse. Warn the patient not to drink alcohol or operate dangerous equipment. Children may be stimulated rather than depressed. They may act restless or nervous.

* Some patients may complain of minor irritating effects like:

    * Dry mouth.
    * Difficult urination.
    * Dizziness.
    * Blurry Vision.
    * Ringing in the ears.
    * Stomach upset.
    * Nausea.
    * Darrhea.
    * Constipation.

* The drug has a drying effect. This may make it diffcult to remove bronchial secretions.
* An overdose of the drug will depress breathing.
* Do not give benylin to:

    * Breast feeding mothers since the drug may reduce their ability to make milk.
    * Patients who must perform dangerous work requiring mental alertness.
    * Patients who are taking other sedative drugs such as actifed, Librium[R], Valium[R], or alcohol.
    * A patient with pneumonia.

STORAGE AND DISPENSING CONDITIONS

* Store this drug at room temperature with the oral tablets and liquids. Benylin will not be damaged by accidental freezing unless it breaks the bottle.
* This is a prescription drug.
* Warn the patient that the drug causes drowsiness. Tell him not to operate dangerous equipment or drink alcohol.

GUIAFENESIN	GLYCERYL GUAIACOLATE	2-G®	ROBITUSSIN®
GUIAFENESIN WITH DEXTROMETHORPHAN	GLYCERYL GUAIACOLATE WITH DM	2-G/DM®	ROBITUSSIN DM®

DESCRIPTION AND USES

* Guiafenesin, formerly known as glyceryl guaiacolate, is an expectorant. It helps make the mucous in the lungs more liquid, less sticky and easier to cough up. Dextromethorphin is a cough suppressant. It helps stop a cough which is not serving a useful purpose.
* Guiafenesin is used to treat coughs due to colds, influenza and similar conditions.
    * The usual adult dose is 1-2 teaspoonfuls every 4-6 hours.
    * Children from 4 to 10 may have 1 teaspoonful.
    * Children under 4 years of age may have 1/2 teaspoonful.

* Guiafenesin with dextromethorphen is used if the patient has a cough caused by something other than sputum in the lungs (such as throat irritation). The usual adult doses is 1-2 teaspoonfuls. Children over the age of 6 may have 1/2 teaspoonful. Do not give it to younger children.

WARNINGS

* Guiafenesin may cause stomach upset, particularly if the dose is too large. Dextromethorphan may cause nausea or dizziness.

* Do not use dextromethorphan if:

    * The patient has a productive cough. Coughing is a normal action necessary to clean the lungs.
    * The patient is a child under the age of 6.

STORAGE AND DISPENSING DIRECTIONS

* Store these cough syrups at room temperature with the other oral liquids. These drugs will not be damaged by accidental freezing unless the bottle is broken.
* These drugs do not require a prescription.

Rev 6/77

PHENYLEPHRINE
0.25% NOSE DROPS

NEO-SYNEPHRINE®

DESCRIPTION AND USES

* Phenylephrine is a decongestant. It is applied directly to the lining of the nose in the form of drops. It constricts the swollen blood vessels and opens the nasal passages so the patient can breathe. The effect is immediate and gives considerable relief. Unfortunately the effect lasts only a short time.

* Place 1 or 2 drops into each side of the nose every 4 hours if needed to relieve congestion and "stuffy nose". The drops must not be used more frequently.

WARNINGS

* The patient may notice a mild stinging sensation when the drops are applied. After several days of use, the drug may irritate the nasal mucosa.

* Phenylephrine interferes with the normal action of the nasal cilia.

* If the drops are used for more than 2 days or more frequently than every 4 hours, the nose may become dependent on them. The patient will then find that he must use the nose drops constantly in order to keep his nasal passages open.

* Do not use phenylephrine:

    * In infants.
    * For more than 2 days.
    * At the same time the patient is using actifed, sudafed, or other oral decongestants.

STORAGE AND DISPENSING DIRECTIONS

* Store this drug at room temperature with the eye and ear drops. It will probably not be damaged by accidental freezing.
* If the drug is exposed to air, metals or strong light, it will discolor and become useless. Discard the solution if it turns black or contains particles.
* This a non-prescription drug. It is recommended that you not use it routinely, however. Use it only when ordered by a physician or as directed in the manual.

PSEUDOEPHEDRINE
60MG TABLETS
30MG/5ML SYRUP

SUDAFED[R]

PSEUDOEPHEDRINE - TRIPOLIDINE
TABLETS AND SYRUP

ACTIFED[R]

DESCRIPTION AND USES

* Sudafed contains the decongestant psuedoephedrine. Actifed contains the antihistamine triprolidine as well as pseudophedrine.

* The decongestant constricts the blood vessels in the mucous membranes lining the nasal passages and the eustachian tube. This relieves the nasal congestant and plugged up ear sensation that often accompanies allergies, otitis media, serous otities, influenza, and the common cold.

    * The usual adult dose is one tablet 3 or 4 times daily.
    * Children from age 6 to 12 may have 1 teaspoonful or 1/2 tablet 4 times daily.
    * Children from 3 to 5 may have 1 teaspoonful 3 times daily.
    * Children from 1 to 3 may have 1/2 teaspoonful 3 times daily.
    * Do not give actifed or sudafed to children under 1 year of age.

WARNINGS

* Pseudoephedrine (Sudafed) has few side effects.

* The antihistamine triprolidine causes drowsiness. Alcohol and sedative drugs will increase the drowsiness caused by actifed.

* Do not give <u>Actifed</u> to:

    * Breast feeding mothers since the antihistamine may decrease their ability to make milk.
    * Patients who are taking other sedative drugs such as alcohol, Benylin, Librium, or Valium.
    * Patients who must do work requiring mental alertness such as operating dangerous equipment.

STORAGE AND DISPENSING DIRECTIONS

* Store actifed and sudafed at room temperature with the other oral tablets and liquids. The drugs will not be damaged by freezing unless the bottle is broken.
* Check the expiration date before dispensing.
* Sudafed syrup is a non-prescription drug. Sudafed tablets and actifed tablets and liquid are prescription drugs.

TRIAMINIC

DESCRIPTION AND USES

* Triaminic is a combination of two antihistamines and one decongestant. It is similar in its uses and actions to actifed. The decongestant constricts the blood vessels in the mucous membranes lining the nasal passage and the eustachian tube. This relieves the nasal congestion and plugged up ear sensation that accompanies otitis media, serous otitis and the common cold.

    * The usual adult dose is 2 teaspoonfuls 3 or 4 times daily.
    * Children from age 6 to age 12 may have 1 teaspoonful 3 times daily.
    * Children from age 1 to age 6 may have 1/2 teaspoonful 3 times daily.

WARNINGS

* Triaminic has the same side effects that other antihistamine do. It causes drowsiness in the usual dose. Alcohol and other sedative drugs will make the drowsiness worse.

* An overdose of the drug can depress breathing. Be certain to give the correct dose.

* Do not give Triaminic to:

    * Breast feeding mothers since the antihistamine may decrease their ability to make milk.
    * Patients who are taking other sedative drugs such as alcohol, Benylin, Librium, or Valium.
    * Patients who must do work requiring mental alertness such as operating dangerous equipment.

STORAGE AND DISPENSING DIRECTIONS

* Store Triaminic at room temperature with the oral liquids. Accidental freezing will not harm the triaminic unless it breaks the bottle.
* Triaminic is a non-prescription drug.
* Warn the patient to expect some drowsiness. Tell him to avoid alcohol and activities requiring alertness.

SALINE NOSE DROPS

NACL NOSE DROPS
NORMAL SALINE NOSE DROPS
ISOTONIC SODIUM CHLORIDE
SALT WATER NOSE DROPS

DESCRIPTION AND USES

* This produce is a very dilute solution of sodium chloride in water. If the drugs are not stocked in your village, the mother can make her own by placing 1/4 teaspoonful of table salt in a cup of clean water.

* The drops are used to help clean mucous from the baby's nose when he has a cold. Place 3 or 4 drops into each nostril. Let the drops run back into the nose. Use a nasal aspirator syringe to suck out the solution. The saline drops will make the mucous easier to remove.

STORAGE AND DISPENSING DIRECTIONS

* Store this drug at room temperature with the other eye, ear and nose drops. The drug will not be harmed by accidental freezing.
* This a non-prescription drug.

CHLORPROMAZINE — THORAZINE®
50MG TABLETS
50MG/2CC INJECTION

PROCHLORPERAZINE — COMPAZINE®
5MG TABLETS
10MG/2CC INJECTION

DESCRIPTION AND USES

* These drugs are phenothiazine tranquilizers. Like other drugs of the phenothiazine group, they have a wide number of uses and side effects. Only a few of the uses and harmful effects are mentioned here.

* Thorazine and compazine can be used to treat agitation, anxiety, and psychotic states. They are most commonly used to treat mental disorders such as schizophrenia where the patient has lost contact with reality. The drugs may control hallucinations, thought disorders and aggressive behavior .

    * The usual dose of thorazine is 25mg - 50mg by mouth 3 or 4 times daily.
    * The usual injectable dose is 25mg IM. This dose may be repeated in 1/2 hour if needed.
    * The usual dose of compazine for this use is 5 to 10mg by mouth or 5 to 10 I.M.

* Chlorpromazine maybe used as sedative in patients experiencing alcohol withdrawal. Do not use it if the patient is having a seizure. The usual dose is 25 to 50mg IM orally or by IM injection.

* Chlorpromazine may be used as a sedative if a patient has hallucinations and fear due to delerium tremons (d.t.'s). The usual adult dose is 100 to 150mg by mouth or 50mg I.M.

* These drugs may also be used to treat nausea and vomiting if requested by a physician. Do not use them in children.

WARNINGS

* Phenothiazine-type drugs cause <u>many</u> side effects. Some of the more common ones are:

    * Sedation and drowsiness.
    * Low blood pressure.
    * Dry mouth, blurred vision.
    * Constipation.
    * Restlessness.
    * Muscle shaking, tremors, rigidity.
    * Jaundice, photosensitivity, blood disorders or other allergic reactions.
    * Inability to control body temperature.

* Alcohol, antihistamines, and other sedatives will increase the sedative effect.

* Avoid using the drug in the following patients:

    * Elderly patient's with liver, kidney or heart disease.
    * Patients who are drunk or who are using other sedatives.
    * Children.
    * Pregnant women.
    * Patients with asthma, emphe sema or other lung disorders.
    * Patients who must be transported through extreme cold.
    * Patients who are having seizures or who have a history of epilepsy or seizures.

STORAGE AND DISPENSING DIRECTIONS

* Store these drugs at room temperature. The medicines will not be damaged by accidental freezing unless the ampuls are broken.
* Keep these medicines out of direct sunlight or they will discolor. Do not use discolored medication.
* Check the expiration date before using.
* Keep the patient lying down for a half hour after the injection to prevent fainting due to low blood pressure.
* Warn the patient about the sedative effect.
* This is a prescription drug. Use it only with a physician's order or in an emergency according to your standing orders.

DIAZEPAM
5MG TABLETS
10MG INJECTION

VALIUM®

DESCRIPTION AND USES

* Diazepam is a sedative drug with a wide variety of uses. Small doses cause sedation. Larger doses cause sleep. A very large overdose may cause coma and death.
* Valium is used as a sedative to relieve anxiety, nervousness or actue alcohol withdrawal. It is also used to relax skeletal muscles that are in a spasm due to strain or injury. The adult dose is 1 tablet 3 or 4 times daily. Give the patient only a small supply of the medicine. Check with a physician before you give him more.
* Valium injection is used to stop seizures that do not stop on their own in a short period of time.

Adult dose	5 to 10mg IM	3 years old	3mg IM
5 years old	5mg. IM	2 year old	2mg IM
4 years old	4mg IM	1 year old	1mg IM
Phenobarbital Injection is preferred for children			

* Valium can be used to treat hallucinations caused by delerium tremons (d.t.'s). The adult dose is 20mg (4 tablets) by mouth or 10mg IM.

WARNINGS

* Sedation and drowsiness are common. Alcohol and other sedative drugs will increase the drowsiness. Warn the patient not to drink, operate dangerous equipment, or take other drugs. Some patients may become excited, anxious and stimulated by the drug.
* The injectable form of Valium may cause a drop in blood pressure. Keep the patient lying down.
* Valium may be a habit forming drug. Do not allow alcoholics to become addicted to valium instead of alcohol. Avoid overusing this drug, especially for long periods of time.
* These drugs have many side effects. The most common are: fatigue, drowsiness, lack of muscle coordination, dizziness, headache, nausea, vomiting, and constipation. Skin rashes and itching may be due to a drug allergy.
* Do not use Valium if:
    * The patient is drunk. It may be used to treat d.t.'s and alcohol withdrawal as outlined in the standing orders.
    * The patient is depressed or suicidal.
    * The patient is a drug or alcohol abuser and likely to abuse Valium.
    * The patient has a history of jaundice, urinary retention, liver or kidney disease.

STORAGE AND DISPENSING DIRECTIONS

* Store Valium at room temperature. It will not be damaged by accidental freezing unless the syringe is broken.
* Check the expiration date before using.
* This is a controlled drug.
* Give the tablets to patients in small amounts and only with a physician's order, or in an emergency, according to your standing orders. Warn the patient to expect some drowsiness and to avoid the use of alcohol and other sedatives.

PHENOBARBITAL
30MG TABLETS
20MG/5 ML ELIXIR
130MG TUBEX

LUMINAL[R]

DESCRIPTION AND USES

* Phenobarbital has a sedative effect on the brain and the central nervous system. Small doses cause sedation. Large doses cause sleep. Very large doses cause coma and even death.

* The adult sedative dose is 15 to 30mg (1/2 to 1 tablet) by mouth every 6 to 8 hours.

* Phenobarbital may be used to prevent seizures caused by fever in some small children.

    * Children from 6 months to 1 year may have 1-2 teaspoonfuls daily by mouth.
    * Children from age 1 to age 3 years may have 2-3 teaspoonfuls or 1-2 tablets daily by mouth.

* Phenobarbital may be used to stop seizures that do not stop on their own in a short period of time.

    * 1 year old children = 65mg IM (1/2 tubex).
    * 2 year old children = 130mg IM (1 tubex).
    * 3 and 4 year old children 180mg IM (1 1/2 tubex).
    * 5 year old children and adults = 240mg IM (2 tubexes).

    * Give the above dose. Wait a half hour. If the patient is still seizing, give a second dose half as big as the first.

WARNINGS

* Sedation and drowsiness are common. Alcohol and other sedative drugs will increase the drowsiness. Children may become restless or excited rather than drowsy, particular with small doses. An overdose with phenobarbital may cause difficulty walking, depressed breathing, coma and death.
* Phenobarbital may cause dizziness, headache, nausea, diarrhea, skin rash and a number of other uncommon side effects.
* Phenobarbital maybe habit forming in adults.
* Avoid giving phenobarbital to patients who have lung disease, low blood pressure, central nervous system depression, or shock. Avoid giving it to people who are allergic to it or who are stimulated by it.

STORAGE AND DISPENSING DIRECTIONS

* Store these drugs at room temperature. Protect them from theft.
* Freezing may break the glass container of the injection and elixir but will not harm the tablets. If the glass container is not broken, the drugs are safe to use.
* Phenobarbital is a controlled drug as well as a prescription drug. Keep accurate records of when you received the drug, when you used it, and to whom you gave it. Use it only with a physician's order or according to your standing orders in an emergency. This drug is in the village for emergency use.
* Remember to warn the patient about the sedative effect.

EPINEPHRINE INJECTION U.S.P. 1/1000 — ADRENALIN

DESCRIPTION AND USES

* Epinephrine increases the heart rate and blood pressure, dilates the bronchi, and constricts the blood vessels going to the skin and mucous membranes.

* Epinephrine is used to treat acute asthmatic attacks. The drug relaxes the smooth muscles of the bronchi, enlarges the air passages and allows the patient to breathe. It is also used to treat severe drug allergies, such as anaphylactic shock.

* Inject the drug subcutaneously. Brisk massage of the injection site will make the drug act faster. If necessary, repeat the dose in 15 to 20 minutes. if treating asthma. The injection may need to be given every 5 minutes for severe, life-threatening allergic reactions.

Dose for Adults	Dose for 8-16 year olds	Dose for 4-8 year olds
0.5ml s.c.	0.3 ml to 0.4 ml s.c.	0.2 ml s.c.

WARNINGS

* Epinephrine will increase the blood pressure and heart rate. Other common effects include a feeling of restlessness or fear, throbbing headache, weakness, and pale appearance. A very few patients may have heart arrhythmias which may be fatal.

* Do not use epinephrine if:

    * The patient has only a minor asthmatic attack or allergic reaction.
    * The patient has arteriosclerosis of the brain.
    * The patient is in shock from blood loss.

STORAGE AND DISPENSING DIRECTIONS

* Store epinephrine injection in the refrigerator at room temperature. Do not allow it to get hot. It will not be damaged by accidental freezing unless the tubex is broken.
* Keep it out of sunlight. Do not use it if it is discolored.
* Check the expiration date before using.
* The tubex is designed for a single injection. Squirt out the excess until the syringe contains the correct dose. Inject this amount.
* Epinephrine is a prescription drug. In an emergency, use it as directed in your guidelines and standing orders, then contact the physician.

Rev 6/77

IPECAC SYRUP U.S.P.

DIRECTIONS AND USES

* Ipecac causes vomiting. It is given to patients who have taken poisons or an overdose of drugs by mouth.

* The recommended dose is 15ml for adults and children. 15ml is one tablespoonful or approximately one-half of the 30ml bottle supplied to the village. The medicine should be taken with a full glass of water to assist the vomiting action. If the patient has not vomited after 15 to 20 minutes, give him another tablespoonful of ipecac.

WARNINGS

* Do not use ipecac if:

    * The patient is unconscious or semiconscious. He may choke on the vomitus.
    * The patient has swallowed lye, acid, or some other caustic material. The material will damage the esophogus more than the stomach.
    * The patient has swallowed strychnine poison. Strychnine may cause convulsions, especially if the patient is vomiting.
    * The patient has swallowed kerosene, gasoline, or a similar product. If he vomits, it may get in his lungs.

STORAGE AND DISPENSING DIRECTIONS

* Store ipecac at room temperature with the other oral liquids or tablets. Accidental freezing may break the bottle. If the bottle is not broken, the drug should be safe to use.
* Ipecac is a prescription drug. Use it as directed in the manual in an emergency, or as directed by a physician.

Rev 6/77

PILOCARPINE OPHTHALMIC SOLUTION

ISOPTO-CARPINE[R]
PILOCAR[R]

DESCRIPTION AND USES

* Pilocarpine reduces the size of the pupil and decreases the excessive pressure in the eye of a patient with glaucoma.

* If the patient has an attack of acute glaucoma, pilocarpine will reduce the pressure, relieve the pain, and prevent the damage to the retina.

    * The usual dose is 1 or 2 drops in the affected eye every 5 minutes for 30 minutes. The dose is then reduced to 2 drops every 4 hours.

    * The unaffected eye is usually treated with 1-2 drops every 4 hours.

WARNINGS

* Side effects are uncommon. If the large doses of the drops must be used, some of the medicine may be absorbed into the blood stream. The patient may have excessive saliva, sweating, nausea, vomiting, diarrhea, low blood pressure, constriction of the bronchials. If the patient has a history of asthma or urinary obstruction, watch the patient closely.

STORAGE AND DISPENSING DIRECTIONS

* Store this drug at room temperature with the other eye drops. Accidental freezing will not damage it, unless the bottle is broken.
* Pilocarpine is a prescription drug.

COMBISTIX

DESCRIPTION AND USES

* Combistix is a diagnostic tool. It can test the pH (acidity) of the urine, and the amount of glucose and protein in it. There are similar products (clinistix, uristix, etc) that can test for other items in the urine.

* Obtain a fresh urine sample. Dip a plastic combistix strip into the urine. Remove it immediately. Compare the tests squares with the squares on the bottle label. The glucose square must be compared exactly 10 seconds after the strip has been dipped into the urine.

STORAGE AND DISPENSING DIRECTIONS

* Store combistix at room temperature with your other diagnostic equipment. Keep the lid tightly closed.
* Combistix is not dated, but should be reasonably fresh. Do not use a bottle for more than 2 years. Keep the strip in the bottle until just before use.

HYDROCHLOROTHIAZIDE
50MG TABLETS

HYDRO-DIURIL® ESIDREX® ORETIC® HCTZ

DESCRIPTION AND USES

* Hydrochlorothiazide is a diuretic. It helps the body rid itself of excess sodium and water through the urine. It also reduces the blood pressure. It is used to treat hypertension (high blood pressure) and edema caused by pregnancy, premenstrual fluid retention, and congestive heart failure. The usual dose is 25 to 50mg (1/2 to 1 tablet) once or twice a day.

WARNINGS

* Hydrochlorothiazide causes few side effects. A few patients may have nausea, vomiting, diarrhea, dizziness, numbness or tingling, or allergic reactions.

* If the drug is taken for a long period of time, the body may become low on potassium. If the potassium level falls to low, the heart may develop an abnormal rhythm. If the patient is on hydrochlorothiazide for a long period, he should eat foods rich in potassium such as fruit juices, bananas and apricots.

* Do not give this drug to someone with kidney failure or the inability to make or pass urine

STORAGE AND DISPENSING DIRECTIONS

* Store hydrochlorothiazide at room temperature with the other oral tablets. It will not be damaged by accidental freezing.
* Check the expiration date before using.
* Tell the patient that he may pass more urine than normal when he first starts the drug.
* This is a prescription drug.

PROBENECID
500MG TABLETS

BENEMID[R]

DESCRIPTION AND USES

* Probenecid acts on the kidney to prevent the kidney from excreting penicillin or ampicillin into the urine. It is used with penicillin to extend the action of the penicillin in the treatment of gonorrhea. The probenecid has no antibiotic action of its own.

* The usual adult dose is 1.0 Gm (2 tablets) taken a half hour before the injection of 4.8 million units of procaine penicillin G. If the probenecid is used with oral ampicillin, the probenecid is taken at the same time as the ampicillin.

WARNINGS

* If the patient is allergic to penicillin, he may have a prolonged allergic reactions since he cannot rid himself of the penicillin readily.

STORAGE AND DISPENSING DIRECTIONS

* Store probenecid at room temperature with the other oral tablets. It will not be harmed by accidental freezing.
* Check the expiration date before using.
* Probenecid is a prescription drug.

NORTH PACIFIC MEDICAL CENTER
P. O. BOX 95
KODIAK, AK 99615
TELEPHONE (907) 486-4183

RON BROCKMAN, D. O.
ORTHOPAEDIC SURGERY
RICHARD HOLYOKE, PA-C

LOREN HALTER, D. O. (D.A.B.F.P.)
FAMILY MEDICINE
GARY HURLBURT, PA-C

March 18, 1980

Glenn Hackney
Senate
1136 Sunset Drive
Fairbanks, Alaska 99701

Dear Mr. Hackney,

House Bill 79 and Senate Bill 75 will soon be submitted to the floor during the upcoming session.

These bills authorize qualified optometrists to use certain diagnostic drugs in the course of their examinations to help them detect eye diseases. Since optometrists are held legally responsible for detecting eye diseases, they should certainly be allowed to use all of the diagnostic tools available to them, tools which they have already recieved the training to use in their schooling.

The majority of the states have already passed bills authorizing optometrists to utilize diagnostic pharmaceuticals. It would be to the advantage of all Alaskans for our legislators to follow suit and approve these bills. In out-lying areas, such as Kodiak, the optometrists are relied upon to recognize and handle problems that would normally be taken to an opthalmologist in the larger cities. Giving them the authority to use this valuable diagnostic aid will enable them to give better eye care to everyone in their community. House Bill 79 and Senate Bill 75 has our wholehearted support.

Sincerely yours,

Loren D. Halter D.O.

Loren Halter, D.O.

Ron Brockman, D.O.

Ron Brockman DO

Fill

P.O. Box 5492
North Pole, Alaska
March 22, 1980

The Honorable Glenn Hackney
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Glenn:

Just a note to let you know that I am definitely in favor of House Bill 79 and Senate Bill 75.

Optometrists need to be freed of this unnecessary restriction of eye drops for diagnosis. These Bills would only increase their efficiency.

Thanks and a big hello to Esther!

Sincerely,

Esther

(Mrs.) Esther T. De Witt

HB 75

March 14-1981

Dear Glenn Vankney

I would like you to vote for Bill #75, letting Alaskan Doctors of Optometry use eye drops whenever they need to for diagnosing eye problems. This seems only right since they are allowed to in the military and in other States

Mrs Shirley Lewis

Mrs Shirley Lewis
SR Box 30696
Fairbanks Ak 99701

JOHN J. EUFEMIO, M. D.
BOX 907
KODIAK, ALASKA 99615

TELEPHONE 486-4191

14 March 1980

Dear Senator Hackney:

This letter is to inform you of my support of House Bill 79 and Senate Bill 75.

Doctors of Optometry are well qualified to use diagnostic pharmaceutical agents and need them to provide better eye care for the Alaskan consumer.

I hope you will provide the support necessary to pass this much needed legislation.

Yours truly,

John J. Eufemio
M.D. FACS

file
SB 75

Capt Richard L. Wilson
5249-G Broadway
Eielson AFB, AK 99702

March 14, 1980

Hon. Glenn Hackney
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney,

Regarding Senate Bill no 75:

I am in favor of amending Alaska law so that Doctors of Optometry in Alaska can legally use eye drops for diagnosis. Optometrists in the armed forces, of which I am a member, and optometrists in other states have been using eye drops for some time.

I urge passage of Bill 75.

Richard L. Wilson

Fill

3/14/80

Sen Glenn Hackney
Ak State Senate

I would like you to support
Senate Bill #75.

This allows Doctor of Optometry
to use diagnostic eye drops. Otherwise
patient pays more to go to a M.D.
for the eyedrops.

Thank You.

Louise King
SR Box 80391
Fairbanks, Ak. 99701

March 10, 1980

Senator Glenn Hackney
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Sen. Hackney:

We urge your support in seeing that Senate Bill #75 is passed.

We find it very difficult to believe that the Ophthalmologists are opposing the bill. What is their reasoning for such opposition?

32 states, including Georgia, who passed their drug bill Feb., 1980, are either authorized by statue or permitted to legally use diagnostic drugs for detection of eye diseases. Are these 32 states all wrong and the opposition in Alaska correct? Early detection of eye disease is a very important "preventive medicine" issue, not a pokitical issue.

As concerned tax paying citizens we again urge your support.

Molly Rankin

Molly Rankin
SR Box 30075
Fairbanks, Alaska 99701

3/13/82

Dear Senator Hackney,

Please vote yes in favor on Senate Bill # 75 for the use of diagnostic drugs in Optometry.

Robert D Rutt

751 OLD RICHARDSON HWY

FBKS, AK

P O Box 1091
Fairbanks AK 99707
March 12, 1980

The Honorable Senator Glen Hackney
State of Alaska
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney,

I urge you to support Senate Bill 75. This Bill, by allowing properly trained optometrists to administer diagnostic eye drops, would alleviate inequities in the medical practice in this state and improve health care for Alaskans.

Thank you for your consideration of my opinion.

Sincerely,

Susan M. Aronson

Susan M. Aronson

March 13-1980

Senator Glenn Hackney
Alaska State Senate
Pouch V
Juneau, AK 99811

Dear Mr. Hackney,

Please vote for Senate Bill 45. This law will be in the best interests of eye care for Alaskans.

Thank You

Mrs Jeannie Wright
S.R. Box 60612
Fairbanks, AK 99701

DR. CURTIS M. JOHNSON
DR. D. R. SCHMIDT
OPTOMETRISTS
530 SEVENTH AVENUE
FAIRBANKS, ALASKA 99701

Telephone {456-4010 / 452-5252}

Representative Thelma Bucholdt
Pouch V
Juneau, Alaska 99811

Dear Representative Bucholdt;

We support and urge you to support the passage of H. B. 79 which would allow optometrists to use diagnostic pharmaceutical agents.

SIGNATURE	ADDRESS
Shirley Pomeroy	P.O. Box 10347
Lester Secrest	PO Box 1095
[illegible]	110 Brigham Way
[illegible]	1647 MADISON DR., FBKS.
[illegible] L. Melville	SR 50525-P Fbks
Gilbert Sterling	1126 Lakeview Ter. Fbks. AK.
E. A. Rublee	748.5 Gaffney Rd. Fbks., AK.
June M. Rublee	3279 Jefferson Fbk 99701
Gary L. Sawdy	SR 10258, Fairbanks, AK 99701
Louis J. Thornley	SR 30271-A Fairbanks AK 99701
Doug Lanni	mile 195 Rich. hwy 99737
Ron Lanni	Mile 195 Rich. hwy 99737
R. Holman	7m Badger Road FBKS
Anton Malde	Manley Hot Springs
Susan Brickelbey	1400 Wedgewood 6H FBKS.
Mary Cronin	" " " "

File SB 75

Mr. and Mrs. S.H. Carter, Jr.
SR Box 20039
Fairbanks, Alaska 99701

March 7, 1980

The Honorable Glenn Hackney
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney:

We request your support for Senate Bill #75, which is in your committee. It allows optometrists to use certain drugs that relate to their work in detecting eye diseases.

We understand that village health aides, with 20 weeks of training can use these and many other drugs, while the optometrist with 6 to 8 years of training, cannot. This certainly is not in the interest of Alaskans who go to optometrists for their eye examinations.

Very truly yours,

Mr. & Mrs. S.H. Carter, Jr.

Mr. and Mrs. S.H. Carter, Jr.

Jul 531

DR. CURTIS M. JOHNSON
DR. D. R. SCHMIDT
OPTOMETRISTS
330 SEVENTH AVENUE
FAIRBANKS, ALASKA 99701
Telephone [illegible]

Representative Thelma Bucholdt
Pouch V
Juneau, Alaska 99811

Dear Representative Bucholdt;

We support and urge you to support the passage of H. B. 79 which would allow optometrists to use diagnostic pharmaceutical agents.

SIGNATURE	ADDRESS
Patricia Rosen	PO Box 213 Fbks.
Diana Brockelsby	410 Wedgewood 3H, Fbks
Jeanette Kimberlin	SR Box 10413, Fbks. 99701
Rebecca R Owen	PO Box 10258 Fbks. AK. 99701
Lewis J Gibson	4636 8th St Fairbanks 99701
Anna Gibson	4636 8th St. "
Jeff Lucas	301 Glacier Ave
Heather L Sewell	PO Box 234, Clear, AK.
CURT DORAN	542 CRAIG AVE, FAIRBANKS
[illegible]	Box Locke #301, AK 99706
Edgar Olsen	1213 - 5th Fairbanks 99701
Norma Carlo	136 Denkel, Fairbanks
Shawn Block	SR 50505 - Fairbanks
Ken Frost	Box 508 Nikiski AK.
Pat Driscoll	1126 Park Drive

E. E. BACH, O.D.
PHILLIP W. BACH, O.D., PH.D.
OPTOMETRY
SUITE 204 DENALI PROFESSIONAL CENTER
3401 DENALI STREET
ANCHORAGE, ALASKA 99503

March 1, 1980

The Honorable Robert H. Ziegler, Sr.
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Ziegler:

I am taking the liberty of responding to your letter of February 11 to Dr. Craig, a copy of which he has sent to me. Am sending a copy of this letter to Senators Hackney and Colletta since their committees are also involved in SB 75.

First, your exchange of letters between the two professions is an interesting and potentially useful means of furthering communication.

I can understand your reluctance to adjudicate, as a layman, a dispute involving technical considerations, though this occurs frequently in the legislature. However we are not asking you to decide the matter or even take sides; we are simply asking that you and your committee allow the bill to be considered by the full Senate. You can avoid taking sides by passing the bill out without recommendation.

As to the question of compromise you mentioned, you are probably aware of the meeting that took place in Sen. Colletta's office on February 11, perhaps after you wrote your letter. The ophthalmologists would accept nothing less than total withdrawal of the bill. Nevertheless we still developed an amendment (relating to a drug selection body) that would satisfy some concerns raised by Sen. Colletta.

The ophthalmologists do not have a case. And since Alaska is one of only 18 states that still prohibit the use of diagnostic pharmaceuticals by optometrists, I am sure you can understand that there is no way we are going to give up on this issue. You three gentlemen have the power to prevent this from becoming a long and bitter battle, one that the ophthalmologists are ultimately going to lose.

Very truly yours,

Phillip W. Bach

Phillip W. Bach, O.D., Ph.D.

PWB/sn

cc: Senator Glenn Hackney
Senator Mike Colletta

Alaska State Legislature

SENATOR
ROBERT H. ZIEGLER, SR.
307 BAWDEN STREET
KETCHIKAN, ALASKA 99901

POUCH V
JUNEAU, ALASKA 99811

Senate

CHAIRMAN
SENATE JUDICIARY COMMITTEE
IMMEDIATE PAST CHAIRMAN
WESTERN CONFERENCE - COUNCIL OF STATE GOVERNMENTS

VICE CHAIRMAN
SENATE RULES COMMITTEE

MEMBER
SENATE STATE AFFAIRS COMMITTEE
SENATE COMMITTEE ON COMMITTEES
LEGISLATIVE COUNCIL
WESTERN STATES LEGISLATIVE FORESTRY TASK FORCE

February 11, 1980

Dr. Ed Craig
Optometrist
348 Main Street
Ketchikan, Alaska 99901

Dear Ed:

I am sending a copy of this letter, as you will note, together with a copy of your letter to me of January 8, to Dr. Page.

I am enclosing a copy of Dr. Page's letter to me of January 31.

It is quite clear that the opthamologists and the optometrists are never going to see eye to eye (no pun intended). When feuding factions of any given profession can not agree between themselves as to what should or should not be done, and if those feuding factions want a layman to adjudicate their disputes, I personally resent it. If the warring cliques can't resolve their differences, what makes them think that I can?

I don't at this time intend to take any affirmative action on either HB 79 or SB 75. However, in the unlikely event a compromise is struck, I'll move right along.

Please, please, no more literature! I've seen enough from both sides in the last three years to last me a life time.

Regards,

Robert H. Ziegler, Sr.

cc: Dr. Page

Enclosure

RHZ:lk

02093 NL ANCHORAGE ALASKA 160 02-27 500P AST

SB 5

PMS SEN GLEN HACKNEY

JUN

THE ALASKA STATE MEDICAL ASSOCIATION LEGISLATIVE COMMITTEE HAS REVIEWED SB75, AN ACT RELATING TOTHE PRACTICE OF OPTOMETRY. CORRESPONDENCE RELATING TO THE ISSUE DURING THE 1978 LEGISLATIVE SESSION WILL BE FORWARDED. THE POSITION OF 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 FOT THE DRUG CLASS MIOTICS, REQUESTED; IN CONVERSE, THEIR USE WOULD BE APPROPRIATE FOR TREATMENT OF NARROW ANGLE GLAUCOMA, PRECIPITATED BY A MYDRIATIC/ CYCLOPEGIC USE. THIS CONDITION WE UNDERSTAND IS MORE PREVALENT AMONG THE ALASKA NATIVE THAN THE GENERAL POPULATION, SUCH THAT BUSH USE OF THESE DRUGS COULD CARRY INCREASED RISKS.

3. WE APPROVE THE EDUCATIONAL REQUIREMENTS ADDED IN THE 1979 LEGISLATURE. IT FOLLOWS THAT SHOULD THE LEGISLATURE BELIEVE THE PROPOSED LEGISLATION IS IN THE BROAD PUBLIC RATHER THAN FOR SPECIAL INTERESTS NO GRANDFATHER TYPE CLAUSE SHOULD BE ALLOWED.

SINCERELY, WINTHROP FISH, MD,

CHAIRMAN LEGISLATIVE COMMITTEE

ALASKA STATE MEDICAL ASSOCIATION

TELEGRAM

ROA ALASKA COMMUNICATIONS, INC.
P ONE [illegible]-6442
JUNEAU, ALASKA 99802

Ø2Ø94 NL ANCHORAGE ALASKA 159 Ø2-27 5ØØP AST

PMS SENGLENN HACKNEY

JUN

A POTENTIAL THREAT TO THE PUBLIC EXISTS BY THE PASSAGE OF SB75 WHICH ALLOWS NON-PHYSICIAN EYE CARE PRACTITIONERS (OPTOMETRISTS) TO ADMINISTER DANGEROUS EYE MEDICATIONS FOR DIAGNOSTIC PURPOSES WITHOUT PHYSICIAN SUPERVISION. THE DESIRE DRUGS ARE LISTED IN THE PROPOSED BILLS IN THE BROAD GENERAL CATEGORIES OF TOPICAL ANESTHESICS, MYDRIATICS, CYCLOPEGICS AND MIOTICS RATHER THAN BY SPECIFIC DRUGS NAMES WITH DOSAGES. EXAMPLES OF THE DRUGS FOUND IN THESE CATEGORIES INCLUDE SUCH POTENT MEDICATIONS AS COCAINE, ATROPHINE, SCOPOLAMINE, PHENYLEPHRINE, AND PHOSPHOLINE IODINE. ALL OF THESE MEDICATIONS HAVE POTENTIALLY DANGEROUS SYSTEMATIC SIDE EFFECTS. THE SPECIFIC CLASS BIOTICS CONTAIN NO DIAGNOSTIC DRUGS WHATSOEVER AS THEY ARE ALL THERAPUTIC MEDICATIONS USED FOR TREATMENT OF GLAUCOMA OR CERTAIN CASES OF CROSSED EYES. THE ANCHORAGE MEDICAL SOCIETY VOTED OVERWHELMINGLY TO OPPOSE THISE LEGISLATION AS PASSAGE WOULD PERMIT NON-MEDICAL PRACTITIONERS TO PRESCRIBE OR APPLY DRUGS. THIS IS CONTRARY TO THE HEALTH AND WELFARE OF PEOPLE OF ALASKA.

ANCHORAGE MEDICAL SOCIETY PRESIDENT, JERRY LITTLE, MD.

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

February 26, 1979

Senator Glenn Hackney, Chairman
Alaska State Senate
Health, Education, and Social Services Committee
Pouch V, Mail Stop #3100
Juneau, Alaska 99811

Dear Mr. Hackney:

The Alaska State Medical Association Legislative Committee has reviewed Senate Bill 75, 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 increase 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,

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 contemplated, 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

ANCHORAGE MEDICAL SOCIETY
1135 W. 8TH AVE., SUITE 6
ANCHORAGE, ALASKA 99501
907-277-6891

February 26, 1979

Medical Society Position Paper

A potential threat to the public exists by the passage of HB 79 and SB 75 which allows non-physician eye care practitioners (optometrists) to administer dangerous eye medications, for diagnostic purposes, without physician supervision.

The desired drugs are listed in the proposed bills in the broad general categories of topical anesthesics, mydriatics, cycloplegics and miotics rather than by specific drug names with dosages. Examples of the drugs found in these categories include such potent medications as Cocaine, Atropine, Scopolamine, Phenylephrine and Phospholine Iodide. All of these medications have potentially dangerous systemic side effects. The specific class miotics contain no diagnostic drugs what-so-ever as they are all therapeutic medications used for treatment of glaucoma or certain cases of crossed eyes.

The Anchorage Medical Society voted overwhelmingly to oppose this legislation as passage would permit non-medical practitioners to prescribe or apply drugs. This is contrary to the public interest and a detriment to the health and welfare of the people of Alaska.

Anchorage Medical Society
Jerry Little, M.D., President

JL:ma

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

Chairman Glenn Hackney
Senate HESS Committee
Pouch V
Mail Stop Number 3100
Juneau, Alaska 99811

Dear Chairman Hackney:

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 in 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 side 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

3311 EUREKA St.#3
Anchorage, Ak.99503
March 3,1979

Dear Mr. Hackney,

It is my understanding that Senate Bill 75 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: iet 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 consitutes 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 intraveniously 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

MEMORANDUM

February 5, 1979

TO: Senator Hackney
Chairman, HESS Committee

FROM: Margaret Branson
Representative

RE: SB 75 Optometry and Drugs

As the Chairman of the Committee of first referral, I thought this material on SB 75 properly belongs in your files for consideration by your committee.

FILE

Peninsula Eye Clinic
PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669

TELEPHONE 262-4462

February 1, 1979

Margaret Branson, Representative
Pouch V
Juneau, Alaska 99811

Dear Margaret;

Thank you for notifying me of SB 75! This is the second year for this bill as it was "killed" in the Senate last session. Ophthalmologists have very strong feelings toward this legislation because it is obvious that optometrists have no medical training what-ever (despite their claims) and it is not fair to the public to turn them loose dispensing eye drops. Optometrists are very well trained to fit eye-glasses, but the last few years have desired to expand their endeavours to include the use of eye drops.

Reasons for this desire are purely economic! Therefore - - see the arrival of a national health bill and want a guarantee that they will be included in this legislation as a "primary care providors".

Eye drops are absorbed into the blood stream and become systemic medications. Although rare they can produce serious side reactions such as high blood pressure and indeed shock! It is not fair to the public to relegate such serious matters to a non-medical practionor.

Medicine contends that if non-medical practionors wish to expand their endeavors to include medical functions they should re-cycle themselves thru the medical curriculum rather than going to the legislators and side-passing the educational pre-requisites.

Sincerely,

Peter E. Cannava, M.D.

Peter E. Cannava, M.D.

P.S. Enclosed please find a speech I gave to the local legislators before they departed to Juneau.

P.S. In addition you should be aware that a young Alaskan lost an eye because of an optometrist, in using eye drops, felt secure in making a diagnosis which turned out to be erroneous. The story is enclosed.

PEC/bc

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.

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

festation 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.

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. ●

...tates of America, defendant. In his opinion, Judge Fitzgerald stated, "An optometrist's responsibility is to observe during his eye examinations any mani-

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.

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

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.**

Mary Please have Lois Bro. Sit [illegible] for Senator HESS.

Explorations in Living offers a stimulating learning opportunity for young people and for those who present and guide the program. Hopefully, this new kind of preventive mental health program will help students develop into more informed and responsible citizens.

Explorations in Living can be obtained from Paul B. Amidon and Associates, Inc., 1966 Benson Avenue, St. Paul, Minnesota 55116 (cost is $18.50 per unit).

A GUIDE TO FEDERAL HOUSING PROGRAMS FOR THE MENTALLY DISABLED

This guide is designed to provide specific information about Federal housing programs and their potential for helping develop residential options for people disabled by mental health problems. It is intended primarily for State and local mental health program development staffs and others involved in community care.

The guide begins with an explanation of the Federal housing programs which may be applicable to the mentally disabled. It also discusses funding alternatives for specific residential options. Finally, the guide summarizes various strategies which State and local agencies can use in both securing funds and developing residential programs. Appendices include a list of key people in HUD area and regional offices, names and addresses of relevent projects, and several other important supplemental materials and references.

Published by the National Institute of Mental Health, it is available from Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, Stock No. 017-024-00727-7, at a cost of $3.00 each.

THE SWITCH PROCESS IN MANIC-DEPRESSIVE ILLNESS

In manic-depressive illness, the process of change from a severely depressed to a manic phase can occur anywhere between a few minutes and a few days. Analysis of the "switch process" has given psychobiologists important insights into the chemical processes associated with changes in brain neurons in affective illnesses.

Dr. William E. Bunney, Jr., Chief of the Biological Psychiatry Branch of the National Institute of Mental Health's Intramural Research Program has studied manic-depressive patients, focusing on the neurotransmitter mechanisms that carry impulses from one neuron to another at the synapse. He theorizes that elevated or reduced levels of the neurotransmitters, norepinephrine and dopamine, may be responsible for the sudden shift from one state to the other. In the 14-page monograph, Bunney discusses the switch process and his study of what happens in the brain during the switch.

This publication, published by the National Institute of Mental Health, Division of Scientific and Public Information, is available from Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, Stock No. 017-024-00733-1, 90 cents each.

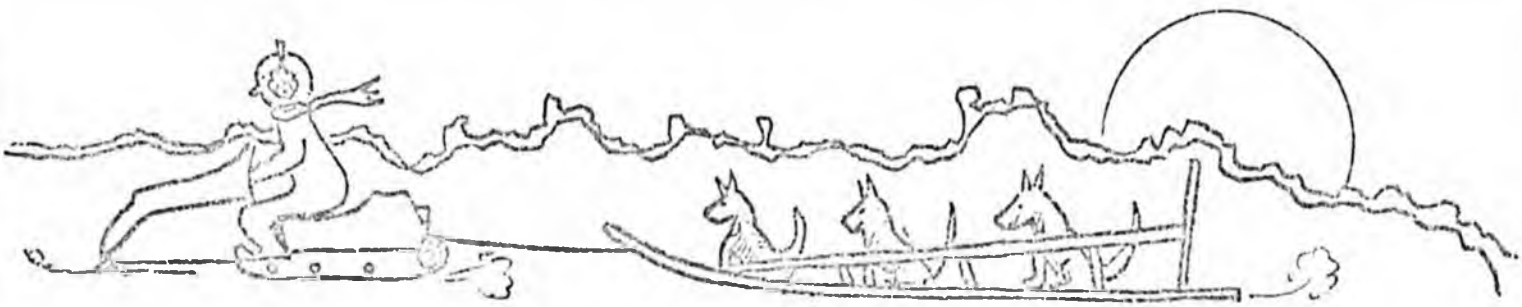
FAMILY VIOLENCE GRANT

The Department of Health and Social Services applied for and received a grant from the Law Enforcement Assistance Administration in the amount of $260,866 to operate a program called the Alaska Family Violence Program. A brief descriptive summary of this program that was taken from the grant award says, "The purpose of Alaska's Family Violence Program is to initiate and monitor a project directed at reducing the incidence of intra-family violance. The program will be implemented by agencies or citizen groups at eight (8) locations throughout Alaska...Nome, Bethel, Anchorage, Kenai, Fairbanks, Barrow, Kodiak and Ketchikan as well as many small communities within their respective locales.

"Various community-wide approaches will be tested. These approaches include: regional shelters and transportation shelters, "safe homes", crisis lines, volunteer advocacy, media and public education, training for criminal justice, medical and mental health personnel, alternatives to prosecution for offenders and innovative procedures for law enforcement personnel responding to family disturbance calls.

"The anticipated impact of this program will not only be an actual reduction in intra-family violence, but will also provide more effective and efficient mechanisms for agency coordination, a reduction in the number of repeat calls, an increase in the number of prosecutions and constructive alternatives to prosecution, decreased public tolerance for intra-family violance, and more information and understanding of the level and nature of intra-family violence in Alaska."

We hope to hear more about this new program as it gets underway. Meanwhile, if you want more information, please contact Sema Lederman, Project Coordinator, 400 Gamble, 3rd Floor, Anchorage, Alaska 99510 (276-1024).



The Division of Mental Health
and Developmental Disabilities
Pouch H-04
Juneau, Alaska 99811

Alaska Anthracite

File with SB —
opp. bill, please.

(3)

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 Glenn Hackney
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney:

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 rationalized.

ROBERT N. PAGE, JR., M.D.
JUNEAU MEDICAL CENTER
R.R. 3, BOX 3051
JUNEAU, ALASKA 99801

PRACTICE LIMITED TO THE EYE

February 27, 1979

Honorable Glenn Hackney
Senator
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney:

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

$250,000 awarded the Steeles 27 Feb 1978

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 be 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 a supper 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 telling 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 reject 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....

VOLUME 3, NUMBER 1
DECEMBER 15, 1978 - JANUARY 1, 1979
ST. PETERSBURG, FLORIDA

EDITORS

Medical Editors: James H. Allen, M.D., New Orleans, La.; Leonard B. Alenick, M.D., Tacoma, Wash.
Contributing Editors: Roland E. Houle, M.D., Quincy, Mass.; David W. Parke, M.D., Meridan, Conn.
Staff Editors (St. Petersburg, Fla.): George P. Russell, Frank T. Barnes, Richard D. Painter
Production Manager: Edward S. Barclay

Published in the Public Interest by The Physicians Education Network, Inc. a non-profit corporation headquartered at 5013 Central Avenue, St. Petersburg, Florida 33710. (813) 347-5111.

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

Continued on page 6

FOUNDER S

Och

The acco
PEN's Intern
legend in the
PEN,. "The
have ever ob
said, "Ophth
one of God's
in the trenche
epidemic of i
lic by some
exaggerations
of a non-argu

Free-lanc
an article titl
Strong," whi
August 25, 1
essence of th
press its app
JAMA for p
terial in a sc

"Alton Ochsn

The tren
ican life, tov
petence whil
Ochsner. "Th
physicians r
I fear we a
technicians,
whole patien
they must si
history, do
the findings
After that,
the laborator
accept it. If
findings and
I know, but

Ochsner
(the Ochsne
American pu
hypochondri
Although Oc
thing about
came convin
difficulties t
diagnosed h
test disagre
Ochsner in
therapy. "Th
office and st
in years.' Wh
derness over
ing carefully
'I wake up
weight in a
one foot aft
is character
to the patie
ceptions, tra
of their con
them. I can'

As Ochs
career, he h
bution to m
to be remem
fessor of su
tions from
dents and fr
at the Ochs
will ever fo
"bull pen"
"Why Clini
barraging a
Why?" dem
analyze and
thought thr
sponse, the
Ochsner int
with one ad

Who w
Remarkable
"indefatigal

"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 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 accommodative 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-

Continued on page 4

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

Continued from page 3

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-

Continued on page 5

JUDGE'S DECISION

Continued from page 4

plastic primary vitreous, a congenital defect 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 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 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. Dr. Krupp, a principal government witness at trial, 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 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.

(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 larval migrans, the disease caused by toxocara canis, 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. Shrank'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.

/s/ James M. Fitzgerald
United States District Judge

---

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 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.

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. 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.

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 amblyopia.

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, M.D.
PEN'S International Advisory Board Chairman

"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 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 to 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)

Date_____ 19____

Name_____

Address_____

City_____ State_____ Zip_____

Telephone: (Area)_____ Number_____

Ophthalmologist?____ Other specialty_____

Profession, other than M.D.?_____

Check enclosed ($250)____ Please bill me_____

☐ Resident Dues $25.00
☐ Affiliate (spouses, office staff) $25.00
☐ Military M.D.s $150.00

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 G. 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

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.

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

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. ●

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

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.

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.

MAIL SUBSCRIBER:

BULK RATE
U.S. POSTAGE
PAID
SEMINOLE, FLA.
PERMIT NO. 11

"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. ●

MAIL SUBSCRIBER:

BULK RATE
U.S. POSTAGE
PAID
SEMINOLE, FLA.
PERMIT NO. 11

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

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.

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 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.

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

EDITORS

Medical Editors: James H. Allen, M.D., New Orleans, La.; Leonard B. Alcnick, M.D., Tacoma, Wash.
Contributing Editors: Roland E. Houle, M.D., Quincy, Mass.; David W. Parke, M.D., Meridan, Conn.
Staff Editors (St. Petersburg, Fla.): George P. Russell, Frank T. Barnes
Production Manager: Edward S. Barclay

Published in the Public Interest by The Physicians Education Network, Inc. a non-profit corporation headquartered at 5013 Central Avenue, St. Petersburg, Florida 33710. (813) 347-5111.

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 of age or after, 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 Ophthalmologist is an

M.D.

an optometrist is not.

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: irregular vasis is a chronic disease characterized by 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. 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 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," 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, "But this was in Huey Long's heyday, and I didn't include Huey in my reckoning — nor a doctor's desire for revenge on me for refusing 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, it will turn out for the best"), personal tragedy has been no stranger to Alton Ochsner. His first 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 Central. 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." ●

1978 American Medical Association®

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)

Date_____ 19____

Name_____

Address_____

City_____ State_____ Zip_____

Telephone: (Area)_____ Number_____

Ophthalmologist?_____ Other specialty_____

Profession, other than M.D.?_____

Check enclosed ($250)_____ Please bill me_____

☐ Resident Dues $25.00
☐ Affiliate (spouses, office staff) $25.00
☐ Military M.D.s $150.00

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, [illegible] curriculum and periodic ther 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

Published in the Public Interest by Ophthalmology

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.

MAIL SUBSCRIBER:

BULK RATE
U.S. POSTAGE
PAID
SEMINOLE, FLA.
PERMIT NO. 11

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

EDITORS

Medical Editors: James H. Allen, M.D., New Orleans, La.; Leonard B. Alenick, M.D., Tacoma, Wash.
Contributing Editors: Roland E. Houle, M.D., Quincy, Mass.; David W. Parke, M.D., Meridan, Conn.
Staff Editors (St. Petersburg, Fla.): George P. Russell, Frank T. Barnes, Richard D. Painter
Production Manager: Edward S. Barclay

Published in the Public Interest by The Physicians Education Network, Inc. a non-profit corporation headquartered at 5013 Central Avenue, St. Petersburg, Florida 33710. (813) 347-5111.

"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.

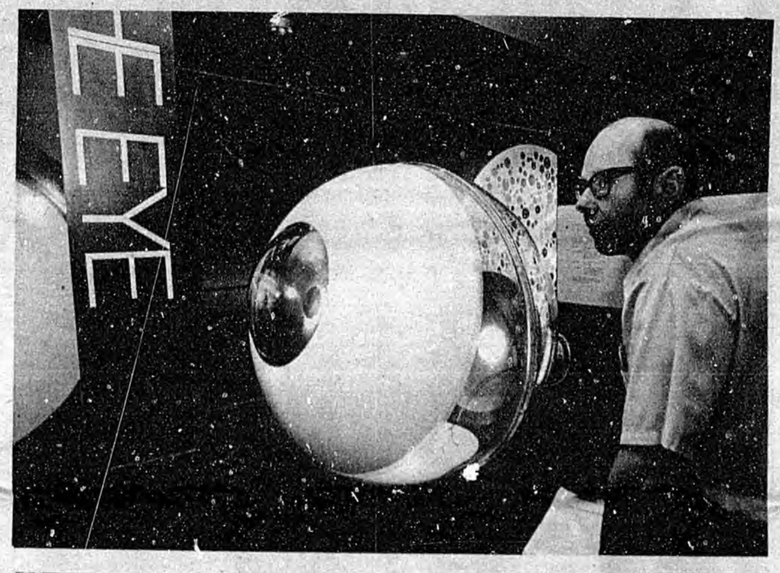
By pushing buttons, the viewer is able to activate functional parts of the exhibit to show how the iris changes its size related to changing levels of light. Supporting exhibits include visual acuity, peripheral vision, color vision, depth perception and even one which shows the viewer the pupil of his own eye dilating and contracting as light values change.

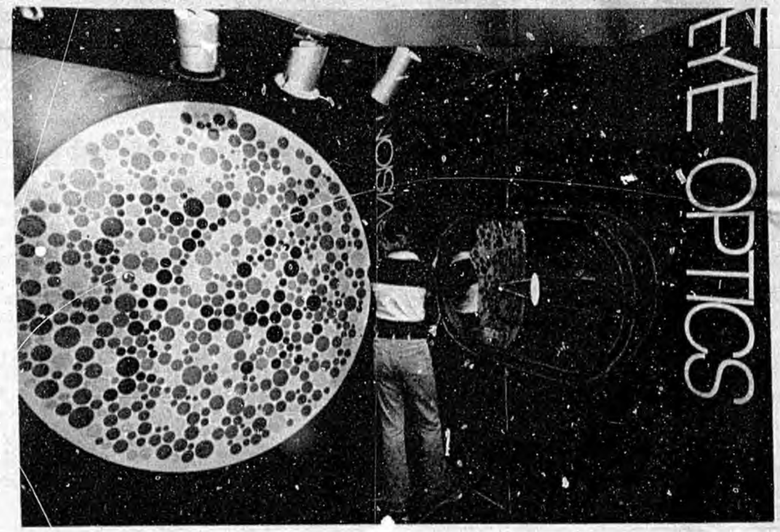
Under Mr. Levy's direction, and in cooperation with expert ophthalmologists, the entire concept, design and construction of the exhibit was completed by the OMSI Exhibits staff.

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 ad[illegible] 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. The bill should be defeated them.

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.

DR. CURTIS M. JOHNSON
DR. D. R. SCHMIDT
OPTOMETRISTS
530 SEVENTH AVENUE
FAIRBANKS, ALASKA 99701

Telephone {456-4010
452-3232

Dear Senator Hackney,

The attached bills, House Bill 79 and Senate Bill 75, are in committee and we expect them to be reported to the floor during the upcoming session. They provide for the use of certain diagnostic drugs by optometrists to aid them in detecting eye diseases. The drugs are instilled as eye drops. Optometrists are legally responsible for detecting eye diseases in the course of their examination.

The types of pharmaceutical agents and their uses are described briefly on the second attachment. These are not used routinely with every patient. They are used when needed to adequately examine the eye for pathology.

Doctors of optometry are well qualified to use drugs. The optometric curriculum includes courses in general and ocular pharmacology. These are circled in the attached curriculum of a typical optometry school. Pharmacology is the study of the mechanism of action of a drug, side effects, disposal by the body, etc. Any practitioner who graduated before pharmacology became a part of his school curriculum would be required to complete an appropriate course before being authorized by the licensing authority to use the drugs.

The fourth attachment shows the history of legislation pertaining to pharmaceuticals used by the profession. This is followed by a map showing those states that presently authorize the use of diagnostic pharmaceutical agents (DPAs) by optometrists. States show white, including Alaska, are those in which their use is not yet permitted.

It is in the interest of every member of the public to support this legislation. The professional man should be given all the appropriate tools of his trade. Therefore the Alaska Optometric Association endorses this bill, and we urge that you give it your support as well.

Very truly yours,

Curtis M. Johnson, O.D.

FUNDUS of the Human Eye

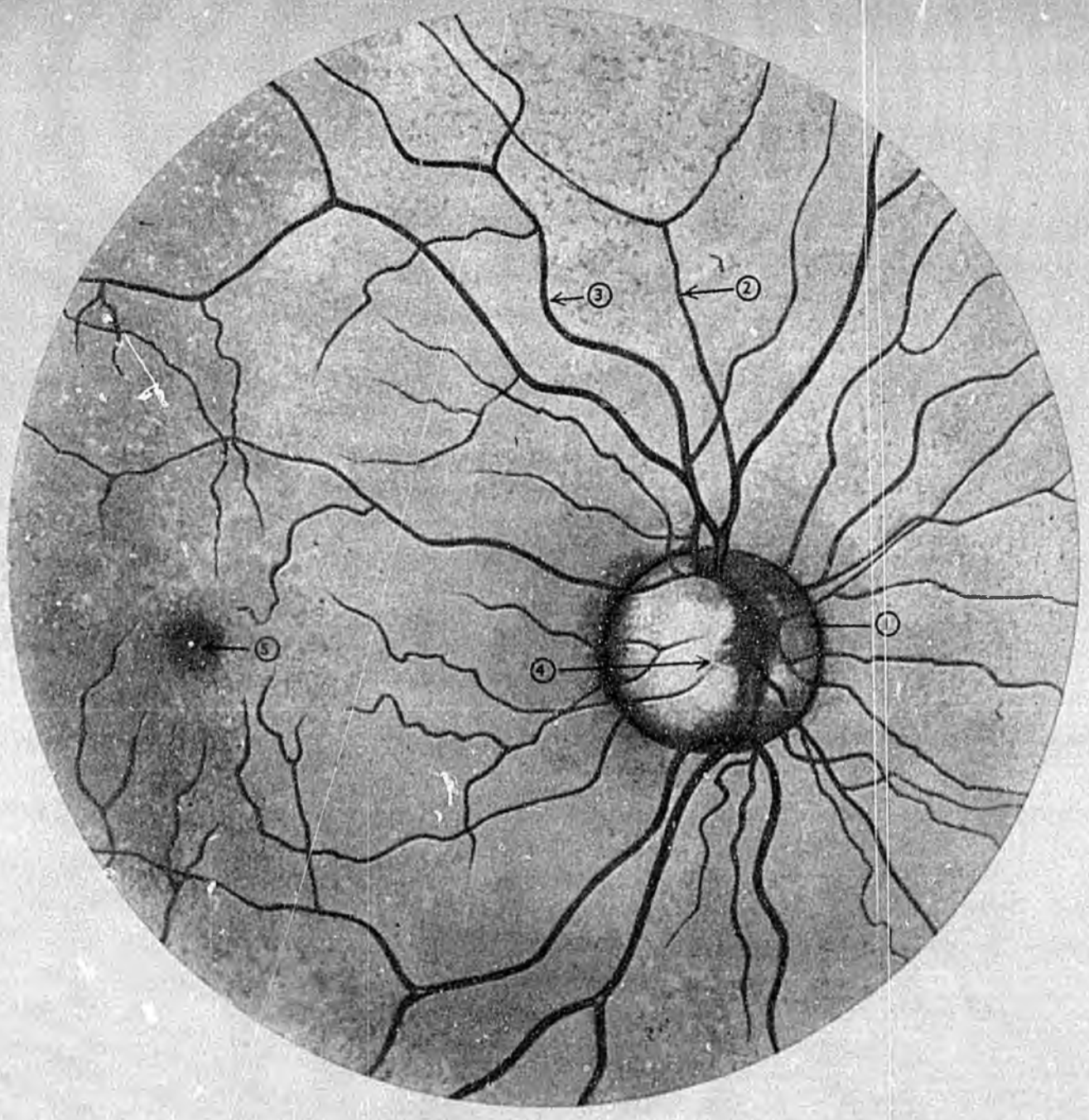
1 OPTIC DISC (NERVE HEAD)
2 ARTERY
3 VEIN
4 PHYSIOLOGICAL CUP
5 MACULA

Examination of the fundus with an ophthalmoscope allows us to see living blood vessels in their natural state.

The disc is examined for clarity of outline, color, shape, elevation above or below surrounding tissues.

Blood vessels are observed for condition, size ratio, tortuosity, regularity of caliber, exudates and hemorrhages.

Study of the fundus may reveal evidence of many systemic diseases as well as eye disease and abnormality.



AMERICAN OPTOMETRIC ASSOCIATION
7000 Chippewa St.
St. Louis, Mo. 63119

G-10 7/69 20L

E. E. BACH, O.D.
PHILLIP W. BACH, O.D., PH.D.
OPTOMETRY
SUITE 204 DENALI PROFESSIONAL CENTER
3401 DENALI STREET
ANCHORAGE, ALASKA 99503

Dear Legislator,

The attached bills, House Bill 79 and Senate Bill 75, are in committee and we expect them to be reported to the floor during the upcoming session. They provide for the use of certain diagnostic drugs by optometrists to aid them in detecting eye diseases. The drugs are instilled as eye drops. Optometrists are legally responsible for detecting eye diseases in the course of their examination.

The types of pharmaceutical agents and their uses are described briefly on the second attachment. These are not used routinely with every patient. They are used when needed to adequately examine the eye for pathology.

Doctors of optometry are well qualified to use drugs. The optometric curriculum includes courses in general and ocular pharmacology. These are circled in the attached curriculum of a typical optometry school. Pharmacology is the study of the mechanism of action of a drug, side effects, disposal by the body, etc. Any practitioner who graduated before pharmacology became a part of his school curriculum would be required to complete an appropriate course before being authorized by the licensing authority to use the drugs.

The fourth attachment shows the history of legislation pertaining to pharmaceuticals used by the profession. This is followed by a map showing those states that presently authorize the use of diagnostic pharmaceutical agents (DPAs) by optometrists. States shown white, including Alaska, are those in which their use is not yet permitted.

It is in the interest of every member of the public to support this legislation. The professional man should be given all the appropriate tools of his trade. Therefore the Alaska Optometric Association endorses this bill, and we urge that you give it your support as well.

Very truly yours,

Phillip W Bach

Phillip W. Bach, O.D., Ph.D.

E. E. BACH, O.D.
PHILLIP W. BACH, O.D., PH.D.
OPTOMETRY
SUITE 204 DENALI PROFESSIONAL CENTER
3401 DENALI STREET
ANCHORAGE, ALASKA 99503

Dear Legislator,

The attached bills, House Bill 79 and Senate Bill 75, are in committee and we expect them to be reported to the floor during the upcoming session. They provide for the use of certain diagnostic drugs by optometrists to aid them in detecting eye diseases. The drugs are instilled as eye drops. Optometrists are legally responsible for detecting eye diseases in the course of their examination.

The types of pharmaceutical agents and their uses are described briefly on the second attachment. These are not used routinely with every patient. They are used when needed to adequately examine the eye for pathology.

Doctors of optometry are well qualified to use drugs. The optometric curriculum includes courses in general and ocular pharmacology. These are circled on the attached curriculum of a typical optometry school. Pharmacology is the study of the mechanism of action of a drug, side effects, disposal by the body, etc. Any practitioner who graduated before pharmacology became a part of his school curriculum would be required to complete an appropriate course before being authorized by the licensing authority to use the drugs.

The fourth attachment shows the history of legislation pertaining to pharmaceuticals used by the profession. This is followed by a map showing those states that presently authorize the use of diagnostic pharmaceutical agents (DPAs) by optometrists. States shown white, including Alaska, are those in which their use is not yet permitted.

It is in the interest of every member of the public to support this legislation. The professional man should be given all the appropriate tools of his trade. Therefore the Alaska Optometric Association endorses this bill, and we urge that you give it your support as well.

Very truly yours,

Phillip W Bach

Phillip W. Bach, O.D., Ph.D.

DEFINITIONS

Mydriatics - this type of pharmaceutical agent dilates the pupil to provide an improved view of the retina. This is particularly useful in patients with small pupils or those who have central cataracts (opacifications in the lens of the eye).

Corneal anesthetics - these temporarily remove corneal sensitivity to allow special viewing instruments to be placed in contact with the cornea.

Cycloplegics - used to inactivate the nearpoint focusing mechanism of the eye. This provides a better estimate of the required correcting lens power in certain cases, such as some farsighted individuals.

Miotics - these constrict the pupil and lower the fluid pressure in the eye in the rare cases where the pressure is raised abnormally by the mydriatic.

COURSE DESCRIPTIONS

ANATOMY (ANAT.)
BIOCHEMISTRY (BYC.)
MICROBIOLOGY (MIC.)
OPTOMETRY (OPT.)
PATHOLOGY (PAT.)
PHARMACOLOGY (PHR.)
PHYSIOLOGICAL OPTICS (P.O.)
PHYSIOLOGY AND BIOPHYSICS (PHY.)

PROFESSIONAL CURRICULUM

First Professional Year

FALL QUARTER

P.O. Visual Optics I.—Principles of geometrical optics as it applies to thin and thick lens systems, mirrors and prisms. Introduction to lens aberrations and methods of minimizing their effects. 3 hours lecture, 2 hours laboratory. (Rosenblum)

ANAT. Gross Human Anatomy.—Structure of the human body with special emphasis on anatomy of the head and neck. Anatomy of the orbit and adjacent structures; the cranial nerves associated with vision and their cortical connections. Blood supply to the eye and orbit; embryology of the eye. 4 hours lecture, 12 hours laboratory. (Lin)

OPT. Optometry and Health Care.—Introduction to concepts in health care, and health care professions, the profession of optometry, its history, education and health service. 2 hours lecture. (Eskridge)

P.O. Comparative Neurobiology of Vision.—Considerations of the physiological and anatomical mechanisms underlying behavioral responses to light and an introduction to visual science. 2 hours lecture. (Christensen)

OPT. Epidemiology and Public Health.—Introduction to principles and methods of epidemiology as they relate to visual and systemic health problems.

WINTER QUARTER

P.O. Visual Optics II.—Optics of the eye including refractive errors and retinal image size. Measurement and specification of visual stimuli including radiometry, photometry, and colorimetry. 3 hours lecture, 2 hours laboratory. (Christensen)

ANAT. Neuroanatomy.—Gross and microscopic anatomy of the human central nervous system. 3 hours lecture, 4 hours laboratory. (Lin)

OPT. Clinical Orientation.—Preview of some of the problems encountered in the clinical practice of optometry. Discussion of some of the elementary techniques used in examination of the human visual system along with clinic observation. 2 hours lecture and demonstration. (Eskridge)

HIST. Histology.—Microscopic structure of body tissues and organs as a basis for understanding function and as a background for studying abnormal structure.

Laboratory exercises to develop the student's ability in independent observation of microscopic detail. 3 hours lecture, 6 hours laboratory. (Mayne)

ANAT. Anatomy of the Eye.—Detailed macroscopic, and light and electron microscopic study of the eyeball, optic nerve, and visual pathways. Embryology of the eye. 3 hours lecture, 3 hours laboratory. (Hickey)

SPRING QUARTER

P.O. Visual Optics III.—Principles of physical optics including diffraction, interference, polarization, reflections, scatter, birefringence and holography. 4 hours lecture, 2 hours laboratory. (Rosenblum)

BYC. Introductory Biochemistry.—Introduction to biochemistry with emphasis on visual pigments and other ocular substances. 3 hours lecture. (McKibbin)

PHY. Mammalian Physiology.—Function of the body's major organ systems. Physiology of central, peripheral, and autonomic nervous systems, cardiovascular, respiratory, endocrine, digestive, and reproductive systems. 3 hours lecture, 3 hours laboratory. (Shoemaker and staff)

P.O. Visual Psychophysics and Physiology I.—Psychophysical methods. Absolute sensitivity of the visual system, light and dark adaptation. Visual photochemistry and retinal current generation. Color vision. Spatial and temporal factors in vision. Motion perception. Acuity. 5 hours lecture, 2 hours laboratory. (Greenspon, Christensen)

OPT. Introduction to Clinical Practice.—Continuation of Clinical Orientation I. 1 hour. (Eskridge)

Second Professional Year

FALL QUARTER

OPT. Clinical Examination of the Visual System I.—Procedures used for examination of the human visual system. Detailed use of direct and indirect ophthalmoscope, tonometer, biomicroscope and perimeter. 4 hours lecture, 6 hours laboratory. (Amos and Setzer)

P.O. Eye Movement Mechanisms.—Descriptive aspects of eye movement and their control mechanisms. Physiological and anatomical characteristics of the extraocular muscles and eye movements, accommodation and pupillary responses. 4 hours lecture, 2 hours laboratory. (Christensen and Wilson)

OPT. Ophthalmic Materials I.—History of ophthalmic materials, physical characteristics, lens power, ophthalmic prisms, multifocal lenses, lens specification, inspection, verification. 2 hours lecture, 3 hours laboratory. (Wild, Peters and A. Pierce)

P.O. Visual Psychophysics and Physiology II.—Features detection in the visual nervous system. Visual development and deprivation studies. Electrophysiological measures of vision function. 3 hours lecture and demonstration. (Greenspon and staff)

MIC. Microbiology.—Introduction to bacteriology, virology, and immunology and their application to the ocular system. 5 hours lecture, 2 hours laboratory. (Cassell and staff)

WINTER QUARTER

OPT. Clinical Examination of the Visual System II.—Optical and biological variables determining the refractive state of the eye. Subjective and objective methods of measurement and methods of correcting refractive anomalies; skiametry, keratometry, visual acuity, subjective refraction, amplitude of accomodation. 4 hours lecture, 6 hours laboratory. (Amos and Setzer)

P.O. Normal Binocular Vision.—Characteristics of normal vision with two eyes. Binocular correspondence, disparity detection, stereopsis, and integration of binocular stimulation. 4 hours lecture, 2 hours laboratory. (Staff)

OPT. Ophthalmic Materials II.—Lens aberrations, performance controlled lenses, transmission, reflection, special lenses, physical characteristics of frames, fitting and adjusting. 2 hours lecture, 3 hours laboratory. (Wild, Peters and A. Pierce)

P.O. Vegetative Physiology of the Eye.—Physiology of tears, cornea, intraocular fluids and lens. Intraocular pressure and mechanisms for its control. 4 hours lecture, 5 four hour laboratories. (Wilson)

SPRING QUARTER

OPT. Clinical Examination of the Visual System III.—Clinical examination and evaluation of oculomotor systems, binocular functions, and color vision. 4 hours lecture, 6 hours laboratory. (Amos and Setzer)

OPT. Diagnosis and Treatment of Anomalies of Binocular Vision I.—Diagnosis and treatment of amblyopia, strabismus, suppression, anomalous correspondence. 4 hours lecture, 2 hours laboratory. (Staff)

OPT. Ophthalmic Materials III.—Optics of eikonic lenses, low vision aids, contact lenses. Design, fabrication, verification, and modification of contact lenses. 2 hours lecture, 3 hours laboratory. (Norden and A. Pierce)

P.O. Visual Perception.—Perception as a constructive act. Attention. Role of vision in perception. Perceptual plasticity and adaptation. 4 hours lecture, 2 hours laboratory. (Greenspon)

OPT. Applied Behavioral Science.—Interpersonal relationships and communication, patient, professional and community. 2 hours lecture. (Wechsler)

Third Professional Year

SUMMER QUARTER

OPT. Clinical Practice of Optometry I.—Examination, diagnosis, treatment, and follow-up care for selected clinic patients. 16 hours clinic. (Optometry faculty)

OPT. Clinical Colloquia.—Consideration of special testing and diagnostic techniques used in optometric practice case reports. 2 hours seminar. (Eskridge)

FALL QUARTER

OPT. Clinical Practice of Optometry II.—Theory and practice of optometric clinical care of patients: prescribing of optical aids and ophthalmic dispensing. 8 hours clinic. (Optometry faculty)

OPT. Clinical Ocular Disease I.—Consideration of the symptomology and signs of ocular disease and ocular manifestations of systemic disease. 2 hours lecture. (Keller)

OPT. Diagnosis and Treatment of Anomalies of Binocular Vision II.—Diagnosis and treatment of oculomotor problems. 3 hours lecture, 2 hours laboratory. (Mohindra and Sawyer)

OPT. Advanced Clinical Topics I.—2 hours lecture, 2 hours laboratory. (Alexander and Norden)

PAT. Systemic Pathology.—General pathologic processes and diseases of the major organ systems. 4 hours lecture, 4 hours laboratory. (Hartley)

OPT. Pediatric Optometry.—Pediatric epidemiology. Considerations of examination, diagnosis, and treatment of vision problems of children. 2 hours lecture. (Mohindra)

WINTER QUARTER

OPT. Clinical Practice of Optometry III.—Continuation of Clinical Practice of Optometry II. 8 hours clinic. (Optometry faculty)

OPT. Clinical Ocular Disease II.—Continuation of Clinical Ocular Disease I with emphasis on the systematic study and classification of ocular diseases, and their ophthalmological management. 2 hours lecture. (Keller)

OPT. Clinical Medicine for Optometrists.—Signs and symptoms of systemic diseases especially related to the eye and vision. 4 hours lecture and hospital rounds. (Schnaper and staff)

OPT. Advanced Clinical Topics II.—2 hours lecture, 2 hours laboratory. (Alexander and Norden)

OPT. Contact Lenses I.—Historical development, physical and optical properties of contact lenses and their adaptation to the human eye, with emphasis on anatomical and physiological implications. 3 hours lecture, 4 hours laboratory. (Leach and Wechsler)

OPT. Developmental Aspects of Visual Performance.—Evaluation and care of patients with visual performance problems. Role of developmental and learning disorders in such problems. 2 hours lecture and 5 two hour laboratories. (J. Pierce and Schuller

OPT. Aniseikonia.—Theory, diagnostic techniques and treatment of aniseikonic patients. Emphasis on use of eikonic lenses. 1 hour lecture, 3 two hour laboratories. (Eskridge)

SPRING QUARTER

OPT. Clinical Practice of Optometry IV.—Continuation of Clinical Practice of Optometry III. 8 hours clinic. (Optometry faculty)

OPT. Clinical Ocular Disease III.—Continuation of Ocular Disease II.—2 hours lecture. (Keller)

OPT. Low Vision.—Examination and care of partially sighted patients. 2 hours lecture, 2 hours laboratory. (Nowakowski)

OPT. Advanced Clinical Topics III.—2 hours lecture, 2 hours laboratory. (Alexander and Norden)

PHR. Systemic Pharmacology.—Drugs and drug actions. Role of systemic drugs in diagnosis and therapy. Side effects of drug use. 3 hours lecture. (Teague and staff)

OPT. Contact Lenses II.—Continuation of Contact Lenses I. 4 hours lecture, 4 hours laboratory. (Leach and Wechsler)

OPT. Geriatric Optometry.—Geriatric epidemiology. Consideration of examination, diagnosis, and treatment of visual problems of geriatric patients. Special emphasis on management of pre- and post-aphakic, convalescent, and senile patients. 2 hours lecture. (Potter)

Fourth Professional Year

SUMMER QUARTER

OPT. Advanced Clinical Practice of Optometry I.—Optometric examination, diagnosis and treatment of patients in outpatient clinics of the Medical Center on a rotating internship basis. Service performed independently by student clinicians under supervision of the clinic staff. 16 hours clinic. (Optometry faculty)

OPT. Special Clinical Practice I.—Clinical practice in contact lenses, aniseikonia, special optical aids for partially sighted, strabismus diagnosis, vision training and orthoptics, developmental vision. Services performed independently by student clinicians under supervision of the clinic staff. 2 hours lecture, 12 hours clinic. (Optometry faculty)

OPT. Clinical Colloquia I.—2 hours seminar. (Keller)

FALL QUARTER

OPT. Advanced Clinical Practice of Optometry II.—Continuation of rotating internship program in general optometry clinic service. 16 hours clinic. (Optometry faculty)

OPT. Special Clinical Practice II.—Continuation of Special Clinical Practice I. 12 hours. (Optometry faculty)

OPT. Clinical Colloquia II.—Continuation of Clinical Colloquia I. 1 hour seminar. (Eskridge)

OPT. Community Aspects of Optometry I.—Legal development; governmental relationships; licensing procedures; reciprocity; malpractice; state boards, detailed study of the optometric laws of at least one state; representative organizations in optometry; professional ethics and codes of ethics. 1 hour lecture. (Wechsler)

OPT. Ocular Pharmacology I.—Characteristics of drugs producing miosis, mydriasis, cycloplegia, accommodative spasm and anaesthesia of ocular surfaces. Use and side effects of commonly used ophthalmic drugs. 2 hours lecture. (Chang)

OPT. Contact Lenses III.—Continuation of Contact Lenses II. 2 hours lecture. (Leach and Wechsler)

WINTER QUARTER

OPT. Advanced Clinical Practice of Optometry III.—Continuation of rotating internship program in general optometry clinic service. 16 hours clinic. (Optometry faculty)

OPT. Special Clinical Practice III.—Continuation of Special Clinical Practice II. 12 hours clinic. (Optometry faculty)

OPT. Clinical Colloquia III.—Continuation of Clinical Colloquia II. 1 hour seminar. (Eskridge)

OPT. Community Aspects of Optometry II.—Establishment and management of an optometric practice; economics, taxes, insurance, accounting methods, office design, mode of practice, practice administration, and patient relations, professional organizations and societies. 2 hours lecture. (Wechsler)

OPT. Ocular Pharmacology II.—Continuation of Ocular Pharmacology I. 2 hours lecture. (Chang)

SPRING QUARTER

OPT. Advanced Clinical Practice of Optometry IV.—Continuation of rotating internship program in general optometry clinic service. 16 hours clinic. (Optometry faculty)

OPT. Special Clinical Practice IV.—Continuation of Special Clinical Practice III. 12 hours. (Optometry faculty)

OPT. Clinical Colloquia IV.—Continuation of Clinical Colloquia III. 1 hour seminar. (Eskridge)

OPT. Special Topics in Optometry and Visual Science.—Independent or joint study in selected topics of clinical optometry or visual science. 2 hours lecture. (Staff)

OPT. Community Health.—Role of the optometrist in community health care. Local, state, and federal organizations involved in health care. Study of comprehensive health planning and new trends in health care delivery. Hospital organization. 2 hour lecture. (Newcomb)

For nondiscriminatory policies and Title IX information, see page 13.

For information about any program of the School of Optometry, write:

Dean, School of Optometry
The Medical Center
The University of Alabama in Birmingham
University Station
Birmingham, Alabama 35294

UAB Bulletin
Vol. 9, No. 27, November 1976

EDITORS: **Ms. Dariane Jamison**
School of Optometry

Ms. Jerri Beck
UAB Office of Public Affairs

The University of Alabama in Birmingham
University Station
Birmingham, Alabama 35294

Equal Opportunities in Education and Employment

Published seven times in May and September; six times in February, November, and December; five times in January and October; four times in March and July; three times in April, June, and August

The University of Alabama in Birmingham

SCHOOL OF OPTOMETRY

Bulletin

Catalog Issue 1977-78

University Station
Birmingham, Alabama 35294

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

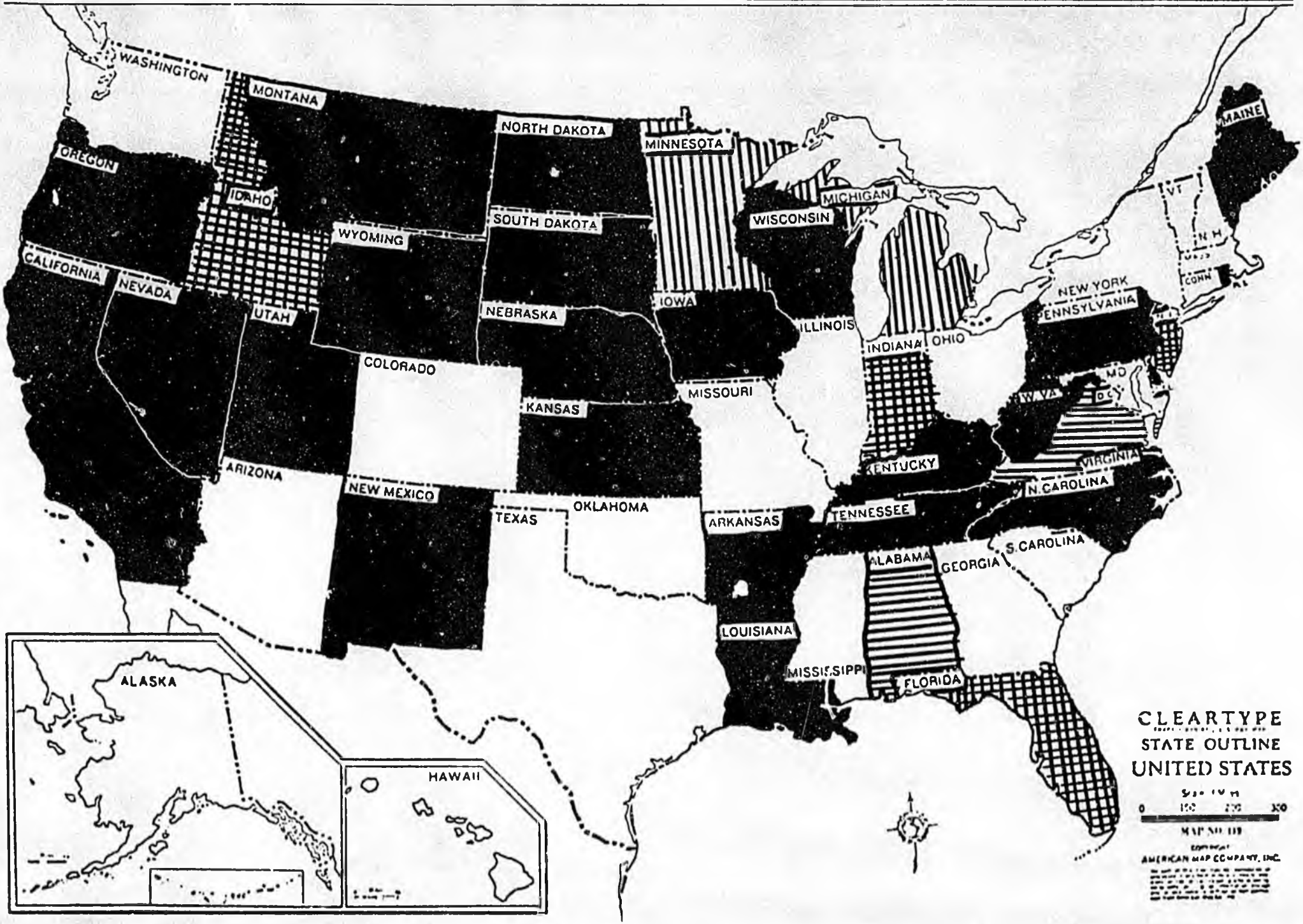
*both diagnostic and therapeutic

[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.

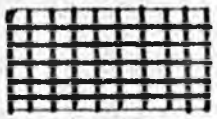
UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

JUNE 8, 1979

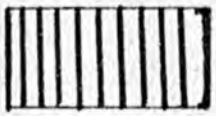


UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

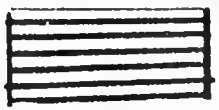
Authorized by Optometrists by Statute



Permitted by Opinion of Attorney General or State Board Statement



No Statutory Prohibition



No Statutory Prohibition but Negative A.G. Opinion

7 HB

SRA 378-C
Anchorage, Alaska 99507
March 11, 1979

Senator Glenn Hackney:

As a taxpayer and voter in the state of Alaska, and as an ophthalmologist, I feel I should express an opinion concerning House Bill No. 79 (Senate Bill No. 75). I wish to point out that I am not in a private practice, and I will derive no financial benefit from the outcome of this bill.

First, both in its derivation as a word and its meaning from any dictionary, optometry has always referred to the measurement of the visual function of the eye so as to prescribe corrective lenses. The diagnosis and treatment of eye disease has always been in the realm of ophthalmology. In this framework, I know of no eye medications that are necessary for the practice of optometry. Certainly "diagnostic drugs" has nothing to do with optometry, and would serve as a seemingly clever (but dishonest) disguise to further confuse an already confused public concerning who's who in eye care. If the optometrists argue that certain drugs are necessary to their practice, then one might wonder how they have been able to practice their specialty all these years without them.

I am a bit chagrined to see such petty bickering at a professional level over one's image and income take up legislative time. I hope you realize that at the core of this dispute is what constitutes the practice of medicine, and this is not just a quarrel among eye care professionals. Improvement of vision through corrective lenses is a satisfying accomplishment for so many patients. I do not understand why optometrists are unhappy with their present situation. For those who want to involve themselves with eye disease, a medical school education and ophthalmology training is always available as proper prerequisites. I have met two optometrist-ophthalmologists and know of several others, so this educational path is in fact available. Please give careful thought to the average Alaskan who you represent and the need for such a bill. I think you will agree that when special interests are set aside, you all should be spending your time on more important legislation.

Sincerely,

James E Cox

James E. Cox, M.D.

February 14, 1979

Senator Hackney,
Thanks for your help last year.
Bill

Senator Glenn Hackney
Chairman, Senate HESS Committee
Pouch V
Mail Stop Number 3100
Juneau, Alaska 99811

Dear Senator Hackney:

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

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 have 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 in 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.

Southern California College of Optometry
2001 Associated Road · Fullerton · California 92631 · (714) 870-7226

DR. RICHARD L. HOPPING
President

DISTRIBUTION: Dr. Lemoine
Senator Hackney
Dr. Thomas
Dr. Moscovice
Dr. Tietz

The enclosed catalogs and material are being sent to you as requested by Dr. Susan Klein. These materials were made available to the Project Advisory Committee at the recent meeting here at SCCO.

Edie Palmer

Edie Palmer
Secretary to Dr. Hopping

The logo of the American Optometric Association signifies, in simplest terms, a commitment to all the elements of a good vision examination and care. Doctors of optometry who are members of the American Optometric Association are concerned with far more than your eyes or fashionable glasses and frames.

In fact, an examination by an optometrist is also a good place to begin guarding your family's total health. Besides diagnosing vision problems and prescribing the lenses to correct them, an optometrist is qualified to detect eye diseases and abnormalities as well as health problems such as diabetes or high blood pressure. To become licensed to practice, today's optometrist must have a minimum of 2 to 3 years undergraduate education plus at least 4 years at a specialized college of optometry.

The doctors of optometry who are members of the American Optometric Association are totally committed to the ideal that every member of your family should receive the best vision care possible. And, for that reason, they want you to know what to look for in a thorough vision examination:

1 On your first visit, you should receive a comprehensive examination. This usually takes anywhere from 30 to 60 minutes.

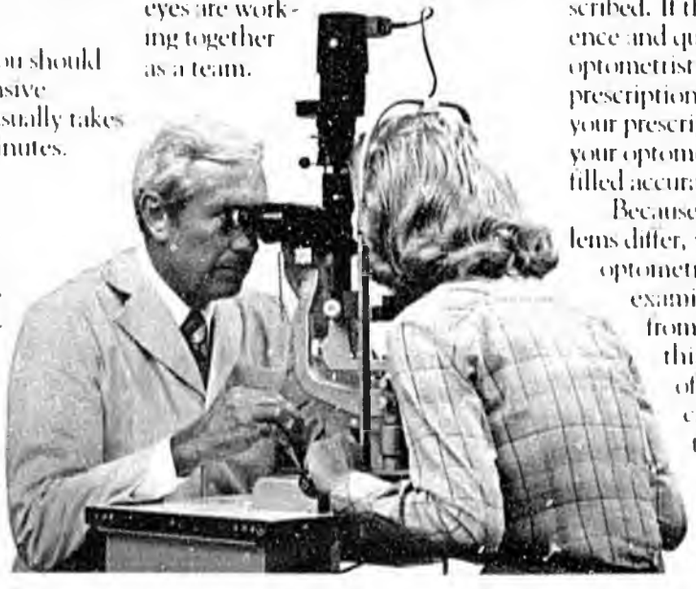
2 Your health history should most likely be taken before the examination begins. Allergies, diseases such as diabetes and ailments such as high blood pressure can affect the results of vision tests. So can certain prescription and non-prescription drugs you may be taking.

3 The exterior of your eyes and the surrounding area should be inspected for eye disease.

4 Then the interior of your eyes should be examined for any signs of systemic or eye diseases. It is here that your optometrist can see blood vessels in their natural state and can therefore detect certain signs or symptoms of diabetes or hypertension. When signs or symptoms are discovered, you'll be referred to your family physician or a specialist if necessary.

5 Your vision should be tested to evaluate how well you see at near and far distances. At the same time, the refractive state of your eyes should be measured to determine nearsightedness, farsightedness, astigmatism or other visual problems.

6 Your eye coordination and eye muscle control should be examined to be certain your eyes are working together as a team.



7 Finally, the ability of your eyes to change focus easily from far to near and near to far should be measured.

Those are the basics. However, if you are over 35 or if a need is indicated, it's likely that you'll be given other special tests such as one for glaucoma. You may also be tested for color perception, depth perception, field of vision, visual/perceptual abilities and other vision skills.

When your optometrist has completed your examination and evaluated all the results, corrective lenses or vision therapy may be prescribed. If that's the case, for convenience and quality assurance, your optometrist can properly fill your prescription. Or, if you decide to take your prescription elsewhere, have your optometrist verify that it was filled accurately.

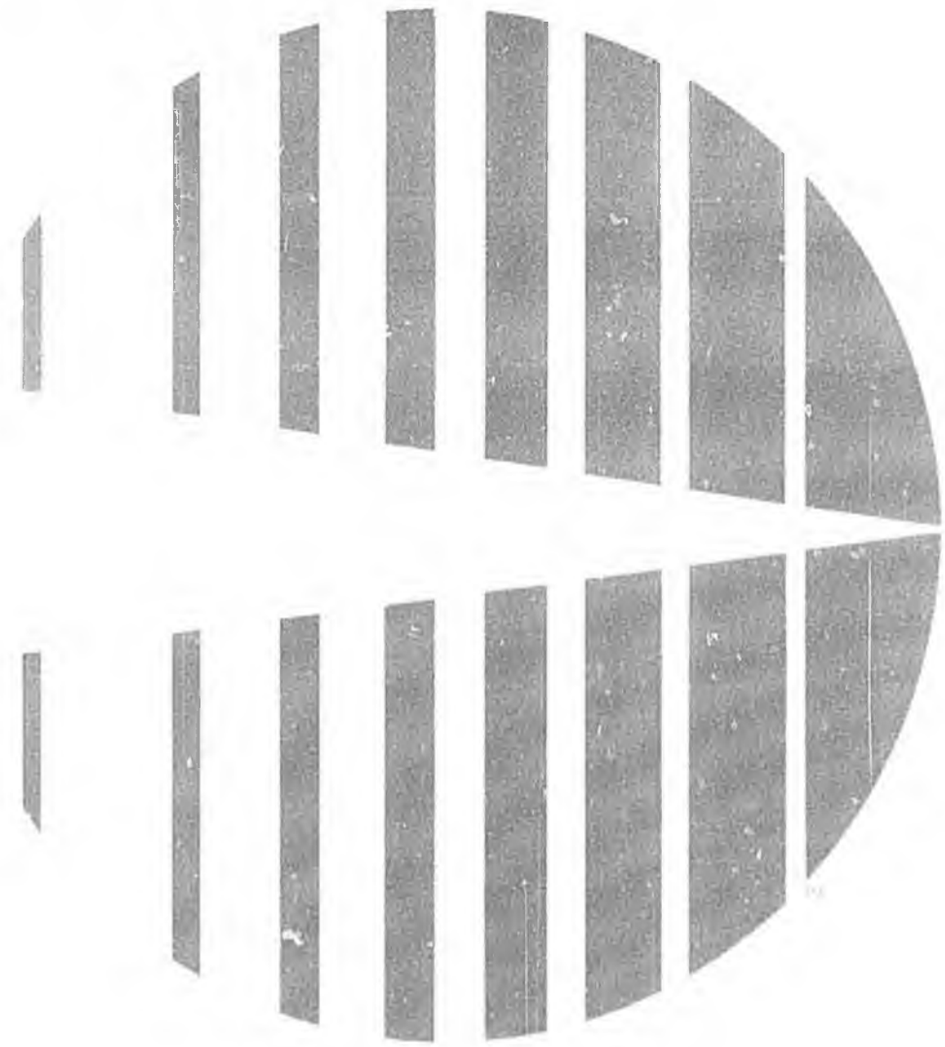
Because people's needs and problems differ, you may find that your optometrist approaches your examination with variations from this list. However, one thing that you may be sure of: members of the American Optometric Association are dedicated to the principle that you and your family should have the highest quality total vision care possible.

Your Family Doctor of Optometry. The person to see. And keep seeing.

American Optometric Association

There are 7 things to look for in good vision care.

Here's one of the best places to start:



TM Trademark of the American Optometric Association

P. O. Drawer P, Boulder, Colorado 80302 • (303) 492-8666

WICHE
Western Interstate Commission for Higher Education
affirmative action/equal opportunity employer

January 30, 1979

The Honorable Glenn Hackney
State Capitol
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney,

I am sending along the enclosed information, as a result of your conversation with Phil. These materials were distributed at the Optometry Education Project Advisory Committee meeting in Fullerton on January 27, and Phil felt you should see this in light of your pending business.

Minutes of the meeting and related information will follow shortly.

Cordially,

Linda Dunham

Linda Dunham
Secretary

Please file with 3375

A REPORT TO THE PRESIDENT & CONGRESS

ON THE STATUS OF HEALTH PROFESSIONS PERSONNEL

IN THE UNITED STATES

August 1978

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Health Resources Administration
Bureau of Health Manpower
Manpower Analysis Branch

DHEW Publication No. (HRA) 78-93

VI. OPTOMETRY

Optometrists represent only a small proportion of all health practitioners, but they play a significant role in providing health services, mainly as the point of entry to the health care system for the provision of vision care services. Optometrists examine eyes for vision defects and other abnormal conditions, test depth and color perception, and when necessary prescribe lenses and treatment. As providers of primary health care, optometrists may refer patients for treatment of ocular and systemic diseases to ophthalmologists. Conversely, some of the vision services usually provided by optometrists may also be rendered by ophthalmologists.

From all indications, there appears to be a shortage of optometrists and other vision care practitioners in the United States. The number of optometrists has grown only slightly in recent years, and less growth is anticipated than in other health professions. Since a large number of optometrists graduated through the G.I. Bill and will likely be retiring in the next 10 to 15 years, the expected net addition of new practitioners in the field will have a somewhat smaller impact on total supply than in other health disciplines. However, by 1990 supply and requirements should be more or less in balance.

A number of issues and trends relate directly to the optometrist's role in the health care system and the provision of vision care services. A factor likely to affect the practice of optometry and provision of services is the increase in continuing education requirements as a pre-requisite to licensure renewal. Optometrists are increasingly being included in various health care programs, which should affect the overall provision of vision care and the requirements for their services. In organized health delivery settings more attention is being paid to quality assessment of vision care. Judgments about quality of care and practitioner proficiency are normally difficult, but optometry normally deals with readily visualized or measurable conditions and is more amenable to the comparision of practice to standards than are most health professions. Peer review may be used to measure and assure the quality of medical and optometric practice, but the role of optometrists in the review responsibilities of Professional Standards Review Organization has yet to be determined. Among other changes that will affect the profession is the increasingly widespread use of auxiliaries which will have an impact on provision of services and on the requirements for practitioners. New technological developments may also change the scope of practice.

A major issue that has surrounded optometry for many years, of course, is the relationship between optometry and ophthalmology. While some overlap in services, specifically refractive services, exists at present, there are specific unique roles in the provision of vision

care for both professions. Future interactions between the professions will impact on the provision of vision care services, on requirements for these services, and on training and education for both professions. These and other issues are important and developments must be monitored in order to evaluate the role of optometrists in the provision of vision care services.

Number and Characteristics of Optometrists

The number of active optometrists has increased only slightly in recent years, despite the impetus provided by recent Federal legislation. The number of new optometrists has only slightly exceeded the number of optometrists leaving the profession. In 1975, it is estimated that there were 19,900 active optometrists (civilian and military). Of these, approximately 19,200 were providing some form of patient care.

On the basis of limited historical data, the number of active civilian optometrists has increased only moderately in recent years, and has not kept up with population growth. Such increases in supply as have occurred are due to the rise in graduates from schools supported under the Health Professions Educational Assistance Act of 1963.

In view of the overall increase in the number of active civilian optometrists, the ratio of active optometrists to population has declined slightly, from 9.3 active civilian optometrists per 100,000 population in 1968 to 9.2 per 100,000 in 1973.

The effects of the G.I. Bill of the 1950's and the sudden increase in numbers of optometrists completing their education can still be seen today. One half of all optometrists are between 45 and 60 years of age. (Table A-VI-I) On the other hand, recent increases in supply are becoming increasingly evident, as nearly 20 percent of active optometrists are under age 35, and optometry is expected to become an increasingly younger group.

Relatively few women are in optometry, with the proportion of active female optometrists only slightly more than 2 percent. However, the population of females in schools of optometry now exceeds 10 percent, and the proportion of women is expected to rise somewhat in the coming years.

Overall numbers of minorities in optometry are also quite small, although the field appears to be unusually attractive for those of Japanese/Chinese descent (Table A-VI-2). Although only 480 active optometrists (2.5 percent of the total) in 1973 were members of racial/ethnic minority groups, fully three-fifths of this total were Japanese/Chinese. Intensive recruiting efforts have served recently to increase the number and proportion of minorities in the field.

Few optometrists work exclusively in activities other than patient care, and relatively few optometrists work part-time. If full-time is defined as working 30 or more hours a week, more than nine out of ten active optometrists worked on a full-time basis. Among the active optometrists, only a small proportion (3.5 percent) were engaged exclusively in non-patient care activities, generally consisting of teaching, research or administration.

Optometrists are usually self-employed. In 1973, the number and percent who were self-employed (Table A-VI-3), mostly in solo practice, was nearly 14,900 or 77 percent of all active optometrists. As with podiatrists and other health professionals, however, there is movement in optometry away from solo practice and toward partnerships or groups. (Table A-VI-4) In 1973, employed optometrists accounted for 3,600 or nearly 20 percent of active optometrists. Because of the costs of setting up a solo practice and the rapidly expanding nature of optometric practice, optometry graduates appear to be increasingly favoring associateship or partnership arrangements from among the available career alternatives.

Newly graduated optometrists also exhibit a far greater tendency than other optometrists to be employed rather than self-employed (Table VI-2). Although nearly 20 percent of all active optometrists were employed, this proportion varied from 50 percent of those under 30 years of age, to only 13 percent of those 50-59 years of age. Also, while less than 3 of 5 self-employed optometrists under 30 years of age were in solo practice, more than 4 of 5 self-employed optometrists over 40 were in this form of practice. A comparison of 1968 and 1973 data for principal form of employment shows a decline in the proportion who were self-employed and a corresponding increase in the proportion employed. While military service accounts for a large percent of those employed, a large number were employed by optometrists and other employers. This trend toward multiple practitioner arrangements and salaried employment may have implications for the characteristics of optometric clinical practice such as productivity, number and types of services offered by the practitioner, and even the geographic distribution of optometrists.

Developments in Licensure of Optometrists

The regulation of the practice of optometry has undergone a number of significant changes since 1973. The most pervasive has been the increase in continuing education requirements. Optometry appears to have one of the most major and significant continuing education programs of all the health professions. Beginning with Iowa in 1938, forty-two States have adopted some form of continuing education as a requirement to license renewal, although the nature of the requirements imposed by States vary considerably. Most States specify that credit may be given for optometric or other scientific education, lectures, symposiums, courses approved by the board for post-graduate study at a school of optometry, and courses given by the American

Optometric Association. Such programs are offered by over 100 organizations, making it easier for optometrists to update their credentials.

Geographic Distribution of Optometrists

On the basis of most measures of determining geographic unevenness of distribution of health manpower, it is generally recognized that optometrists are more evenly distributed than most other health professions. However, there continues to be disparity in the provision of optometric services to various areas of the country. This reflects the fact that the distribution of optometrists on a geographic basis needs to be linked directly to consideration of the distribution of ophthalmologists, many of whom provide some similar services. Although the distribution of optometrists is somewhat uneven, the distribution of ophthalmologists does little to alleviate the situation. A substantial proportion of the population in the United States has little or no access to the services of ophthalmologists.

Among the four geographic regions, the ratio of active optometrists to resident population varied from 6.9 per 100,000 in the South to 10.9 per 100,000 in the West, a difference of nearly 60 percent, (Table A-VI-5). Among the States, Illinois had the highest ratio, 14 per 100,000, while the lowest State, Alabama, had a ratio (5 per 100,000) only about one-third that of Illinois.

Although the same two States, California and New York, have the largest numbers of both ophthalmologists and optometrists in the Nation, there is no apparent correlation between the relative numbers of ophthalmologists and optometrists at least as related to population. On a regional basis, for both ophthalmologists and optometrists the Pacific States have the highest ratios of practitioners to population, while the lowest ratios for both disciplines occur in the East South Central States.

Nationally, there are 2 optometrists to 1 ophthalmologist and this ratio is approximated or exceeded in most States. However, notable exceptions exist. Only in Maryland and the District of Columbia, which also rank very high in relative numbers of all physicians, does the number of active ophthalmologists exceed the number of active optometrists. Although seven States--Maine, Rhode Island, Indiana, Illinois, North Dakota, South Dakota, and Nebraska--had more than three times as many optometrists as ophthalmologists, a number of other States had less than three optometrists for each two ophthalmologists. Thus, while some states are able to provide added vision services through ophthalmologists, others cannot. In addition the services of ophthalmologists are rendered primarily in large metropolitan areas, while the ratio of optometrists to population is about the same (9 per 100,000) in metropolitan as in non-metropolitan counties. Nevertheless, optometrists provide a greater proportion of total vision care in non-metropolitan and rural areas.

Although the ratio of optometrists to population is somewhat greater in counties in SMSA's over 1 million population than in counties in SMSA's of smaller size, their distribution still remains better than that of most health professionals. It is only in non-metropolitan counties that substantially lower than average ratios of optometrists to population exist. The percent of optometrists practicing in metropolitan areas is somewhat higher than the percent of the resident population, whereas the percent of ophthalmologists practicing in these areas substantially exceeds the percent of the resident population. In non-metropolitan areas this pattern is reversed, with the percent of persons residing in those areas being more than 2 1/2 times the percent of opthalmologists, and somewhat larger than the percent of optometrists.

An examination of persons-per-optometrist ratios for counties, often used to show geographic distribution, indicates large variation exists between the ratios. As a matter of fact, there are 840 counties (more than one fourth of all counties) that have no optometrists at all, and 552 counties (18 percent) that have a ratio of 15,000 or more residents per optometrist, far above the ratio recommended by the American Optometric Association of approximately 7,000 residents per optometrist, or 14.5 optometrists per 100,000 population.

Optometric Education

In the recent past, enrollments and subsequent graduates in schools of optometry peaked in the early 1950's, reaching their highest level until the early 1970's. (Table VI-1) In academic year 1951-2, the 10 schools of optometry enrolled 2,435 students and graduated 961 students. At that time, only 3 years of optometric school curriculum were required. During the decade of the 1950's, enrollments declined sharply, reaching the level of 1,101 students and 316 graduates in academic year 1960-61. Coincidental with the enactment and implementation of the Health Professional Educational Assistance Act of 1963, enrollment and graduates began to rise sharply. Total enrollment increased from 1,547 students in academic year 1964-65 to 3,909 students in academic year 1975-76, an increase of more than 150 percent. First-year enrollments during the same period rose more than 80 percent, from 593 to 1,078, (the larger increase in total enrollment was due to the increase in the number of years of professional education). The number of graduates rose by 140 percent, from 377 to 905 during the same period. Part of the increase in the number of graduates reflects the increase from 10 to 13 in the number of schools of optometry during this time.

In academic year 1976-77, the Nation's optometrists were being trained in 13 accredited schools and colleges of optometry. Regionally, the schools of optometry are relatively evenly distributed, although the Northeast, South, and West had three schools each, while the North Central States had four.

All of the 13 optometry schools have a 6-year curriculum which includes a minimum of 2 years of pre-optometry education at an accredited college plus 4 years of professional training at a school of optometry leading to a Doctor of Optometry degree (O.D.). In 1976, the 12 schools with 4 years of classes enrolled 1,078 first-year students and graduated 905 students. Nearly one-half of these students graduated from three schools: the Illinois, Pennsylvania and Southern Colleges of Optometry. The Pennsylvania College of Optometry produced the most graduates, 144; of the established schools, the Ohio State University College of Optometry graduated the fewest students, 52.

First-year enrollment in the 13 schools of Optometry totalled 1,078 students in academic year 1975-76 (Table VI-2). The Southern and Illinois Colleges of Optometry had the largest first-year enrollments, 152 and 151 students respectively.

In 1976, 72 or nearly 9 percent of the graduates were women. This number is expected to rise substantially in the upcoming years as more than 14 percent of the entering class in 1975-76 were female.

The location of the school of optometry is a prime factor in determining where the optometrist actually practices after graduation. More than four out of five optometrists under age 45 practice in States with schools of optometry, and are graduates from the school(s) within the State. The proportion of all active optometrists who graduated from schools within their State of practice is more than 92 percent in Illinois, 86 percent in Pennsylvania, 81 percent in California and 77 percent in Massachusetts (Tables A-VI-5 and A-VI-7).

Data from the 1973 inventory of optometrists show that schools of optometry make a varied contribution of optometrists to non-metropolitan areas. More than 2 of 5 graduates of two schools, the Southern College of Optometry and the Pacific University College of Optometry, practice in non-metropolitan areas. Three other schools have contributed nearly one-third of their graduates to these areas--Illinois, Houston, and Indiana. Together, these schools account for three out of four optometrists practicing in non-metropolitan areas. One school, the Illinois College of Optometry and its predecessors in Illinois, graduated approximately one-third of all active optometrists in the United States (Table A-VI-8).

Trends in Optometry Education

Optometry is one of several health professions that serves the public as a means of entry into the health care system. As such, the forces for change in the optometric curriculum are similar to those confronting the other health disciplines. Most notable among these forces is the rapid expansion of knowledge of the eyes, the expanding

scope of optometric practice, increased social awareness of the importance of proper eye care, student demands for improved curricular relevance, and the priorities of external funding sources. Since many disease entities have observable manifestations in the eye, the optometry curriculum is being broadened to improve the continuity of vision care for the patient, serving as a bridge between the medical and optometric professions. This is resulting in a trend toward primary vision health care in optometric practice.

The changes that are occurring in optometric education fall into two basic categories: content of curricula and location of training. Curricula content is being changed in many ways, including revisions to accommodate the addition of new knowledge and new areas of emphasis. Courses in human nutrition and in the behavioral and sociological aspects of health and disease are new areas of content and areas of increased emphasis, and added emphasis is being placed on the areas of low vision training, rehabilitative procedures, pediatric and geriatric optometry, as well as on training in community, environmental and public health. The most common areas of change are in training of students to detect pathological departure from the health of the eye, as well as the use of diagnostic drugs. The latter has necessitated increased curricular emphasis on general and ocular pharmacology. Congress recognized the need for change by a provision in PL 94-484 for grants and contracts for curriculum development in schools of optometry.

Other curricular trends are: earlier student contact with patients to improve the student's perception of the relevance of the basic sciences to clinical practice; elimination or modification of the "lock-step" curriculum to permit the student to progress more at his own pace; the greater use of modern educational technology such as the use of television and computer-assisted instruction; and the increased offering of electives to permit the student to pursue knowledge in areas of special interest. Remedial programs are also being offered with the objective of retaining students in academic difficulty in schools and reducing attrition rates in schools. As indicated earlier, continuing education has become a major activity of many schools, since a large majority of the States now require a demonstration of competency in order to obtain re-licensure for optometric practice.

Major changes have been made recently in the specific setting or location of training. Numerous instances exist where the student is receiving part of his instruction in external clinical settings such as preceptor offices, health maintenance organizations, community clinics and special optometric clinics established in underserved areas. These off-campus training sites have greatly facilitated the teaching of the utilization of optometric auxiliaries, demonstrated new services, provided health services, exposed students to rural and inner city practice possibilities and developed interdisciplinary learning opportunities.

Optometrists and Delivery of Care

The role of the optometrist as a provider of primary care has increased steadily in importance in re·ent years. The optometrist also has assumed a larger role in military settings, as well as in institutional care as typified by the presence of optometrists in Health Maintenance Organizations. In this setting, the optometrist may evaluate all patients who report any visual problems. In a number of States, optometry State laws have been redefined to reflect the recognition of optometrists as primary vision care providers. In these states, optometrists may ascertain the presence of disease or pathological conditions and refer the patient to the appropriate medical practitioner for further diagnosis and treatment.

In terms of the need for vision care services, both met and unmet, about half of the population who require some form of vision care services actually receive them. About nine out of ten of the patients who need vision care services require services which are within the present scope of optometry. Only about 10 percent of the population with vision care problems require medical treatment or surgery which must be provided by ophthalmologists, as shown by the 1960 NCHS Survey of Ophthalmologists.

In terms of actual services currently being provided, about two-thirds of the population, or 33 million people receiving vision or eye care receive such care from optometrists. About one-third or 17 million of the population seek and receive vision or eye care from ophthalmologists. As reports show, a substantial area of overlap of services exists in the provision of refractive services, and at least some proportion of the population that receives ophthalmological care could go to optometrists for this care.

The number of optometrists is increasing, and so is the number of patients each can see, (i.e. productivity). A major factor in this increased productivity on the part of optometrists is their rising use of auxiliaries. While only about one-third of active optometrists in 1973 utilized full-time auxiliaries, there appears to be a far greater tendency on the part of younger, newly graduated optometrists to utilize auxiliaries than optometrists in practice for a number of years. In part, this may reflect the training in optometry schools that emphasize utilization of auxiliary services in optometric practice. While data on specific services provided by chairside optometric auxiliaries does not exist, data from a 1973 survey suggest considerably greater productivity on the part of optometrists utilizing auxiliaries than optometrists without such services.

On the average, optometrists working in patient care activities on a full-time basis perform approximately 1,350 vision analyses (basic measure of productivity) a year, or about one vision analysis per hour for an optometrist working approximately 30 hours per week. Those optometrists utilizing full-time auxiliaries perform approximately

1,600 vision analyses annually, or nearly 20 percent more than the average of all active optometrists.

Optometrists in smaller metropolitan areas also appear to have far greater productivity (in terms of number of vision analyses) than do optometrists in larger metropolitan areas. This may be related to the availability of ophthalmological services in the larger metropolitan areas, in that some patients may utilize the services of an ophthalmologist instead of an optometrist. In non-metropolitan areas, on the other hand, the reverse pattern in productivity seems to be true. Optometrists in larger counties perform more vision analyses, on the average, than do their counterparts in smaller counties.

The Future Supply of Optometrists

The supply of optometrists is expected to rise sharply in the coming years. Several projections of the supply of active optometrists to 1990 are presented here under different assumptions as to graduate input over the projection period. 1/ The projection findings under each set of these different assumptions are described below and are summarized in Tables VI-3 and VI-4.

The basic determinant of the future supply of optometrists is very clearly the current and anticipated enrollment in optometry schools. As indicated earlier, optometry enrollments have grown rapidly since the early 1960's, with new Federal legislation providing much of the impetus for the recent increases. In terms of the projected supply of optometrists, the most realistic assumption is that schools will meet the capitation requirements set down by P.L. 94-484, that of increasing full-time first-year enrollments in the 1978-79 academic year in each school by 5 percent or 5 students over the 1976-77 enrollment, depending on the size of the 1976-77 first year class. No additional growth or enrollment per existing school or college is anticipated, although the basic projection series also assumes that one new school of optometry will open during the projection period--most likely a Southern regional school. The basic projection of the graduating classes of 1973-74 through 1989-90 then results in a total gross graduate input of 16,757 for that period. On this basis, the supply of active optometrists is expected to increase from 19,900 in 1975 to 22,000 in 1980 and to 26,700 in 1990. Thus, the number of active optometrists is expected to increase by about one-third between 1975 and 1990, or about 2 percent a year, slightly faster than the growth between 1970 and 1975. The ratio of active optometrists to population is projected to increase somewhat by 1990, reaching 10.9 per 100,000 population, as compared with 9.3 per 100,000 population in 1975. For the purposes of this report, the basic assumption is believed to provide the most realistic supply estimates.

1/ See Appendix (A-VI-8) for description of Methodology.

By way of contrast, if full-time first year enrollments should rise substantially beyond those mandated by the legislation and assumed in the basic projection series, the increases in active optometrists would be even larger. For this "high" projection series, an annual increase of 1 percent per year in enrollment per existing school above and beyond increases described in the basic series was used, and again it was assumed that only one new school would open in academic year 1981-82. In this estimate, the number of optometrists would be slightly higher than the basic estimate, or 27,100 by 1990, a ratio of 11.1 optometrists per 100,000 population.

On the other hand, if schools meet the requirements of P.L. 94-484 by providing for the specified proportion of full-time students to be comprised of residents of States in which there are no accredited schools of optometry and if no new schools of optometry open, then first-year enrollments would then be maintained at about the 1976-77 levels. Under this "low" estimate, the supply of optometrists would reach 26,100 by 1990, for a population ratio of 10.6 optometrists per 100,000 population.

Although the distribution of future graduates can not be projected with any degree of precision, current estimates are based upon the assumption that there will be little improvement in the geographic distribution of optometrists. The proportion of recent graduates from schools of optometry practicing in non-metropolitan areas is about the same or slightly lower for nine out of ten established optometry schools as compared to the proportion of total graduates practicing in these areas.

Requirements for Optometrists

Although it is difficult to determine the exact level of requirements for optometrists, it is likely that the projected supply of optometrists will be roughly in balance with the number of optometrists required.

There are several ways to measure requirements. One measure is the optimum ratio of 14.3 optometrists per 100,000 population utilized by the American Optometric Association. Such a ratio if applied to projected 1990 population would indicate a requirement for about 35,000 optometrists in that year, well above the anticipated supply. Another measure of requirements for optometrists might be to apply the best State ratio in 1975 as a standard to be met by all States. Such a standard would show a requirement for about 34,000 optometrists in 1990, again well above the anticipated supply of 26,700 active optometrists.
Thus, if these "need" related standards are applied, there would appear to be shortage of 7,000-8,000 optometrists projected for 1990.

On the other hand, the Supply Output and Requirements Model (SOAR) generates an increase in requirements for optometrists of nearly one-third in 1990 over current levels. These requirements for optometrists take into account recent trends in per capita utilization of optometric services, and are based on increased utilization of optometric services by the population during 1975 to 1990. Such levels of projected requirements for optometrists are about equal to the projected supply of optometrists in 1990. All things considered, the best judgement is that supply and requirements will be in balance by 1990.

Data and Analytical Needs

As indicated previously, 1973 data from the Optometric Manpower Resources Project supported by the Bureau of Health Manpower are the latest available data on optometrists.

However, more current data on optometrists are currently being collected in States participating in the Cooperative Health Statistics System, and also by means of the Bureau of Health Manpower Inventory. But data and standards are needed in the designation of health manpower shortage areas, and for health manpower analysis of data from small geographic areas. It would also be desirable to have another data point for trend analysis of optometric data. The only reliable data on optometrists are from the NCHS 1968 and 1973 surveys.

Optometrist Projection Methodology

Estimates of the number of active optometrists for 1975-90 were calculated utilizing the data from the 1973 Bureau of Health Manpower/American Optometric Association survey of optometrists as a base. It was assumed that the base reflected a point in time of December 31, 1973. Data on graduates of optometry for 1974 through 1976 were obtained from school reports on FY 76 Capitation Grant applications; the American Optometric Association provided estimates of first-year enrollments through 1975-76. Graduate projections to 1990 were computed from the number of first-year students reported 4 years earlier utilizing an attrition rate of 12 percent in both the basic methodology and the alternative supply projections in line with the most recent experience. Thus, 88 percent of entering optometry students are projected to graduate 4 years later. If a different attrition rate were used, of course, the graduate component would change somewhat, but the overall impact on the total supply estimates would be minor. Under the basic methodology, for example, if a 10

percent attrition rate were used, only about 300 additional graduates would be expected over the projection period. If a 15 percent attrition rate were used, about 500 fewer graduates of optometry schools would be expected over the projection period.

Separation rates used in the basic methodology and in the alternative approaches were derived from age specific death and retirement rates for white males developed by the National Center for Health Statistics, 1/ and the Bureau of Labor Statistics. 2/

There was no evidence to suggest that optometrists, on the average, tend to live longer than males in the general working population. For this reason age specific mortality rates developed by the Department of Labor were applied to the optometrist population.

In contrast to the mortality experience, however, information does exist that suggests variation in retirement patterns between optometrists and all working males. For example, in comparing total male labor force participation rates with age-specific proportions of optometrists that are active (1973 Survey data), it was found that, in general, a higher proportion of optometrists were "active" for each age group. Based on these findings, published age-specific retirement rates for all male workers were adjusted to better reflect the apparent experience indicated for optometrists. Over the projection period, use of the adjusted series reduced estimated requirements of optometrists 25 percent below that obtained by not undertaking such a modification.

1/ Death rates from abridged life tables--U.S., 1969-71, white male and white female rates (unpublished 5-year age groups).

2/ Retirement rates are for the general male and female labor force, 1970, as published in Bureau of Labor Statistics. Length of Working Life for Men and Women--1970, Monthly Labor Review, pp. 31-35, February 1976.

Table VI-1. Schools of optometry and number of students and graduates: selected years, 1964-65 through 1975-76

Academic year	Schools	Students 1/		Graduates
		Total	First-year	
1975-76	12	3,909	1,078	905
1974-75	12	3,704	1,024	806
1973-74	12	3,529	988	684
1972-73	12	3,328	984	691
1971-72	12	3,094	906	683
1970-71	11	2,831	884	528
1969-70	11	2,488	786	445
1968-69	10	2,203	771	441
1967-68	10	1,962	649	477
1966-67	10	1,892	669	481
1965-66	10	1,745	643	413
1964-65	10	1,547	593	377

1/ Fall enrollment of undergraduate students.

Source: American Optometric Association.

Table VI-2. Enrollment and graduates in schools and colleges of optometry: 1975-76

School	Total enrollment	1st	2nd	3rd	4th	Graduates (1976)
Total	1,209	1,010	1,002	221	206	205
University of Alabama	107	41	23	20	23	22
Southern California College of Optometry	351	98	105	85	63	61
University of California	206	68	61	60	59	59
Illinois College of Optometry	570	151	145	136	138	138
Indiana University Division of Optometry	279	70	69	68	72	72
Massachusetts College of Optometry	290	91	88	59	68	68
Ferris State University, Michigan	21	21	-	-	-	-
State University of New York College of Optometry	106	41	23	22	20	20
Ohio State University College of Optometry	219	67	59	51	52	52
Pacific University College of Optometry	301	85	81	67	68	68
Pennsylvania College of Optometry	555	138	139	131	145	144
Southern College of Optometry	590	152	148	165	129	130
University of Houston College of Optometry	266	69	71	57	69	69

Source: Council on Optometric Education, Annual Survey of Optometric Educational Institutions. Bureau of Health Manpower, Health Professions Schools, Selected Enrollment Data 1970-71/1977-78, October, 1976.

Table VI-3. First year enrollments and graduates in optometry schools under basic and alternative assumptions: actual 1971-72 through 1975-76, projected 1976-77 through 1989-90

Academic year	First-year enrollment			Graduates		
	Basic methodology	Alternative assumptions		Basic methodology	Alternative assumptions	
		Low	High		Low	High
1972-73	1,004	1,004	1,004	--	--	--
1973-74	989	989	989	794	704	794
1974-75	1,024	1,024	1,024	806	806	806
1975-76	1,078	1,078	1,078	884	884	884
1976-77	1,134	1,134	1,134	870	870	870
1977-78	1,153	1,134	1,153	901	901	901
1978-79	1,189	1,134	1,189	949	949	949
1979-80	1,189	1,134	1,201	998	998	998
1980-81	1,189	1,134	1,213	1,015	998	1,015
1981-82	1,213	1,134	1,249	1,046	998	1,046
1981-83	1,213	1,134	1,261	1,046	998	1,057
1983-84	1,213	1,134	1,274	1,046	998	1,067
1984-85	1,213	1,134	1,287	1,057	998	1,099
1985-86	1,213	1,134	1,300	1,057	998	1,110
1986-87	1,213	1,134	1,313	1,067	998	1,121
1987-88	--	--	--	1,067	998	1,133
1988-89	--	--	--	1,057	998	1,14
1989-90	--	--	--	1,067	998	1,155

Table VI-4. Supply of active optometrists and optometrist/population ratios, using basic methodology and alternative assumptions: actual 1970 and 1975, projected 1980-90

Projection series	1970	1975	1980	1985	1990
	Number of active optometrists				
Basic methodology...	18,400	19,900	22,000	24,400	26,700
Alternatives:					
Low...	18,400	19,900	22,000	24,200	26,100
High...	18,400	19,900	22,000	24,500	27,100
	Rate per 100,000 population				
Basic methodology...	9.0	9.3	9.9	10.4	10.9
Alternatives:					
Low...	9.0	9.3	9.9	10.3	10.6
High...	9.0	9.3	9.9	10.5	11.1

Source: 1970 active optometrists derived from data collected in the 1968 NCHS Vision and Eye Care Manpower Survey. 1975 active optometrists derived from data collected in the 1972-73 BHM Inventory of Optometrists conducted by the American Optometric Association.

Population: U.S. Bureau of the Census, Current Population Reports, Series P-25, No. 601 (Series II). Total population as of July 1, includes armed forces overseas.

Table A-VI-1. Number and percent of total optometrists by age and activity status: 1973

Age group	All optometrists	Activity status				
		Active	Inactive			
			Total	Retired	Unemployed new graduate	Other unemployed
	Number of optometrists					
All ages	21,697	19,265	2,432	1,217	60	114
Less than 30	1,700	1,690	90	0	50	22
30-39	3,159	3,082	77	5	0	12
40-49	5,674	5,279	395	27	0	29
50-59	6,805	6,236	569	144	0	34
60-69	2,655	2,177	478	341	2	14
70 and over	1,503	793	710	667	0	3
Unknown	33	0	33	33	0	0
	Percent					
All ages	100.0	88.8	11.2	5.6	0.3	0.5
Less than 30	100.0	95.0	5.0	-	2.8	1.2
30-39	100.0	97.6	2.4	0.2	0.1	0.4
40-49	100.0	93.0	7.0	0.5	-	0.5
50-59	100.0	90.6	9.4	2.1	-	0.5
60-69	100.0	82.0	18.0	12.8	0.1	0.5
70 and over	100.0	52.8	47.2	44.4	-	0.2

Note: Percents may not add to totals and subtotals due to independent rounding.

Table A-VI-2. Number and percent of active optometrists by racial/ethnic category: 1973

Racial/ethnic category	Number of optometrists	Percent
All categories	12,265	100.0
White/Caucasian	10,652	96.8
Total minorities	400	3.2
Black/Negro	105	0.5
Japanese/Chinese	200	1.5
Other, Asian	9	1/
Indian/Eskimo/Aleut	12	0.1
Mexican American	37	0.2
Puerto Rican	1	1/
Other Latin American	10	0.1
All other	10	0.1
Not reported	133	0.7

1/ Less than 0.05 percent.

Table A-VI-3. Percent of self-employed optometrists, by form of self-employment and age: 1973

Form of self-employment	All ages	Less than 30	30-39	40-49	50-59	60-69	70 and over
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Solo practice	79.9	50.0	70.7	82.5	83.4	83.2	84.7
Partnership	16.9	34.9	25.0	14.6	13.6	14.4	12.0
Group	3.3	6.2	4.3	2.9	3.0	2.5	2.5
Total	100.0	5.5	15.6	20.2	34.5	11.6	3.0
Solo practice	100.0	4.0	13.0	29.9	36.1	12.1	4.1
Partnership	100.0	11.3	23.1	25.0	27.8	9.9	2.9
Group	100.0	10.5	20.7	25.7	31.4	8.8	2.9

Note: Percents may not add to 100.0 due to rounding.

Table A-VI-4. Number and percent of active optometrists by principal form of employment: 1973

Principal form of employment	Number of optometrists	Percent
Total	12,265	100.0
Self employed:		
Total	10,026	77.3
Solo practice	11,095	61.7
Partnership	2,519	13.1
Group	407	2.5
Employed:		
Total	1,565	10.5
Federal government--military	405	2.1
Federal government--nonmilitary	32	0.2
State or local government	40	0.2
Professional corporation 1/	790	4.1
Optometrist	1,064	5.5
Ophthalmologist	157	0.8
Physician other than ophthalmologist	16	0.1
Multidisciplinary group practice	174	0.9
Nonprofit organization	369	1.9
Profitmaking firm or manufacturer	430	2.2
All other	80	0.4
Not reported	804	4.2

1/ Established after 1969.

Note: Percents may not add to totals and subtotals due to independent rounding.

Table A-VI-5. Number of active optometrists and optometrist/population ratios, by geographic division and State: December 31, 1973

Division and State	Number of active optometrists	Resident population July 1, 1974 (in 1,000's)	Rate per 100,000 population
United States	12,265	209,099	9.2
New England	1,201	12,145	11.9
Connecticut	226	3,030	0.6
Maine	124	1,039	11.9
Massachusetts	749	5,799	12.9
New Hampshire	72	799	9.1
Rhode Island	126	967	13.0
Vermont	44	466	9.4
Middle Atlantic	3,393	37,401	9.1
New Jersey	675	7,325	9.2
New York	1,590	18,214	8.7
Pennsylvania	1,128	11,862	9.5
South Atlantic	2,204	32,602	6.8
Delaware	38	573	6.6
District of Columbia	68	734	9.3
Florida	621	7,745	8.0
Georgia	291	4,810	6.0
Maryland	210	4,074	5.2
North Carolina	336	5,302	6.3
South Carolina	179	2,724	6.6
Virginia	326	4,854	6.7
West Virginia	135	1,780	7.6
East South Central	921	13,206	6.7
Alabama	181	3,546	5.1
Kentucky	225	3,329	6.8
Mississippi	129	2,317	5.4
Tennessee	363	4,895	8.9
West South Central	1,402	20,170	7.1
Arkansas	163	2,035	8.0
Louisiana	225	3,746	6.0
Oklahoma	273	2,669	10.2
Texas	820	11,820	7.0

Table A-VI-5. Number of active optometrists and optometrist/population ratios, by geographic division and State: December 31, 1973 (cont)

Division and State	Number of active optometrists	Resident population July 1, 1974 (in 1,000's)	Rate per 100,000 population
East North Central	3,262	30,022	10.9
Illinois	1,569	11,175	14.0
Indiana	530	5,304	10.1
Michigan	795	9,061	8.2
Ohio	974	10,743	9.1
Wisconsin	436	4,539	9.6
West North Central	1,059	10,915	9.2
Iowa	319	2,863	11.0
Kansas	247	2,264	10.9
Minnesota	361	3,890	9.3
Missouri	422	4,760	8.9
Nebraska	149	1,533	9.7
North Dakota	74	635	11.7
South Dakota	87	602	12.0
Mountain	706	7,200	9.5
Arizona	149	2,073	7.2
Colorado	200	2,460	8.1
Idaho	85	776	11.0
Montana	101	730	13.8
Nevada	48	551	8.7
New Mexico	80	1,099	7.3
Utah	75	1,150	6.5
Wyoming	40	353	11.3
Pacific	3,401	27,473	11.7
Alaska	10	330	5.5
California	2,921	20,652	11.7
Hawaii	74	841	8.8
Oregon	305	2,219	13.7
Washington	385	3,431	11.2

Source: DHEW, HRA, DHM. Optometric Manpower Resources, 1973. DHEW Pub. No. 76-101.

Table A-VI-6. Percent distribution of active optometrists by age in each geographic region: 1973

Age group	All regions	Northeast	North Central	South	West
All ages.	100.0	100.0	100.0	100.0	100.0
Less than 30....	8.0	8.5	7.5	10.1	9.6
30-39.....	16.0	12.9	13.9	17.7	20.9
40-49.....	27.4	27.7	26.7	27.9	27.5
50-59.....	32.4	32.2	34.0	31.0	29.7
60-69.....	11.3	13.7	12.6	9.3	9.0
70 and over.....	4.1	5.0	4.5	3.4	3.3
All ages.	100.0	24.6	30.7	23.0	22.7
Less than 30....	100.0	24.0	26.2	27.2	22.6
30-39.....	100.0	20.0	26.7	26.3	27.1
40-49.....	100.0	25.0	30.0	24.2	20.8
50-59.....	100.0	24.7	33.0	23.4	19.0
60-69.....	100.0	30.1	34.2	19.2	16.4
70 and over.....	100.0	30.1	33.5	19.7	16.6

Note: Percents may not add to 100.0 due to rounding.

Table A-VI-7. Number and percent of active optometrists by school or college of graduation: 1973

School or college	Years of operation	Number of optometrists	Percent
Total	--	19,265	100.0
Northern Illinois	1926-55	4,077	21.2
Southern	1932 to present	2,670	13.9
Pennsylvania	1919 to present	2,470	12.9
Los Angeles 1/	1904 to present	1,525	7.9
Massachusetts	1894 to present	1,210	6.3
Illinois	1955 to present	1,106	6.2
Ohio State University	1914 to present	1,012	5.3
Pacific University	1921 to present	999	5.2
Chicago (Monroe)	1937-55	909	4.7
University of California	1923 to present	874	4.5
Columbia	1910-56	817	4.2
University of Houston	1952 to present	433	2.3
Indiana University	1951 to present	391	2.0
Rochester	1902-36	103	0.5
Needles	1907-26	67	0.4
All other 2/	--	316	1.7
Not reported	--	162	0.8

1/ Name was changed in 1975 to Southern California College of Optometry.

2/ Includes 2 Canadian schools.

Sources: Gregg, James D. The Story of Optometry. New York, The Ronald Press Co., 1965. Librarian, American Optometric Association Archives, St. Louis, Missouri.

Table A-VI-8. Number and percent of optometrists active in the same State and in the same geographic region as the school from which graduated: 1973

School or college	Active optometrists	In same State		In same census region	
		Number	Percent	Number	Percent
Los Angeles 1/	1,525	1,215	79.7	1,410	92.5
Univ of California	974	751	65.9	881	91.6
Illinois 2/	6,219	1,452	23.4	3,916	63.0
Indiana University	391	207	52.9	282	72.1
Massachusetts	1,210	503	47.9	1,094	89.0
Ohio State Univ	1,012	612	60.5	710	70.2
Pacific Univ	999	253	25.3	797	79.8
Pennsylvania	2,470	977	39.2	1,886	76.1
Southern	2,670	309	11.5	2,030	75.0
Univ of Houston	433	196	45.3	319	73.7

1/ Name was changed in 1975 to Southern California College of Optometry.

2/ Includes also Northern Illinois, Chicago (Monroe), and Needles.

CONCLUSIONS OF THE HRA STUDY

The following set of conclusions responds directly to the Congressional charge concerning whether it is appropriate overall to alter Part B reimbursement under Medicare for services provided by optometrists related to aphakic and cataract conditions. These conclusions have been derived by the Health Resources Administration from factual information, analytic findings, and professional judgments assembled during the Study.

1. Qualifications of optometrists. Optometry is a profession qualified to provide a broad range of services beyond refraction and the provision of eyeglasses. Furthermore, the services provided appear to be effective in patient management, including the management of aphakic and cataract patients. They are reasonable, non-experimental, safe, and generally acceptable to the vision/eye care community and the public.

2. Services related to aphakic and cataract conditions. Many of these services are the same as the specific diagnostic, therapeutic, and consultative services currently covered under Part B of Medicare when provided to pre- and post-surgery cataract patients by ophthalmologists or other doctors of medicine and osteopathy. (See Table 1, Part I Section I-B).

3. Detection and diagnosis of disease. Evidence presented during this study supports the conclusion that optometrists, in general, are qualified to provide services for the detection and preliminary diagnosis of ocular disease and ocular manifestation of systemic disease. Referral, where indicated, is made to ophthalmologists and other health care practitioners for definitive diagnosis and medical or surgical treatment.

4. Standards of Procedure. Clinical standards committees of professional associations have identified effective instrumentation and procedures that are available to and utilized by optometrists which are effective in the diagnosis/detection of disease, notwithstanding limitation by certain State jurisdictions regarding the use of topical drugs.

5. Quality Assurance. Quality assurance is attainable in the provision by optometrists of reasonable, safe, nonexperimental, and acceptable services to all patients including the Medicare eligible population. The development of criteria of care for diagnostic, therapeutic, and consultative services provided by optometrists, and similar to those existing for certain other health professional groups, does appear feasible in both organized and independent health care settings. Such criteria currently exist in a number of individual situations or are in various stages of development.

6. Access to services. Vision/eye care services for aphakic and cataract patients, as well as for patients more generally, can be made more accessible to the Medicare eligible population by providing reimbursement for services when provided by optometrists. In general, optometrists are more widely distributed geographically and practice in many smaller communities where other vision/eye care practitioners are not available.

7. Equity. Financial equity can be extended to those Medicare beneficiaries who currently obtain necessary and reasonable health services from optometrists but who do not currently receive the reimbursement to which they should be entitled.

8. Delivery patterns. It is reasonable to infer that inclusion of services under Medicare for aphakic patients when provided by optometrists would not significantly alter existing provider delivery patterns within the vision/eye care community. However, the impact upon such delivery patterns of the inclusion of services by optometrists for cataract patients, while likely to be small, is less clear.

9. Costs. It is reasonable to infer that the inclusion of services related to aphakic and cataract conditions when provided by optometrists would result in some added costs to the Medicare program. These added costs would be partly associated with Medicare enrollees currently served by optometrists without reimbursement, as well as those patients not now receiving care, who would do so as a result of the inclusion of such services under Medicare. Estimates suggest, however, that such added costs would not be significant in the context of overall Medicare costs for vision/eye care services and service benefits. (See the Study Summary, Part I, p. 28). This is viewed particularly so in the instance of extended reimbursement for services provided by optometrists to aphakic patients.

RECOMMENDATIONS AND ADDITIONAL CONSIDERATIONS OFFERED BY STUDY CONSULTANTS

In reviewing study materials, expert consultants to the study concluded that steps should be taken immediately to extend reimbursement under Part B for services provided by optometrists to both aphakic and cataract patients. It was their collective judgement that referral delivery patterns, costs, and administrative features of the program, would not be significantly affected if reimbursement of optometrists were extended to cataract, as well as aphakic, patients. Thus, study consultants recommended the following:

1. Based primarily on considerations of patient needs, qualifications of optometry to provide services effective in patient management, and increased access of Medicare beneficiaries to vision/eye care services, it is recommended that covered services related to aphakia when provided by optometrists be reimbursable under Part B of Title XVIII. This recommendation is presented in direct response to the requirements of Section 109 of the Social Security Amendments of 1975 (P.L. 94-182).

2. Based on the same considerations as indicated above, it is recommended that covered services related to cataract conditions, when provided by optometrists, be reimbursable under Part B of Title XVIII.

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.

ATTACHMENT

LISTING OF EXPERT CONSULTANTS, STUDY STAFF, FORMAL AGENCY LIAISON

and

I. Expert Consultants

Ron G. Fair, O.D.
Practicing Optometrist
Brighton, Colorado

James P. Gills, M.D.
Practicing Ophthalmologist
New Port Richey, Florida

Robinson D. Harley, M.D.
Practicing Ophthalmologist
Philadelphia, Pennsylvania

Albert N. Lemoine, M.D.
Department of Ophthalmology
The University of Kansas School of Medicine
Kansas City, Kansas

Carroll M. Martus, O.D.
Practicing Optometrist
Marblehead, Massachusetts

Michael J. Obremsky, O.D.
Practicing Optometrist
Annandale, Virginia

Henry B. Peters, O.D.
Dean, School of Optometry
University of Alabama
Birmingham, Alabama

R. Roy Rusk
Director, Program
American Foundation of Overseas Blind, Inc.
New York, New York

William K. Selden, Litt.D.
Princeton, New Jersey

II. Key Study Staff

Paul M. Schwab, M.A., M.P.H.
Office of the Administrator
Health Resources Administration

Thomas D. Hatch
Nathan Watzman, Ph.D.
Grace Madison, J.D.
David B. Hoover, M.P.H.
Division of Associated Health Professions
Bureau of Health Manpower, HRA

Stuart Bernstein, B.A.
Larry W. Lacy, M.A.
Manpower Analysis Branch
Office of the Director
Bureau of Health Manpower, HRA

III. Formal Agency Liaison

Samuel W. Kidder, Pharm.D., M.P.H.
Office of the Assistant Secretary for Health

Linda L. Cohen, M.D.
Bureau of Quality Assurance, Health Services Administration

Luigi Giacometti, Ph.D.
National Eye Institute, National Institutes of Health

Peter W. Ries, Ph.D.
National Center for Health Statistics, Health Resources Administration

Alvin Abrams, M.D.
National Center for Health Services Research
Health Resources Administration

Harold Fishman
Bureau of Health Insurance, Social Security Administration

James Caple
Office of Research Statistics, Social Security Administration

IV. Secretarial and Meeting Coordination Assistance

Shirley G. Miller
Roberta Light
Frances A. Gaetano
Division of Associated Health Professions
Bureau of Health Manpower, HRA

V. Library and Reference Services

Elizabeth Martinsen
Manpower Analysis Staff
Office of the Director
Bureau of Health Manpower, HRA

stration

Adopted by the American Optometric Association House of Delegates

A primary care optometrist is defined as the eyecare professional of first contact for the patient, makes the initial assessment and attempts to solve as many of the patient's problems as possible, coordinates the remainder of the health care team, includ ng ancillary personnel as well as c nsultants, that are necessary in dealing with the patient's problems; provides continued contact with the patient and often his/her family regarding eyecare needs; and is responsible for his/her eyecare.

Juneau MEDICAL SOCIETY

P. O. BOX 3-3000 • JUNEAU, ALASKA 99802 • TELEPHONE (907) 586-2611

March 9, 1979

The Honorable Glenn Hackney
Chairman
Health, Education & Social
Services Committee
The State Senate
Pouch V
Juneau, AK 99811

SB 75 - 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

JUNEAU MEDICAL CENTER
R.R. 3, BOX 3051
JUNEAU, ALASKA 99801

PRACTICE LIMITED TO THE EYE

ROBERT N. PAGE, JR., M.D.

file SB 75

January 31, 1980

Senator Glenn Hackney
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney:

You will be considering HB 79 and Senate Bill 75. If passed, these bills would permit Optometry, a non-medical measuring science, the use of potentially dangerous prescription drugs. These drugs would be used for the diagnosis of disease, for the determination of the absence of disease and, in certain cases, in the treatment of disease.

Most of your constituents and Americans in general are unaware of the fact that Optometry is in no way a medical science. Optometry's national advertising ("Your Family Doctor of Optometry"), as well as their lobbying before this and other state legislatures, has been deceptive.

If this legislature grants the privilege of practicing medicine to this non-medical group by legislative fiat rather than by educational achievement, it will further compound this public deception.

There is amassed ample irrefutable evidence that this policy has caused great harm, unnecessary suffering, loss of vision and economic loss in the form of recovered damages. I enclose examples of such evidence.

I know you are burdened by many more important issues; few, however, have the potential of impacting as heavily and adversely on Alaskans' public safety from a health point of view.

Please consider these points and call on me at any time if I can help.

Sincerely,

Robert N. Page, M.D.

Enclosures

HOW DOES OPHTHALMOLOGY (M.D.) TRAINING COMPARE WITH OPTOMETRY (O.D.) TRAINING?

OPTOMETRIC EDUCATION DEFICIENCY DOCUMENTED

As prepared by John W. Gamel, M.D., University of Louisville School of Medicine

EDUCATIONAL BACKGROUND REQUIRED FOR DELIVERY OF EYE CARE:

Comparison between Optometry and Ophthalmology*

REQUIREMENT	OPTOMETRY	OPHTHALMOLOGY
Admission	2 years of college	4 years of college plus 4 years of medical school
Total Training after High School	6 years	12 years
Class and Laboratory time	1,650 hours	3,249 hours
Supervised Practice of General Medicine (Internal Medicine, General Surgery, Obstetrics-Gynecology, Psychiatry, Primary Care)	0 hours	3,240 hours
Supervised Practice of Medicine and Surgery of the Eye	0 hours	5,250 hours
TOTAL TRAINING HOURS	1,650 hours	11,739 hours
Number of years during which training occurred	4 years	7 years
Hours per year	412½ hours	1,677 hours

* Information abstracted from:

1. Course Handbook of Indiana University, Division of Optometry, 1975-76.
2. American Association of Medical Colleges Curriculum Directory, p. 86 87 (re: University of Louisville School of Medicine).
3. Residency Training Schedule, Department of Ophthalmology, University of Louisville.

(over)

Conclusion: An Ophthalmologist (M.D.) receives more hours of training each year of his rigorous program, than an optometrist (O.D.) receives in his entire four-year curriculum.

OPHTHALMOLOGY
11,739 HOURS

OPTOMETRY
1,650 HOURS

THE OPHTHALMOLOGIST (M.D.) HAS OVER 700% MORE HOURS!

John W. Gamel, M.D., Assistant Professor and Director, Pathology Laboratory and Medical Retinal Service, University of Louisville (Kentucky) School of Medicine has provided new, conclusive evidence that optometric education is "woefully inadequate" for these technicians to attempt to provide any medical eye services. The Gamel study reveals that the graduate ophthalmologist (M.D.) has received more hours in each year of his rigorous program than an optometrist receives in his entire four-year curriculum. Excluding any differences in content, the data shows the ophthalmologist (M.D.) has over twice as many hours of class and laboratory study as the optometrist. Furthermore, the ophthalmologist (M.D.) has infinitely more medical and surgical supervised experience in patient care than the optometrist. In total, the ophthalmologist (M.D.) has over 700% more hours of training than the graduate optometrist.

RESIDENCY TRAINING SCHEDULE, DEPARTMENT OF OPHTHALMOLOGY UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE

Summary of Hours of Didactic Learning Offered During Residency:

Ongoing Lectures:

Monday, a.m.	1 hour
Tuesday, a.m.	1 hour
Thursday, a.m.	2 hours
Friday, a.m.	1 hour
TOTAL	5 hours per week

Basic Science Courses:
40 hrs per wk lectures/labs
Duration: 10 weeks

Home Study Course:
20 hrs per month
Duration: 24 months

BREAKDOWN OF HOURS SPENT IN EDUCATION OF OPHTHALMOLOGIST:

1. Class & Laboratory:		
Medical School		
1st year	871	
2nd year	748	
		1,619
2. Residency:		
Lectures:		
5 hrs per wk x 150 weeks	750	
Basic Science		
40 hrs per wk x 10 weeks	400	
Home Study		
20 hrs per mo x 24 mos	480	
		1,630
TOTAL DIDACTIC TRAINING (HRS.) (1 + 2)		3,249
3. Supervised Practice of General Medicine 54 wks x 60 hrs per wk (includes night calls & weekends)		3,240
4. Supervised Practice of Medicine and Surgery of the Eye 35 hrs per wk x 150 weeks		5,250
TOTAL TIME SPENT IN SUPERVISED PRACTICE (HRS.) (3 + 4)		8,490
TOTAL TIME SPENT IN FORMAL EDUCATION OF OPHTHALMOLOGIST AT THE UNIVERSITY OF LOUISVILLE (HRS.) (1 + 2 + 3 + 4)		11,739

"M.D. IS THE MAJOR DIFFERENCE"

THE PEN...

PRO BONO PUBLICO

Published in the Public Interest by Ophthalmology

VOL. 3 NO. 15 OCTOBER 1, 1979

U.S. Naval Medical Officers Expose Policy Which Threatens Quality Eye Care Throughout Military

Naval Regional Medical Center at Camp LeJeune, North Carolina

The military ophthalmologists at Camp LeJeune, N.C., have pinpointed "fear of retaliation" as the reason medical officers have not exposed the extent of unnecessary damage which has occurred in the armed forces as the result of allowing medical functions to non-medical optometrists.

Reporting that "primary eye care" performed by optometrists has caused irreversible eye damage and untold suffering for military personnel and their dependents around the world, Lieutenant Commander (LCDR) U.S. Naval Reserve (USNR) Gregory W. Cobb, M.D., Chief of Ophthalmology, Naval Regional Medical Center at Camp LeJeune, and Frederic D. Young, M.D., LCDR, USNR, an ophthalmologist at the same facility, have risked the wrath of the establishment and expressed their concerns directly to Representative Melvin Price, Chairman of the House Armed Services Committee, to Representative Butler Derrick of South Carolina, and to Vice Admiral W. P. Arentzen, Surgeon General of the Navy.

Upon hearing that Representative Price's committee had not received any complaints from active duty ophthalmologists on the matter of "extending

Continued on page 2

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.

Kentucky O.D. Overlooks Eye Cancer; M.D. Diagnosis Is Malignant Melanoma

Dr. Millett's History of the Case of Elvis R. Johnson — Summarized for Readers

- **April 16, 1979**

Mr. Elvis R. Johnson, formerly a Lexington, Kentucky house painter, was taken to the emergency room of the VA Medical Center, complaining of a dark spot on his left eye and decreased vision in the eye. Medical doctors immediately suspected a malignant melanoma which had spread beyond the eye itself — highly dangerous and potentially fatal.

- **April 23, 1979**

A complete metastatic work-up confirmed the suspicion of the malignancy and that it had spread beyond the eye but not throughout the body. The decision was made to perform an "orbital exenteration" — complete removal of the eye and all structures surrounding it. This operation leaves a deep, permanent disfiguring scar.

- **May 4, 1979**

The surgery was performed on May 4, 1979. Mr. Johnson is recovering nicely, and the malignancy has been removed. He is permanently disfigured. Microscopic examination of the specimen confirmed the pre-operative diagnosis and the need for drastic surgery.

Transcript of Tape-Recorded Interview

This is Adrienne J. Millett, M.D., staff ophthalmologist at the Veteran's Administration Medical Center in Lexington, Kentucky, and here with me today are Mr. Elvis R. Johnson, a patient of mine at the VA Hospital, and his son, Mr. Elvis L.

Continued on page 3

Misplaced Confidence — Tragic Hindsight

As the adjacent interview of patient Elvis R. Johnson and his son, Elvis L. Johnson, reveals, an impressive array of office equipment convinced the Johnsons, of Lexington, Kentucky, to place medical confidence in an optometrist.

A black spot in the eye (which was ultimately diagnosed by an M.D. as potentially fatal Malignant Melanoma) was dismissed as "nothing to worry about" over a year ago. The optometrist attempted to correct the situation with glasses and recommended frame adjustments — while the malignant tumor grew and spread.

Elvis R. Johnson is blind and disfigured — but happy to be alive. His son, who helped him to choose the well-equipped limited practitioner, is sadder but wiser — and knows the "major difference." The surgeon, Adrienne J. Millett, M.D., Assistant Professor, Department of Ophthalmology at the University of Kentucky's Albert B. Chandler Medical Center, performed the surgery, and conducted the interview for PEN. The Johnsons are anxious to share their story to protect others.

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.

On Selecting Adjectives for the Eye Care Crisis

Scandalous. Absurd. Courageous. Determined. Tragic.

These are powerful adjectives. The truth of the public danger from the invasion of medicine by non-medical practitioners, and reports of medical resistance to this threat, cannot be written without resorting to these strong words. The message we bring you in these pages each month contains strong words, for what is occurring throughout our nation, in both civilian and military eye health care, has been labeled a crisis by independent journalist V. H. Krulak — and to confront a crisis, weak words are impotent.

Consider the plight of Kentuckians Elvis R. Johnson and Elvis L. Johnson as detailed on page 1 of this issue, and decide if tragic is too strong a word. The father is blinded, the son is guilt-ridden, having been misled into believing that fancy equipment used by an optometrist could substitute for a medically trained mind. Kentucky legislators were similarly misled last year when optometrists were given the right to legally use dangerous drugs and eye drops.

Consider the reaction of Kentucky medical leaders in launching an uphill optometric drug law repeal campaign and decide if determined and even courageous are overstatements. It may take years, but the quality of eye health care in Kentucky is at stake, and courage is involved because the leaders of this effort will be vilified and boycotted from optometric referrals. The hole in Mr. Johnson's head, which could have been averted by appropriate referral, concerns them more than the financial benefits of optometric goodwill.

Speaking of courage, consider the action of Lieutenant Commanders **Cobb and Young** (see page 1) in lifting the lid on a scandalous military eye health care dilemma which threatens the precious gift of eyesight for military families everywhere. Following the lead of Colonel Appleton, they have put their military careers on the line by speaking out to preserve "the magic sense" for their patients. Is courageous an exaggeration in peacetime?

Ponder the absurdity of the petition of optometrist Maynard to the Arizona legislature (see page 3). In presenting a bill which would allow the practice of surgery to optometrists — the use of any device to treat the "abnormal conditions of the human eye or its adnexa" (adjacent parts) — he has proposed the exact equivalent of legalizing brain surgery by barbers. Is absurd too flamboyant? Determined also applies in this case — opportunist Maynard has mobilized Medicine under the leadership of the Arizona Ophthalmological Society legislative chairman, Thomas F. Moore, M.D., who is determinedly alerting all to the danger in the Grand Canyon state.

Eyesight to many is as precious as life itself. Thus, it is not possible to comment on action which recklessly risks blindness without resorting to superlatives.

If you feel that scandalous, absurd, courageous, determined, and tragic do not apply to the concerns raised in this issue, then try shocking, ridiculous, brave, dedicated, and oh, so sad — and tell a friend that entrusting eye health care to a limited practitioner is a very risky business.

JHA

MILITARY EYE CARE THREAT

Continued from page 1

the privileges of optometrists", the naval officers registered their protests loud and clear in letters dated August 17 and 24, 1979.

The letters, signed by both officers, pointed out that they served at Camp LeJeune as the "referral center" for five military optometrists (four Navy, one Air Force).

They told the Congressmen, "Hardly a week passes without our becoming aware of another example of the optometric mismanagement of ocular disease. We are continually astounded by the lack of understanding of basic ocular disease, its diagnosis and treatment revealed in the chart entries and consultation summaries from these young, supposedly well-trained optometrists."

Cases Provided

To illustrate their point, physicians Cobb and Young cited two sample cases of optometric mismanagement.

In the first instance, they reported that a dependent child was seen by an optometrist at the Naval Hospital at Cherry Point, N.C., in 1976 and 1977 at ages six and seven. On both occasions, it was noted that the child suffered from a high degree of farsightedness in both eyes, a turning inward (esotropia) of the left eye, and amblyopia (lazy eye) of the left eye.

At the later visit in 1977, the vision in the child's left eye was 20/80, poor compared to a normal vision of 20/20. Without determining the cause of the poor vision, the optometrist prescribed "circle exercises" with the right eye covered. The M.D.s noted that this was totally inadequate therapy for amblyopia. The parents had stated to the M.D.s that "no follow-up care" was provided and they were not advised of the urgency of aggressive treatment of amblyopia before the age of nine or ten, when visual maturity is reached and the condition becomes irreversible.

At age nine the same patient was seen by an optometrist at Cherry Point complaining of pain in the left eye. At this time vision had dropped to 20/100 and the esotropia was still present. This optometrist told the parents no facilities for treatment of the child's condition were available in the Navy; this, despite the fact that two ophthalmologists, to whom referrals were routinely made, were stationed at Camp LeJeune just 40 miles away.

Continued on page 4

THE PEN... EDITORS

VOLUME 3, NUMBER 15
OCTOBER 1, 1979
ST. PETERSBURG, FLORIDA

Medical Editors: James H. Allen, M.D., New Orleans, La.; Leonard B. Alenick, M.D., Tacoma, Wash.
Contributing Editors: Roland E. Houle, M.D., Quincy, Mass.; David W. Parke, M.D., Meridan, Conn.
Staff Editors (St. Petersburg, Fla.): George P. Russell, Frank T. Barnes, Daniel R. Casseday
Production Manager: Edward S. Barclay

Published in the Public Interest by The Physicians Education Network, Inc. a non-profit corporation headquartered at 5013 Central Avenue, St. Petersburg, Florida 33710. (813) 321-2258.

COL. BUDD APPLETON, M.D.

Navy Eye Care Exposé Saluted By Former U.S. Army Eye Care Chief

Colonel Budd Appleton, M.D., the first senior military officer to speak out publicly against drug use by civilian opportunists, and a staunch advocate of medical supervision of optometrists in the military, resigned from the service in 1978 under heavy political pressure. The career military officer, who served as ophthalmology consultant to the Surgeon General, was given the choice of stepping down as consultant or remaining silent in public.

The Colonel, who had served the Army with distinction for 24 years, and who held the highest leadership position in ophthalmology in the army, had testified as a civilian at state legislative hearings in opposition to proposed optometric drug bills. Col. Appleton's testimony was widely sought to provide factual rebuttals to optometry's claims about the safety of military policy which permitted optometrists the use of drugs.

When asked to comment on the actions taken by Lieutenant Commanders Cobb and Young, Col. Appleton told PEN, "I admire the courage of these fine officers, and fervently hope that their efforts will serve to bring this matter into the public spotlight. I believe young military ophthalmologists should not be reluctant to cite instances of malpractice when they occur. It is my observation that most senior military medical officers, including hospital commanders, understand the issues, and the necessity for placing optometric care under medical supervision. In my opinion the only time the proper relationship is interrupted is when optometry interrupts it — through political pressure. It was my opposition to this kind of intervention that brought about my retirement."

Lt. Cdrs. Cobb and Young, in alleging that fear of retaliation was the reason military M.D.s had not exposed existing problems within the military, pointed to the experience of Col. Appleton. In their letter to Congressman Melvin Price, they stated, "In our opinion you have received no complaints from active duty ophthalmologists because the chain of command tends to suppress problems, keeping them at the local level, and there is real fear of retaliation for making waves such as that experienced by Col. Budd Appleton." ●

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.

Happier days . . . Elvis R. Johnson, Kentucky victim of tragic optometric oversight

MALIGNANT MELANOMA

Continued from page 1

Johnson, both from Lexington. Mr. Johnson has been employed most recently as a painter.

Dr. Millett: Mr. Johnson, can you tell us when you were last employed?

Patient Johnson: Well, I went to work and lasted until what was the Friday before the 16th. I don't remember the month. But I was laid off because I couldn't see well enough to do the job. Then I came into the VA Hospital the 16th and . . .

Dr. Millett: That was the 16th of April.

Patient: . . . yes, and on a later day the 23rd, I was admitted.

Dr. Millett: To the VA Hospital?

Patient: Yes, and my eye was removed. I don't remember the exact date. My son brought me.

Dr. Millett: How long had you been having trouble with your eye?

Patient: Well, the real bad trouble about a year.

Dr. Millett: And Mr. Elvis L. Johnson, can you tell us the history of your father's eye complaints as you know them to be?

E. L. Johnson (son): Well, about a year and a half ago a small black place had come up in his eye.

Dr. Millett: Which eye?

Son: His left eye. At first we thought it might be a bruise or something like that, but it didn't go away. I had been going to an optometrist to get contact lenses fitted for myself, and he had all this fancy equipment. The way he carried on his procedures, I thought he was really good and knew his business. So I decided to take my dad in to see him.

Dr. Millett: For what reason?

Son: Because of this black place in his eye. On my last visit to him before I took my father in, I had asked him about this spot in my dad's eye and he said, well, without seeing him he couldn't tell me what it was, but if I brought him in, he'd be glad to examine him.

So I made an appointment for him the next day. I worked right across the street from there at the time, so I dropped my dad off and went on to work. Dad came over about an hour and a half or two hours later and said that he was ready to go home. I asked Dad what the optometrist had said about the place in his eye and Dad told me he said, "It's nothing to worry about, I think I caught it in time." From there he just proceeded to make him a pair of glasses and that was it.

Dr. Millett: Is that what you recollect, Mr. Johnson?

Continued on page 4

Arizona Citizens Threatened By Bill That Gives Optometrists Surgery/M.D. Functions

Offering what he termed a definition of optometry that will be recognized nationwide in a few years, Robert Maynard, O.D., past President of the Arizona Optometric Association, has presented to the Joint Health Committee of the Arizona legislature a proposed bill that would expand the practice of optometry medically and surgically to be the equivalent to the practice of ophthalmology.

Senator Robert B. Usdane, Chairman of the Allied Health Committee, who opposed the optometric proposal, told PEN in a telephone interview that the non-restrictive proposal, in his opinion, would expand optometric services beyond the use of drugs or the prescribing of medications.

When questioned as to whether the optometrists had explained how the permissive bill would benefit Arizona's citizens, Senator Usdane answered no, but noted that discussion of the issue had been limited.

The proposal submitted by optometrist Maynard would amend the Arizona Revised Statute, Section 32-1701, to read, "Practice of optometry" means any one or a combination of the following practices:

(a) The examination of the human eye by any method to diagnose or to treat any abnormal condition of the human eye or its adnexa (adjacent parts);

(b) The employment of instruments, devices, pharmaceutical agents and procedures intended for the purposes of investigation, examining, treating, diagnosing, or correcting visual defects or abnormal conditions of the human eye or its adnexa; or

(c) The prescribing and application of lenses, devices containing lenses, prisms, contact lenses, orthoptics, vision training, pharmaceutical agents, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa.

Although the broadly permissive bill was rejected by the Allied Health Committee, optometrist Maynard, who then presented a bill limited to diagnostic drug use by optometrists, left no doubt that his constituents considered a drug use bill only an interim measure.

The Joint Allied Health Committee, acting to protect the public health, voted not to recommend either proposal. This action means that the Committee will not introduce or sponsor the optometric drug bill. Senator Usdane pointed out, however, that this action would not preclude the possibility of a bill being introduced by one or more legislators during the legislative session.

ARIZONA STATE SEN. ROBERT B. USDANE

. . . voted against dangerous proposal

According to James W. McMahon, attorney for the Arizona Ophthalmological Society (AOS), there is little doubt that an optometric bill will be introduced in some form [illegible]

Truman D. Plainer, M.D., of Tempe, Vice-Chairman of the Physicians Education Network, Inc. (PEN), has reported that medical leaders view the current effort as evidence that optometry's desire to obtain diagnostic drugs was, and is, the first step in the eventual assumption of all ocular care by optometrists, even though they are not trained or qualified for this function.

Dr. Plainer further commented that ophthalmologists feel that the optometric initiative documents what most have known all along, that the purpose of optometrists in Arizona in introducing optometric drug bills is not to "do a better job" as they have claimed, but to become licensed as ophthalmologists via legislative fiat to the detriment of the public interest. ●

Suit Prepared To Stop Use Of Eye Drugs At University Of Alabama Optometry School

The Alabama State Licensing Board for the Healing Arts is preparing to file suit against the University of Alabama at Birmingham (UAB) School of Optometry to stop optometrists at the school from administering prescription drugs, according to the *Mobile Press*.

The newspaper reports that although no suit has been filed yet, George Hardesty, Jr., executive officer for the Licensing Board, has confirmed it was being prepared.

Hardesty told the *Mobile Press* the suit would be an effort "to get a judicial determination" on whether Alabama law allows optometrists to use prescription drugs in the eyes of patients or to write prescriptions for those drugs.

In a letter to Charles N. Robbins, M.D., president of the Alabama Academy of Ophthalmology, dated March 19, 1979, Dr. Charles A. McCallum, vice-president for Health Affairs at UAB, said that state law permits optometrists "to use drugs for diagnostic purposes, but not for therapeutic purposes, and this is the policy followed by our School of Optometry."

The *Mobile Press* reports that when interviewed, Dr. Robbins said Alabama has not passed a law allowing optometrists — who are non-medical practitioners — the use of drugs for diagnostic purposes. He noted that optometrists are trained in the testing of eyesight, the prescription of glasses, and the manufacture of glasses. They are not, he said, trained in the diagnosis, medical or surgical treatment of eye diseases or malfunctions. He emphasized that ophthalmologists — medical doctors who specialize in eye care — have, in addition to their general medical training, special post-graduate training in eye diseases, diagnosis, and treatment, including the use of drugs and surgery.

According to the newspaper the Alabama law regulating optometrists states: "Provided, however, nothing in this section shall be construed so as to permit the administering of drugs in any form or prescribing of drugs for the medical treatment of eye diseases or the performance of surgery of any nature for any purpose."

The paper reports that in 1976 the then State Attorney General, Bill Baxley, issued an opinion on the law that "the practice of optometry does not permit the administration of topical drugs in any form to the human eye for the purpose of diagnosis." The Attorney General's opinion, however, does not carry the weight of law, and must be tested in court. ●

MILITARY EYE CARE THREAT

from page 2

The child was subsequently seen by a civilian ophthalmologist. He diagnosed her condition properly, and informed the child's parents that the help she needed *was* available in the Navy at nearby Camp LeJeune.

The patient, now nine years of age and nearing maturity, will require a much longer course of therapy for her amblyopia. More importantly, the delay in treatment may well have produced irreversible damage.

"Gross Malpractice"

Terming the optometric mismanagement of this case "gross malpractice", the naval officers report that litigation against the government is likely to be instituted, since they have already been contacted by attorneys.

In further support of their allegations, the two officers made reference to a serious case reported in September 1978.

According to the M.D.s, an enlisted man aboard ship in the Mediterranean explained to the general medical officer (M.D.) in early August of 1978 that he was suffering from double vision (diplopia) and headaches. The physician was concerned about swelling of the patient's optic nerve head — a serious sign — and promptly referred the patient to the "eye doctor", specifically stating ophthalmology, at the Naval Hospital in Rota, Spain.

Since there was no ophthalmologist at this hospital, the patient was seen by an optometrist. According to the patient, the optometrist noted he had crossed eyes, which he said was no problem, but that surgery to reposition the eye muscle would be necessary in the future. The ship's physician, apparently content that his patient had been seen by an eye specialist, failed to pursue the matter further.

About a month after the optometric examination Drs. Cobb and Young saw the patient. Their examination revealed decreased vision in both eyes, obvious swelling of both optic nerve heads, paralysis of both sixth cranial nerves, which paralyze the muscles which rotate the eyes, consistent with increased pressure inside the skull, affecting the brain. The patient was transferred immediately to the National Naval Medical Center in Bethesda, Md., where sophisticated skull X-rays revealed a chronic subdural hematoma (blood clot in the brain). In less than 36 hours after seeing the ophthalmologist, the patient underwent brain surgery to remove the clot.

This patient suffered needlessly, and could have lost all vision or his life as a result of optometric misdiagnosis. More significant is the fact, they note, that the optometrist failed to recognize that sudden, unexplained double vision in a young adult is an ominous sign requiring immediate, thorough medical evaluation.

Another ophthalmologist, John D. Walker, M.D., Lieutenant Colonel in the United States Army, residing in Berea, Kentucky, presented his personal views on military optometry. He said, "I am opposed to their prescription of eye medications, because of the possibility that this may delude either the optometrist and/or the patient into thinking that appropriate treatment has been given, and therefore delay referral to appropriate medical care facilities."

He states that while the ophthalmologist is the local medical eye authority, he still is within the military chain of command. He notes that the ophthalmologist is responsible to the Chief, Department of Surgery; Chief, Professional Services; and the Medical Treatment Facility Commander, in that order. He reports that these individuals, by regulation, may treat ophthalmologists, optometrists, and physician's assistants as equals in rank, ignoring the difference in their educational qualifications and medical knowledge. ●

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 grc vs)

Date_____ 19____

Name_____

Address_____

City_____ State____ Zip_____

Telephone: (Area)_____ Number_____

Ophthalmologist?____ Other specialty_____

Profession, other than M.D.?_____

Check enclosed ($250)_____ Please bill me_____

☐ Resident Dues $25.00
☐ Affiliate (spouses, office staff) $25.00
☐ Military M.D.s $150.00

MALIGNANT MELANOMA

Continued from page 3

Patient: Yes. I remember him saying, "You came to me in time," and that he could help me.

Dr. Millett: And how was it that he offered to help you?

Patient: He ran tests on his machine, fitted me with glasses, and told me it would be a few days, then I would get my glasses. Then I went to Indiana and this eye started giving me trouble so I came back to Lexington in March of '79. I couldn't see when I went to work so I came to the VA Hospital and that's when I had to have my eye removed.

Dr. Millett: At the time you went to see the optometrist, were you having trouble with your vision?

Patient: Yes. I thought it was both eyes, but I guess it was just the left one because it kept getting worse all the time. When I came to the VA Hospital I found out what really happened. I had a tumor that had to be removed.

Dr. Millett: Did the optometrist offer you a return appointment or offer you a referral to a physician?

Patient: No, he did not.

Son: The only thing he wanted was for Dad to come back in for refitting of his frames because they didn't fit him properly. And as Dad was in the VA Hospital at the time, I told him that wouldn't be possible. The one thing is that from the time he got his glasses on, we were around him all the time.

We really couldn't tell that much of a change in the black spot so we continued thinking it was a bruise. In January he left for Indianapolis and after not having seen him for a couple of months, we noticed the big change . . . it was staring you right in the face.

Dr. Millett: How many times would you estimate the black spot had enlarged, if you had to just guess?

Son: From the first time I saw it, at least ten times, if not more.

Dr. Millett: Was it obvious at that time, or were you looking for it?

Son: It was very obvious. You couldn't miss it.

Dr. Millett: Did it continue to enlarge from January until April, when your father came to the VA Hospital?

Son: He came back in March and yes, it did continue to enlarge, but I couldn't tell that much of a change from the time he got back to the time he was admitted to the hospital. I feel that if the optometrist had done his job properly, and actually examined my dad like he should have, he should have at least noticed something wrong and recommended us to a specialist.

Dr. Millett: Mr. Johnson, can you describe for us the series of events that happened to you when you came to the VA Hospital in April of 1979?

Patient: I was taken to the Eye Clinic where a doctor examined me. He had four or five others look at my eye, and they decided it was a tumor. Then he took me in and talked to me and told me what it was.

Dr. Millett: And what did he tell you?

Patient: He said it was a malignant tumor, and it would have to be taken care of. They arranged to bring me in on April 23, and I lost the eye some days later.

Dr. Millett: What did the doctors do with you while you were in the hospital?

Patient: They ran scans of my brain, liver, and bone for some days before they operated.

Dr. Millett: Did the doctors find any evidence of spread of this tumor?

Patient: Yes ma'am, I think they had.

Dr. Millett: Where was that spread?

Patient: It was in my left eye and the left corner of my eye.

Dr. Millett: Was it spread anywhere else throughout your body that the doctors were able to detect?

Patient: As far as they could tell with the scans they ran it was stable in that one place.

Dr. Millett: You went to the operating table on May 4, 1979. What sort of procedure did you have?

Patient: A fellow told me what they would be doing, and what they would give me. Before I went into surgery a doctor took some pictures of me; then I went into surgery. When I woke up my eye was gone and the operation was complete.

Dr. Millett: Mr. Johnson, do you have any comments that might summarize your feelings about what happened to you?

Patient: My story might be of use to other people; if they came up with a problem like mine, they should go to people who can help them. I made a mistake in going to an optometrist in the first place. I guess the man wasn't equipped to find anything, or else he didn't want to find anything. I don't know, but I'd advise them to go where they could get themselves taken care of properly before it gets too late, like it was for me.

Dr. Millett: Do you have any last comments that you would like to make to the people who will read this publication?

Son: His modern equipment made me feel that the optometrist was properly trained to detect what was there, but he failed to do his job. If a man can't do that then you know he really doesn't have any business in the job to begin with. Optometrists, I believe, should be left to making glasses and contact lenses, but not diagnosing illness. If anything like this comes up again, you can be sure I'm not going to take my dad to an optometrist again. ●

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 NOW PUBLISHED MONTHLY UNTIL NOVEMBER

"M.D. IS THE MAJOR DIFFERENCE"

THE PEN...

PRO BONO PUBLICO

Published in the Public Interest by Ophthalmology

VOL. 3, NO. 13 AUGUST 1, 1979

ORGANIZED OPTOMETRY CO-DEFENDANT

Glaucoma Victim Blames Optometric Ads, 3 O.D.s in Indiana Lawsuit

John Collins, a glaucoma victim, has filed suit against three Indiana optometrists and the 20,600-member American Optometric Association (AOA) for alleged negligence that has caused his condition of glaucoma to progress from a non-impairing, controllable problem to that of disabling, irreversible near-blindness.

The former Indiana resident, now residing in Charleston, West Virginia, has filed suit in the U.S. District Court of Southern Indiana, and the amount in controversy exceeds $10,000 exclusive of interest and costs.

According to the complaint filed by Howard S. Young, Jr., attorney for the plaintiff, sometime prior to 1977, Collins began to develop glaucoma in his eyes of which he was unaware and in the first part of 1977 noticed impairment in his vision.

The complaint states that on or about May 21, 1977, John Collins went to the defendant, Dr. Kenneth Van Arsdall, an optometrist practicing in Columbus, Indiana. It is alleged that this optometrist, who prescribed glasses, negligently failed to detect, diagnose, or treat the plaintiff's condition of glaucoma.

The complaint further alleges that Collins went to two other optometrists, also practicing in Columbus, Indiana, one in September, 1977, and the other in October, 1977, and that they too failed to detect, diagnose, or treat glaucoma in the plaintiff's eyes.

It is claimed that as a result of this negligence, John Collins' glaucoma was not diagnosed or treated until late December of 1977, at which time Collins' vision was substantially and permanently damaged so that he is nearly blind.

The complaint also states that in order to induce members of the public to seek the services of optometrists, including the named defendants, the American Optometric Association negligently advertised, informed, and represented to the public, including the plaintiff, that optometrists were educated and qualified to detect and diagnose glaucoma and to give the best vision care possible. AOA also represented that optometrists were capable of giving preventive care, when in fact some members of its association were not so qualified.

Claiming damages in excess of $10,000, the plaintiff alleges that he has incurred large medical expenses, lost earnings, and suffered pain and agony, all of which may continue. He states that his earning capacity has been permanently impaired, and that he is also permanently impaired in his ability to perform the ordinary activities of daily life.

The allegation of AOA negligence in advertising was a concern of Virginia Governor John N. Dalton when he vetoed for the second straight year an optometric drug bill.

In his veto message Governor Dalton made specific reference to the on-going optometric advertising. In this regard the Governor said, "There is further concern over public misunderstanding that complete medical care has been effected after having an optometric examination. Recent advertising in national magazines and on television by the American Optometric Association has reaffirmed my concern in this regard."

Continued on page 3

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.

Blind Victim of O.D. Oversight Sues; Settles For $53,500

WINONA T. BROWN

"No amount of money can pay for loss of my eye"

Optometric mismanagement and failure to refer promptly to a medical doctor have cost a Seattle, Washington, woman the sight of her right eye, and provides further evidence for the growing file of PEN cases that non-medical practitioners are not qualified to diagnose or treat disorders of the eye.

The victim, Winona T. Brown, experienced continued difficulty for a 12-month period adjusting to contact lenses prescribed by her optometrist. Finally, her right eye developed an infected ulcer, causing excruciating pain. Ms. Brown was eventually referred to an ophthalmologist. Despite immediate hospitalization, with intensive medical and surgical treatment, Ms. Brown has permanently lost vision in her right eye.

Ms. Brown received damages in the amount of $53,500 in an out-of-court settlement with the op-

Continued on page 3

OPTOMETRIC MISMANAGEMENT

Total Settlement to New Jersey Glaucoma Victim May Exceed Half Million Dollars

A New Jersey optometrist's failure to detect glaucoma and to refer the patient for appropriate medical treatment has resulted in near total blindness for the patient, and an out-of-court settlement that will cost the optometrist $25,000 in a lump sum plus $20,000 a year for the patient's lifetime plus attorney's fees. The patient has a life expectancy of 25 years.

According to Alfred Dimiero, attorney for Eleanor Steward, age 49, a resident of Newark, his client noted a loss of peripheral vision and first saw the optometrist in November, 1975. On examination, the optometrist determined that the patient was able to perceive light in her left eye, but could not see images. The optometrist, however, failed to determine why this was the case. He never examined the interior of the patient's left eye, never inquired as to the history relating to that eye, and took an incorrect pressure reading with a Schiotz tonometer.

The plaintiff's attorney relates that, on examining the patient's right eye, the optometrist detected no disease and declared the vision to be good. The optometrist prescribed bifocals with a balance lens for the left eye which, being blind, could not be helped by eyeglasses.

After some 15 months the optometrist's patient, Eleanor Steward, was examined by an Ophthalmologist, a medical eye specialist, who found that the patient was suffering from advanced glaucoma in both eyes with permanent loss of vision. Because of the delay in diagnosis and treatment, she is now blind in the left eye and can see only hand movements with the right eye.●

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.

Who Should Pay The Price of Incompetence?

Justice may be blind, and retribution may be slow, but documented evidence appearing in this issue of THE PEN attests to the fact that if blindness results from negligence on the part of those professing to accept the responsibility for sight, the cost can be astronomically high.

In a letter to the editors of the *American Optometric Association News* which appeared in the July 15, 1979 issue, optometrist Harold L. Castleman of Chambersburg, Pennsylvania, wrote:

"Dear Sir:

I grieve everytime I read the *AOA News* in which articles and advertisements proclaim the drop in malpractice insurance rates through the Aetna Life & Casualty Co. My insurance is costing me $250.00 this year, far above the figures you quote. Aetna requires us to have $1 million in personal liability which runs the premium up and is a whole different ballgame."

To O.D. Castleman we say, "You ain't seen nothin' yet."

Medical doctors, who are by no means without blame in some instances, have had to accept the high cost of insurance protection, as a part of the cost they must pay for the privilege of attempting to heal the sick.

If optometrists, who are not trained or qualified to perform medical functions, persist in their efforts to achieve medical status through legislative channels, the "new ballgame" that optometrist Castleman refers to hasn't even been developed yet. And there can be no doubt that in comparison to the present, it will make Russian roulette look like a game of Parcheesi.

High as the present cost may be in terms of malpractice insurance, if damages due to mismanagement continue to mount, the cost to the optometric profession will soar. More importantly, the cost in suffering and loss of vision to those who have entrusted their eyesight to them will climb.

Optometry has for many years been an honorable and necessary profession. Today, however, the validity and credibility of the profession and all who practice it are being undermined and seriously damaged by those few misguided zealots who for reasons of social status or economic gain seek to function beyond their training and their capabilities without regard for patient well-being or patient safety.

The ultimate cost is one that defies calculation. It is the cost of being blind. No amount of money, however astronomical the sum, can replace the God-given gift of sight, as Ms. Brown states in her deposition on page 1.

Acceptance of such a fate is hard enough if the victim is confident that all that could have been done was done, but to be doomed to darkness knowing that such a fate need not have been, is not acceptable.

The ultimate cost, blindness, can be drastically cut, if not eliminated, by demanding that every man, woman, and child in this nation be assured only medical care by M.D.s, not pseudo-medical care by non-medical practitioners.

Optometric contentions that would substitute quantity for quality and convenience for competency must be challenged by rational persons and must be constantly refuted.

We recognize that there are many practitioners in the field of optometry who believe as we do, that medicine is a function for only those trained and qualified to perform in that field: medical doctors.

However, if it takes the naked truth and horror stories told in gruesome detail to awaken the American people, then that is but another cost that all of optometry must pay for the actions of a few. Yes, the cost is high, but if, indeed, as optometrist Castleman says, there is to be a "whole new ballgame", medicine is committed to making it one that makes the patient, not the non-medical practitioner, the league champion. Batter up! JHA

Michigan Ophthalmologists Launch Aggressive Campaign With Positive Ads in Regional Editions of National Magazines

Michigan has taken a bold new approach to the invasion of medicine by optometrists — non-medical practitioners.

Although Michigan was the first state to defeat optometric drug legislation in 1966 and has successfully resisted since that time, the state in the past two years has been confronted with serious new challenges.

According to Justin L. Moran, Director of Public Information and Communications for the Michigan Ophthalmological Society (MOS), the first challenge came from the development of prepaid "eye care" programs that discriminated against Ophthalmologists.

The second challenge was, according to Moran, the national advertising campaign undertaken by the American Optometric Association. As one of the top five markets in the United States, Moran said, Detroit was particularly affected by the misleading campaign.

To meet the first challenge, that of providing complete high quality eye care through pre-paid eye care programs, Michigan Ophthalmologists formed Medical Eye Services of Michigan, Inc. (MESOM). This organization provides panels of Ophthalmologists for third party payment programs such as Blue Cross/Blue Shield and offers employers a self-insured eye care program administered by Mutual Eye Claim Audits, Inc. of Indianapolis, Indiana. This program is particularly significant in Michigan, one of the most highly industrialized states in the union, where much of the eye care provided is handled through insured plans.

To counter the challenges of the current national advertising campaign sponsored by the American Optometric Association, Michigan decided to take the offensive and launch a full-scale hard-hitting marketing effort designed to educate and inform the public. That program, now underway, includes a series of strong, positive, paid advertisements, which have been placed in the Michigan editions of leading national magazines.

The first advertisement, which is carried on the back page of this issue of THE PEN, was placed in the Michigan editions of *Time*, *Newsweek* and *U.S. News & World Report*. The first advertisement appeared in full color. Others will be black and white.

In addition, Moran reports, a third advertisement is being produced which will be placed in the television program guides of metropolitan area Sunday newspapers.

Weekly News Magazines Chosen

According to Moran, weekly news magazines were chosen for the primary media effort because of their excellent penetration among influential leaders in the state, and among individuals likely to become involved in providing or negotiating for pre-paid eye care programs. To make certain union leaders at all levels receive Ophthalmology's message, reprints of the ads are being mailed to all 2800 elected union officials in the state shortly after they appear in the various publications.

The third ad, which has a headline reading, "When an M.D. prescribes your glasses, you get the finest eye care possible", is being placed in television program guides to reach the mass market, and patients most likely to respond to hearing television advertising sponsored by optometry.

Although it is too early to evaluate the full impact of the advertising effort, Moran believes it has already had one good effect. In his view, the first ad brought home to Michigan optometrists the realization that such a campaign could have deadly impact, and prompted a resolution from the Michigan Optometric Association, which called for the immediate cancellation of AOA's $6 million dollar national ad campaign.

Moran states that the Michigan initiative originated with the MOS Executive Council and Society president, Philip C. Hessburg, M.D. The MOS Secretary Jerome D. Davis, M.D., who serves as chairman of the Society's Public Information and Communication Council, was assigned to implement the council's decision.

In addition to retaining marketing professional Justin Moran to act as Director of Public Information and Communications, the MOS and MESOM commissioned a prominent Detroit marketing and research organization, Lincorp Research, Inc., to identify attitudes and opinions which had to be corrected in order to motivate the public to seek eye care from Ophthalmologists.

In addition to determining that the public did not know the difference between optometrists and Ophthalmologists, the firm turned up two other significant findings, Moran said.

The research firm discovered that the public views optometrists as being in the same relationship to Ophthalmologists as osteopathic physicians are to physicians, and believe they have the same training and perform substantially the same services.

They also found that the public generally viewed eye care in a mechanical rather than a medical context. The reasoning: to correct poor vision, one needs eyeglasses. To get these appliances one must see the "mechanic" who fits and sells them (e.g. the "eye doctor"). Findings showed little comprehension of the eye as an organ of the body, subject to disease or injury, which might require the services of a physician or surgeon.

Three Advertising Objectives

After selecting Buckheim and Rowland, Inc., of Ann Arbor, to produce and place its advertising, MESOM studied the research data and on the basis of the findings formulated three objectives for its advertising. They were:

1) To create awareness of the fact that there is a significant difference between an Ophthalmologist and an optometrist;

2) To create awareness of the fact that an Ophthalmologist is better qualified to care for the eye, including routine examinations for corrective lenses, because of his medical education; and

3) To create awareness that prepaid eye care programs that do not provide an opportunity to choose eye care by Ophthalmologists are inferior fringe benefits.

According to Justin Moran, the Michigan program has been so well received by the medical profession, businessmen, union leaders, and others that Dr. Hessburg has contacted the presidents of all state Ophthalmological societies offering to share with them the Michigan experience.

Moran says, "Clearly, in order to protect the public health, our ultimate objective must be to preserve the position of the Ophthalmologist as the provider of primary eye care. Time may very well prove that the best way to do this is to use marketing techniques to motivate and modify patient behavior. While the use of such an approach is new for a medical specialty, Michigan's Ophthalmologists appear to be demonstrating that it can be done successfully in an ethical, tasteful, easily understood, and extremely effective manner." ●

THE PEN...

VOLUME 3, NUMBER 13
AUGUST 1, 1979
ST. PETERSBURG, FLORIDA

EDITORS

Medical Editors: James H. Allen, M.D., New Orleans, La.; Leonard B. Alenick, M.D., Tacoma, Wash.
Contributing Editors: Roland E. Houle, M.D., Quincy, Mass.; David W. Parke, M.D., Meridan, Conn.
Staff Editors (St. Petersburg, Fla.): George P. Russell, Frank T. Barnes, Daniel R. Casseday
Production Manager: Edward S. Barclay

Published in the Public Interest by The Physicians Education Network, Inc. a non-profit corporation headquartered at 5013 Central Avenue, St. Petersburg, Florida 33710. (813) 321-2258.

VICTIM BLAMES ADS *Continued from page 1*

Although recent advertising efforts have been greatly expanded, optometry made the same claims long before initiating its media blitz. In a pamphlet titled "Answers to Your Questions About Glaucoma" which was disseminated long before '77, the AOA had this to say about the detection of glaucoma:

"Glaucoma is most frequently detected during a professional vision examination. Optometrists check carefully for glaucoma in the 'eye health' part of an optometric examination by inspecting the interior of the eye, giving field-of-vision tests and taking eye pressure measurements . . . (with) a tonometer. Used routinely by optometrists, it records quite accurately subtle and gradual changes in pressure as well as dramatic changes the patient may be aware of because of discomfort or impaired vision."

The Collins case, which is scheduled for hearing in November, 1979, will undoubtedly attract national attention, and may well spark a rash of similar suits, since many cases of glaucoma overlooked by optometrists have been reported by medical doctors and patients across the nation. ●

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)

Date_____ 19____

Name_____

Address_____

City_____ State_____ Zip_____

Telephone: (Area)_____ Number_____

Ophthalmologist?_____ Other specialty_____

Profession, other than M.D.?_____

Check enclosed ($250)_____ Please bill me_____

☐ Resident Dues $25.00
☐ Affiliate (spouses, office staff) $25.00
☐ Military M.D.s $150.00

$53,500 SETTLEMENT *Continued from page 1*

tometrist and his insurance carrier. But, as she sadly notes, "No amount of money can pay for the loss of my eye and the agony I went through."

Motivated by a sincere desire to protect other innocent people from a similar fate, Ms. Brown has provided the following testimony of her tragic experience:

While waiting in an optometrist's office where I had taken my mother to have her hearing aid fixed, I read information about contact lenses. I only wore glasses for close work in my office job and had always hated to wear glasses so I became interested in wearing contacts.

The optometrist informed me there would be a charge for the examination, but if I decided to purchase contacts, it would be included in the purchase price. The cost was $400.00 for one kind and $450.00 for another kind. He advised bifocal lenses, which he said were semi-soft, or if I cared to have the soft lens, he could make one eye for distance and one eye for close. He suggested the bifocal. These, he said, were new and somewhat difficult to fit but as he put it, very interesting. I trusted his advice.

On January 15, 1977, I signed a contract.

The contacts were changed many times over the period of nearly one year. They would be mailed to me about one week before an appointment.

I received my last pair in December 1977. One night around midnight, I woke in terrible pain. Both eyes were swollen closed and my face was puffed. I had some Tylenol No. 3 on hand so I took some for the pain. That was not strong enough.

The next morning, I was still in horrible pain. I called the optometrist's office as soon as it was open and was advised to alternate between hot and cold packs.

The next day there was no improvement. I called again and told them (both husband and wife are optometrists) it felt like I had glass in my eye and that I thought I must have an infection. The woman "doctor" informed me they knew I did not have glass in my eye and I did not have an infection. She said I could go to hospital first aid but she wanted to warn me, it had cost one of their patients eighty five dollars to do that.

Finally, a friend was worried because I had not been to work, and she called me. She had her husband take me to the optometrist's office. By that time there was a white film covering my right eye, and it looked horrible, and my pain was excruciating. The man optometrist took one look and ran for the telephone. He called an Ophthalmologist and then took me to his office. The Ophthalmologist had me admitted to the hospital where I finally had expert help.

The doctor was in to see me as many as three times a day, as well as bringing his colleagues for conferences. The Ophthalmologist was able to save my eye, but not my sight in my right eye. The antibiotics which were necessary to fight the germ affected my intestines, therefore, all through the year of 1978, I was ill, because I still had to be on medicine for the eye. For months my face was swollen and there was no shape to my eye. I had to go to work in that condition.

After I was well enough to think straight, I decided to get advice from an attorney. I felt if I could take the optometrist to court, and get it on record, I may be able to keep this from happening to some one else. I would shudder every time I saw a television advertisement where optometrists were fitting contact lenses.

As it turned out, I wasn't the first to bring suit against the optometrists' insurance company. My own attorney had brought suit against them for another party. The insurance company offered us an out-of-court settlement which we accepted in the amount of $53,500 in my case.

I hope and pray that laws will be passed to prevent this sort of thing from happening. No amount of money can pay for the loss of my eye and the agony I went through.

On February 18, 1979, one of Seattle's best Ophthalmologists did surgery on my right eye. He first had to remove the cataract that had been caused, he then had to graft the white part of my eye which was so thin and then over all of that, he transplanted a cornea. Some of the stitches are covered up and will remain. Some have dissolved and a week ago he removed half from the cornea. In all there were nearly forty stitches in the eye. I was in surgery for two hours. My eye now looks pretty much like the other one. I still can not see and I know I will never regain the vision I had but I am so thankful for all my doctors of Ophthalmology. ●

Optometry Kills National Television Commercials

Facing a decline in membership attributed to a $200 special assessment for this year's portion of a multimillion dollar national advertising campaign, the American Optometric Association (AOA) has decided to eliminate television ads and restrict expenditures to $500,000 this year, down from $1.3 million in 1978.

The possible effects of exaggeration in optometric advertising is reflected in the suit, in which AOA is a co-defendant, brought by John Collins (See page 1).

According to the July 1 *American Optometric Association News*, after several days of debate at the AOA annual meeting held in Anaheim, California, June 17-23, the AOA House of Delegates compromised on a resolution by the Michigan Optometric Association to terminate the 2.5-year National Consumer Communications Program (NCCP) and instead resolved to more diligently concentrate efforts on collecting the special assessments.

The AOA *News* reported that, "Indications are that the association could witness a potential 15% to 20% decline in membership a year from now if 1979 and 1980 NCCP assessments are not paid. Many state optometric associations, primarily those serving industrial states, indicated severe membership losses based upon current collections received."

The AOA *News* also stated that AOA Trustee John D. Tumblin, O.D., former chairman of the AOA Advisory Committee on the NCCP, said no monies have been allocated for the final years of the NCCP. "Nevertheless," Tumblin said, "a loss of even one member is too much for this association to accept." ●

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.

Only an Ophthalmologist can diagnose and treat these four common eye diseases.

Melanoma

You'll probably never have the four diseases pictured here. But how can you make sure?

You should know that all four of them can lead to permanent blindness. And one, melanoma, is a cancer.

Nobody likes to think about eye diseases. But as long as you have a choice, isn't it better to think about them before... rather than after? That's why there's no better time than now to see an ophthalmologist.

Cataract

Fungal Corneal Ulcer

Why an ophthalmologist? Because he's a physician. Fully trained and qualified to examine the eye; not only to prescribe glasses but also to diagnose all abnormalities; and—above all—to prescribe corrective treatment, including drugs, therapy, and, when necessary, surgery.

And, being a physician, an ophthalmologist can also check your eyes for symptoms of other diseases like high blood pressure and diabetes.

Glaucoma

Some group benefit programs only permit you to see an optometrist. Make sure yours permits you to choose an ophthalmologist. Then see him. It could mean the difference between vision... and blindness.

This message presented as a public service by

MESOM

Medical Eye Services OF MICHIGAN, INC.

A non-profit advisor to eye care programs.

1010 Antietam Road, Detroit, MI 48207 (313) 962-2394

Reprinted with the permission of the Medical Eye Services of Michigan, this advertisement appeared in full color in the Michigan editions of Time, Newsweek, and U.S. News & World Report.

MARVIN J. GRENDAHL, M.D.
OPHTHALMOLOGY
3500 LATOUCHE
ANCHORAGE, ALASKA 99504
277-2661

ALLOW ME TO INTRODUCE MYSELF -- MY NAME IS MARVIN GRANDAHL.

I AM GRADUATED FROM THE UNIVERSITY OF MINNESOTA WITH A BACHELOR OF ARTS DEGREE.

I AM A GRADUATE OF THE UNIVERSITY OF MINNESOTA MEDICAL SCHOOL.

I HAVE COMPLETED MY PH.D. THESIS WORK IN PHYSIOLOGY AT THE UNIVERISTY OF MINNESOTA. AT THAT TIME, I WAS A TEACHING ASSOCIATE IN THE DEPARTMENT OF PHYSIOLOGY AND A CARDIOVASCULAR RESEARCH FELLOW. I WAS ALSO A NIH RESEARCH FELLOW DURING THAT TIME.

I WAS AN OPHTHALMOLOGY FELLOW AT THE MAYO CLINIC IN ROCHESTER, MINNESOTA.

I AM NOW AN OPHTHALMOLOGIST IN PRIVATE PRACTICE IN ANCHORAGE, AND WICH TO URGE YOU TO HELP DEFEAT HOUSE BILL #75 AND SENATE BILL #79.

In reviewing House Bill #75 and Senate Bill #79, Section 2, Subsection 08.72.305 - Use of Drugs for Diagnosis, included in the list of drugs proposed to be used is a class of drugs called miotics. This group of drugs is only therapeutic and has no diagnostic use. They are used for treating chronic glaucoma and acute angle closure glaucoma. What is a therapeutic drug doing in a "diagnostic" bill? Mr. George Hall's and Mr. Sternberg's (both Anchorage optometrists) responses to this question at the March 1, 1978 meeting of the Legislative Coalition of Health Care Professionals in Anchorage and at the 1978 hearings on a similar bill introduced and defeated last year respectively was: "To take care of angle closure." "To use this as a first aid measure." This is treatment.

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 effects.

Cocaine, a topical anesthetic and mydriatic (dilater of the pupil) is a Class II narcotic 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 eye's focusing power and in sufficient doses produce irritability, hallucinations and even coma. Phenylephrin (a mydriatic) 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 Iodine, 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 in the various classes of 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 side effects or untoward reactions are markedly increased.

I. EYE HEALTH CARE PROVIDERS OF THE CONSUMING PUBLIC

The American Optometric Association defines an optometrist as:

"...a health care professional who is specifically educated, highly trained and state licensed to examine, diagnose, and treat conditions of the vision system. Optometrists are highly skilled individuals who examine the eyes and related structures to determine the presence of vision problems, eye diseases and other abnormalities. They gather information on the vision system during the optometric examinations, diagnose any conditions discovered and prescribe optometric treatment such as contact lenses or vision therapy that may be required to provide the patient with clear efficient vision."[1]

A. Although this definition is broad the Alaska legislators have specifically narrowed the definition down considerably. According to the Alaska State Statutes, Title 8, Business and Professions Section 08.72.300, the Statutes define optometry as:

1. "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;

2. "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.

Although the optometrist will or have suggested to you that they are legally bound to diagnose eye disease and that they are in a dilemma,i.e., they cannot diagnose eye diseases without the use of drugs. They are in a dilemma if the broader sense of the definition is used as set forth by the American Optometric Association. The Alaska State Legislators have ingeniously removed that dilemma for the optometrist by limiting diagnosis of visual anomalies muscular anomalies, optical deficiency or deformities and not eye diseases.

The ophthalmologist is a medical doctor who has completed a 3-5 year residency program after one year internship[2] preceeded by 4 years of college and 4 years of medical school. He is trained in the diagnosis and treatment of ocular dysfunction and disease and in the use of all techniques or treatment including drugs, surgery, laser photocoagulation, radiation, etc. Because he has

been trained as a general physician first, his perspective of the eye is broader than the optometrist. He views the eye and its diseases within the context of the whole body physiology and pathology.[3] Further, refraction to the ophthalmologist is viewed as only one necessary step in a differential diagnosis of the patient's complaint, Table 1 demonstrated the overall education and numbers of optometrists and ophthalmologists. From Table 1 it is evident that ophthalmologists have much more training in pharmacology and pathology than the optometrists. Still the optometrists continue to compare their curriculum hours to dental school curriculum hours. This is like comparing apples to oranges. They are not asking to use the drugs dentists use or to diagnose oral pathology. They are asking to do what the ophthalmologist does. Therefore, it is more accurate to compare ophthalmologists curriculum hours to optometric curriculum hours. (Please read Ref.#43, which explains this point in detail for the State of Alaska)

Table 2[4] gives a comparison of consumer services offered by ophthalmologists and optometrists. It is quite apparent that there is considerable overlap. This is most apparent with respect to refractions. The optometrist obviously can do some of the things the ophthalmologist can do; the ophthalmologist can do all of the things the optometrist can do, has the education to better interpret the data acquired, and provide medical/surgical treatment. The ophthalmologist is trained to provide complete eye care and to evaluate ocular dysfunction in the context of total body physiology and pathology. Although the overlap of professional services is greatest for refractions, this is a source of considerable consumer spending in both professions.

II. ECONOMICS (AND PRACTICE)?

Table 3[5] shows the substantial number of public dollars which are expended for eye care. A total of approximately $4,135 million dollars were spent in 1975 for vision care services.[6] The national consumer spending for ophthalmic surgery is not listed. This would make the total ophthalmologic dollar spent on eye care far greater than the optometric dollar. If optometrists are allowed to expand the scope of their practice through the use of diagnostic drugs, the price of the basic eye examination would undoubtedly rise. Proposed national health care legislation

can be expected to impact heavily upon these figures. For example, if the Kennedy-Mills proposal were to include coverage of sight correction services, total spending for these services would rise by 21% or $866 million dollars per year. It is obvious that there will be considerable effort by vision care providers to ensure their fullest possible participating in this program. The economic stakes are very high.[7] This makes it very clear why optometry has put on an aggressive nationally organized push to legislate themselves into a better position to compete for this consumer dollar. Even though the optometrists in the State of Alaska suggest that this is not a "money bill" -- it is. It is merely the first step toward the national optometric goal to attempt to become the primary eye care provider. We should expect that in the future the Alaska optometrists to follow the attempt of other states optometric associations to next try for the priviledge to use these same diagnostic drugs as theraputic agents. An attempt was made in West Virginia to legislate the privilage of eye surgery but this was defeated.

The optometrists have claimed at their bill hearings in the lower 48 that they see 70% of the eye consumer and therefore are the point of first entry into the eye care system. Looking first at the source of this claim and national statistics, the fallacy of this claim is demonstrated. They have erroneously assumed that the average number of eye consumers seen by each practitioner is the same. Thus the source of the fallacy: that since they compose 70% of the national work force they see 70% of the eye consummers.

Table 1, indicates the total number of practitioners in each group.[8] The median number of patients seen per week by optometrists was 43.2; the median seen by ophthalmologist was 102.[9] The ophthalmologist sees more than twice as many patients as the optometrist while he comprises only 30% of the work force. It is, therefore, clear that the ophthalmologists care for half the patients, while the optometrists, comprising 70% of the nationnl work force, care for the other half. The statistics in Alaska show that there is a total of 40 optometrists[10] and 25 ophthalmologists.[10] Thus the

ophthalmologists make up 39% of the state work force and the optometrists 61%. Applying the same national ratio of eye consumers seen by optometrists and ophthalmologists, it is evident that the ophthalmologists see 56% of the eye care consumer, but makes up 39% of the state work force. The accuracy of the ratio of two to one was checked in the city of Anchorage by comparing the number of eye consumers seen by the most active ophthalmologist in town-40-50 eye consumers-as compared to the most active optometrist in town-20-25 eye consumers-seen in one day. These figures would seem to indicate that although ophthalmologists are a smaller group than optometrists, the public will work out their services given a free market choice.[11] On this point, the eye consumer in the State of Alaska has ready access to the ophthalmologic eye care providers. Some of the states in the lower 48 are mainly rural and ophthalmologists are congregated in the metropolitan areas and the optometrists are distributed over the rural areas. However, much of Alaska is "bush country", so that the ophthalmologists and optometrists are both congregated in Anchorage, Fairbanks, Kenai Peninsula and the southeast. There are only two areas (Kodiak and Bethel) that have a full time optometrist and no full time ophthalmologist, Table-Map 5,6. However, there are other medical doctors in these communities with "medical know how" and there are airports for evacuation in the case of eye emergencies. Furthermore, Kodiak and Bethel are visited on a regular basis by itinerant ophthalmologists. In fact, most areas in Alaska are served by itinerant ophthalmologists both by the Alaska Native Service and by private practicing ophthalmologists, Table-Map 6. In the 14 other states where a similar bill was passed, these states were mainly rural with a maldistribution of ophthalmologists. In these states this was the main reason for passing this legislation. Therefore, this argument for passing house bill 74 or senate bill 75 does not apply to the State of Alaska, because the distribution of ophthalmologists is essentially identical to that of the optometrists. Thus, the health services of ophthalmologists are readily available to

people in all sections of the state and in many small communities through the itinerant program.

In the states where optometric drug laws are in effect, optometrists who which to use drugs much take short slide and lecture courses on pharmacology. This has or will create two classes of optometrists, which can only lead to additional consumer confusion about a profession already shrouded in confusion. In addition, the use of drugs by optometrists could falsely lead patients to believe diagnostic expertise is available from optometrists.

It is misleading to the consumer and legislature to imply that any drug is purely diagnostic. Each of the classes of drugs asked for by optometry have therapeutic uses. Will the optometrists resist the temptation to use these drugs to treat conditions beyond their knowledge and skill?

It has been said by the optometrists that they would like to use dilating eye drops also in the their bush clinics when they see Alaska natives. A unique situation exists within the native population of Alaska. The incidence of angle closure glaucoma is 1 in 1,800, not 1 in 20,000 as in caucasions. To allow the optometrist to use these dilating eye drops would result in many more cases of acute angle closure glaucoma, for which they are not trained to treat, and which requires quick and effective treatment to prevent blindness. Sometimes angle closure glaucoma requires administration of intravenous Diamox, Manitol or urea. This would result in further expenditure of health care dollars.

III. LEGISLATIVE DUTY FOR THE EYE CARE CONSUMER:

As practitioners of an occupation which deals with the integrity of eyesight, optometrists have been recognized by the Washington Legislators as members of a "learned profession".[12] Professionals who deliver health care may be regulated by the state via its

police powers to oversee those activities which are involved with health, education and welfare.[13] The healing arts particularly have been the subject of regulatory legislation which specifies strict requirements for the practive of such professions.[14] The intent of such restrictive legislation is avowadly the protection of the public against injuries it may suffer from the conduct of such business or calling.[15] The state may reasonably impose any condition precedent to the grant of its consent to practive a healing art, which has a real and rational relation to that objective.[16]

The usual means taken by the state in applying these conditions as quality standards has been by imposing licensing requirements and by carefully defining the particular professions involved.[17] Constitutional challenges to this power of the state have been universally defeated when that power has been reasonably exercised.[18]

Licensing requirements usually specify minimum standards of professional competence for the profession covered and frequently the definition of the profession gives broad areas of practice which will be considered appropriate for the practitioner seeking licensure. Additional restrictions upon the practice can be found in state statutes which define unprofessional or unethical conduct.[19]

The above state powers are broad and greatly influence the scope and freedom of practice by the health care provider. Although the right to follow a profession is recognized as a valuable property right which is constitutionally protected,[20] such a right is not absolute; there is no natural or vested right to practive within the healing professions. Any such right is a conditional use.[21]

The justification for such regulations lies in a perceived right and duty of the legislature to protect the citizens of the state from incompetants and fraudulent health practitioners.[22] The Washington Constitution specifically vests exclusive authority in the legislature to:

"...regulate the practice of medicine and surgery and the sale of drugs and medicines."[23]

From this, courts have construed legislative authority to regulate, by means of separate statutory licensing requirements, all of the various professions and occupations engaged in health care delivery. This includes many professions which are not obviously included in "...the practive of medicine..."[24] Further, the state has the power to define what constitutes the practive of any profession and may then confine practitioners of various health disciplines to the particular system of practive in which they have been educated.[25]

This is a logical stance for the legislature to take. If the legislature has an avowed interest in protecting the public,[26] it must make some attempt at defining the scope of appropriate practice which each class may safely employ and to license those within each class to practice upon the public only those skills for which they have demonstrated competent training. That includes courses, testing and most important of all, clinical experience under supervision. This is the legislative intent in enacting licensing statutes.[27] This reasoning is followed with consistency in cases involving almost every viewpoint and aspect of health care.[28]

Great latitutde is given by the courts to the legislature in defining its public health goals. However, the goal is universally stated to be the protection of public health. Health legislation is not passed to promote the personal ends of individuals or to enhance the status or prestige of any given class of practitioners.[29] Although the legislature may enact such regulatory legislation as it may consider necessary, there must be a rational basis upon which the legislative determination rests.[30] This cannot be interpreted as meaning anything less than that such legislation must appear to be rationally directed toward the achievement of the stated legislative goal and to be reasonably rational in the means which it seeks to achieve that goal.

a) Goal - As noted above, the frequently given objective for regulation of health care providers is the protection of the public from incompetent practitioners.[31]

This goal is stated to exist even if it deprives a citizen of a right he otherwise might enjoy in the pursuit of his profession.[32]

This reasoning leads to the conclusion that the legislature has the duty to ensure that its acts and statutes do not tend to increase public exposure to health risk.[33] The stated legislative goal is increased public protection, not increased public risk. Nowhere does case law state that public protection will be qualified - i.e., that the legislature may increase the risk "a little bit", but not "a lot". No such slippery subjective terms appear. The intent is protection. The language is explicit.

b) Means - The means by which the legislature attempts to arrive at its stated goal must be reasonable and rational.[34] The means which have been used by all states to regulate the professions have been noted above. The states have attempted to ensure the competency of each practitioner and then limit each to the area of practice embraced within the training which that practitioner has received.[35] If this means anything, it must mean that before the provider is allowed to administer to an uninformed public, (45% of the public does not know the difference between an ophthalmologist and an optometrist)[48] he must provide evidence of training sufficient to ensure the public from health care which is inadequate. Such inadequacy can range from innocuously improper diagnoses which are nonetheless economically costly, to disabling or fatal mistakes in clinical judgement - either diagnostic or the end result of therapeutics.

Insofar as it can ever be sure of the quality of professional performance, the state has two related ways to oversee clinical performance.

The state may require evidence of formal professional training which has as its foundation and primary goal, a strong commitment to an understanding and clinical application of those methods, techniques and material to which the public will be exposed and which will place it at risk. Such training must satisfactorily convince the legislature that which it certifies the practitioner, the legislative duty to prevent risk of public harm has been met.

Using the data presented in the first portion of this testimony, it is apparent that optometric training as it now exists in the State of Alaska is not directed toward a broad understanding of human pathology/physiology/pharmacology with supervized clinical experience.[43] Training is limited to a superficial, most theoretical, presentation of data concerning ocular dysfunction with inadequate clinical supervised experience. Not only do the data show that the instruction given the optometric student is very limited, but little or no integration of visual disease/function

is made with 'whole body' disease/function. The eye is studied in isolation as an optical instrument. To use an analogy, an operating room nurse could teach an optometrist about eye surgery, just as a pharmacologist Ph.D. can teach an optometrist about pharmacology. However, no one would want an optometrist to perform surgery with an education based only on lectures and theoretical familiarity with the subject. The prescribing and using of drugs, just like the performance of surgery, must be founded on a broad-based curriculum involving many hours of supervised clinical experience using drugs. To allow any health care provider to practice with only limited classroom experience and testing violates the legislative duty to protect the public from risk of incompetency from lack of clinical experience.[43]

As a second step. the legislature can require continuing education for those practitioners who have already completedbroad formal training upon which additional, up-dated information may be rationally correlated. This type of post-graduate instruction always preseumes in-depth background knowledge. It is used to present newly altered clinical concepts or additional practical experience (e.g., using operating microscopes, intraocular lens implants, vitrectomies, etc) for those practitioners with clinical experience sufficient to allow them to understand the usefulness or pitfalls, to see the advantages or clear disadvantages, to comprehend the clinical reliability or dangers of the material which the course is presenting. Crash courses which involve totally new material, presented to practitioners without that clinical judgement or experience necessary to actually grasp the real impact of the data presented, let alone the nuances, can be expected to create clinicians who will test their newly acquired knowlege in the public sphere. The hazards of such an appraoch are obvious. Again, such an approach does not satisfy the legislative duty to reduce public risk.

I must conclude that for the state to allow graduates of optometric schools, who are unarguably well-trained in the limited sphere of practice which optometry has exercised to date, to extend their

clincial practice to include the application of drugs to the eye would be an irrational approach toward the protection of public health.[43] If the curricula of optometric schools demonstrated sufficiently integrated instruction in human anatomy/pharmacology/physiology/pathology to provide the optometric graduate with an adequate basis for making appropriate clinical decisions of diagnosis, then such a legislative extension of clinical opportunity, and responsibility would be reasonable. Crash courses are not an adequate substitue[38] for many hours of supervised clinical experience.[43]

It should be repeated that the strong interest of the state in protecting the public, has traditionally and appropriately placed rigid conditions and restrictions upon the right to affect public health.[39] It should also be repeated that this power to restrict health care practice is recognized as proper regardless of its effect upon the economic interests of those regulated.[40]

It is doubtfull that an informed public would voluntarily accept a role as an on-the-job training clinical practice model so that the optometrists can gain the clinical experience needed to use drugs. The consumer public currently has expectations which include a higher standard of knowledge by the medical service provider than ever before. These expectations directly flow from the public's increased understanding that they each, as individual complex biologic units, are biochemically affected in manifold ways via the environment, foods and drugs. Any legislative change which would franchise greater administration of drugs and which simultaneously does not require firm, convincing evidence of a profound understanding of the disease to be detected, its effect on the human body, the biochemistry of the drug to be used, ignores the public right to be protected from incompetency and the public right to make decisions concerning its health care. The public has a right to understand that any practitioner, presuming to diagnosis ocular disease that usually have total body manifestations, is making diagnostic decisions based upon training which comprehends all of the above principles.

IV. AGENCY ACTION FOR ASSURRANCE OF THE HIGHEST QUALITY EYE CARE FOR THE CONSUMER.

The public should be able to rely upon state certification of competency. Legislation which does not demand evidence of such competency before certification fails in its duty to provide public protection in matters of health.

Currently, states have little control over the calibre of training which optometrists acquire prior to licensure. An optometrist may have trained in an optometric school unaffiliated with any medical center, he may have obtained the minimal training necessary to qualify for graduation, but once having graduated, he can apply for and obtain a license with ease.[41]

The State Board of Optometry certifies the competency to use drugs of those optometrists which it approves for licensing.[42] Two problems are immediately apparent:

1) The members of the Board of Optometry have little personal experience in ocular pharmacology, ocular pathology, and diagnosis. They are themselves graduate of optometry schools which have offered limited training because the board members took their training when little time was devoted to course work in pharmacology, and now have little experience with drugs. It is difficult to see how such a Board can adequately evaluate such clinical ability in optometric applicants for licensure, nor is it clear how such a Board can construct any 'refresher' course that would adequately prepare the optometrist for his broadened responsibilities. What is usually used is a 'canned' course, prepared elsewhere.

2) The ability of the Board to carry out its mandate to protect the public from those few individuals that would use these diagnostic drugs also as theraputic drugs would find themselves in a frustrated position. The Board can do nothing to prevent this and the fine for practicing medicine without a medical license is only $100.00.

The regulation of the profession by the Optometric Board will be considered appropriate so long as it is reasonable and necessary in the interest of health, safety of the people.[44] Licensing of optometrists by a Board itself lacking in the necessary qualifications to evaluate clinical performance and knowledge, is manifestly unreasonable. To grant the right to optometrists to use diagnostic drugs who are poorly qualified to do so, is not a reasonable, or an appropriate, or a necessary means of 'protecting'the public health.

The regulation of the practice of optometry is not for the benefit of the licensee, but for the state and its people.[45] Certainly, if the practice of medicine and surgery is a proper subject for careful and precise legislation, so also should be legislation which concerns eye care and those who provide it to the public.[46]

V. CONCLUSION

Having looked critically at the past trend toward the expansion of optometric sercies into medical care, and with the present trend of more and more states defeating this kind of bill, it is proper that some statement be made regarding an appropriate role for this vision care professional.

If the optometrist will be expected to diagnose eye disease, then one of two events must occur:

1) optometric training must be upgraded substantially enough to provide him with clinical expertise sufficient to satisfy appropriate public expectations of high competencey; or

2) optometrists must work in an association with ophthalmologists close enough to provide for the day-to-day transmission of diagnotic information from the M.D. to the O.D., and allow the latter to obtain practical involvement in treatment rationals and administration. This would be similar to the military, Veterans Administration and Alaska Native Service, where the optometrist use these drugs under the direct supervision of the ophthalmologists.[47]

Having once recoginzed the above solutions two problems immediately present themselves. The first solution would require the relocation of optometric schools to permit integration with medical training and include a complete restructuring of optometric training. So much change would be needed that any difference between the ophthalmologist and optometrist would evaporate. However, if any group of practitioners presumes to medically minister to the public it must accept the rigorous training which must preceed such responsibility. There is no quick and easy path to competent understanding of a subject becoming increasingly complex year-by-year. The optometrists seem to want to become doctors, but do not want to go through the extensive number of years training it requires. This is particularly true when the results of error or incompetency can be blindness.

The second solution, close day-to-day association of optometrist/ ophthalmologist, creates a psychological hurdle - perhaps an economic one as well. Optometrists would be required to visualize themselves in a supportive role. This is difficult for any professional to do, especially if he has historically been conditioned to see himself as a member of a separate group, practicing independently. So long as he can offer only limited eye care, he is in a supportive role to those who offer complete eye care. This cooperative association is currently working well in the Veteran's Administration System, the military and the Alaska Native Service It could work well in private care.

Finally, if state legislatures believe that it is proper to expand the medical opportunities of this health-care group of practitioners via redefinition and short-course catch-up lectures without restructuring fundamental educational requirements and experience, there can be little rationale for not doing the same for all paramedical groups, e.g. naturopaths, acupuncturists, and faith healers.

Rationally, the legislature must either strictly require very high state-of-the-art medical training standards to protect its citizens or it should minimize that responsibility and lower its standards to permit each group to economically advance at the public expense. The latter practice would also reduce the educational time and

experience required to produce specialist M.D.'s- but, of course, such physicians would be recognized as marginally or totally incompetent. Should the standard be any different for optometrists who wish to medically diagnose eye disease that is so closely linked with the body as a hole functioning unit?

Thank you for your time and the opportunity to present this view indorsed by the State Ophthalmologic Association.

TABLE 2

PH. D. THESIS BY DON C. PEARSON, M. D. - APRIL 28, 1977 - WORTHEN
THE OPHTHALMOLOGIC OPTOMETRIC INTERFACE T. A. A. O. O. 1977

Service offered by Optometrist and Ophthalmologist

Service	Optometrists	Ophthalmologists
Refraction	99%	99.5%
Ophthalmoscopy	92%	99.5%
Contact Lenses	79%	58%
Visual Fields	75%	94%
Tonometry	66%	99.5%
Orthoptics	50%	53%
Low-vision aids	49%	55%
Biomicroscopy	32%	99.5%
Aniseikonic Testing	8%	9%
Treatment of eye disease	1-2%	100%
West Virginia and North Carolina		
Surgery	0%	99%

TABLE I

SYMPOSIUM ON LEGISLATION

PH. D. THESIS BY DON C. PEARSON, M. D. - APRIL 28, 1977 - WORTHEN
THE OPHTHALMOLOGIC OPTOMETRIC INTERFACE T. A. A. O. O. 1977

Comparison of Optometry and Ophthalmology

	Optometrists	Ophthalmologists
1 - License	In all states as optometrists	In all states as Physicians and Surgeons
2 - Prerequisite	2 yrs. of college (60% of beginning students have baccalaureate degree or higher	Graduation from Medical School (M.D.) 3 - 4 years College
3 - Curriculum	School or College	Medical school internship, Postgraduate (residency)
Pharmacology	64 hours* 126 hours **	307*** (187 hrs. general with 18 months clinical and 120 hrs. ocular with 4yrs. 6mo. clinical
Pathology	20-60 hours	200 hours general with 3 years clinical and 148 hours ocular with 3 years clinical
4 - Period of training	4 yrs (34-36 months)	3-5yrs. (36-60 months)
5 - Time for education after high school	6-8yrs (54-72 months) Max. 4yr. undergrad. Max. 4yr. Opt. college	11-14yrs. (120 months)
6 - Number of active practicioners	21,900	9,322
7 - Number of students	4,985	1,914 (residents)
8 - Total number of practitioners and students	24,933	10,496
9 - Total number of eye professionals	24,800 (70% of total)	10,629 (30% of total)

* Mr. George Hall's report on Pennsylvania School of Optometry to March 1, 1978 meeting of Legislative Coalition of Health Care Professionals.

** 126 hours - Southern College of Optometry

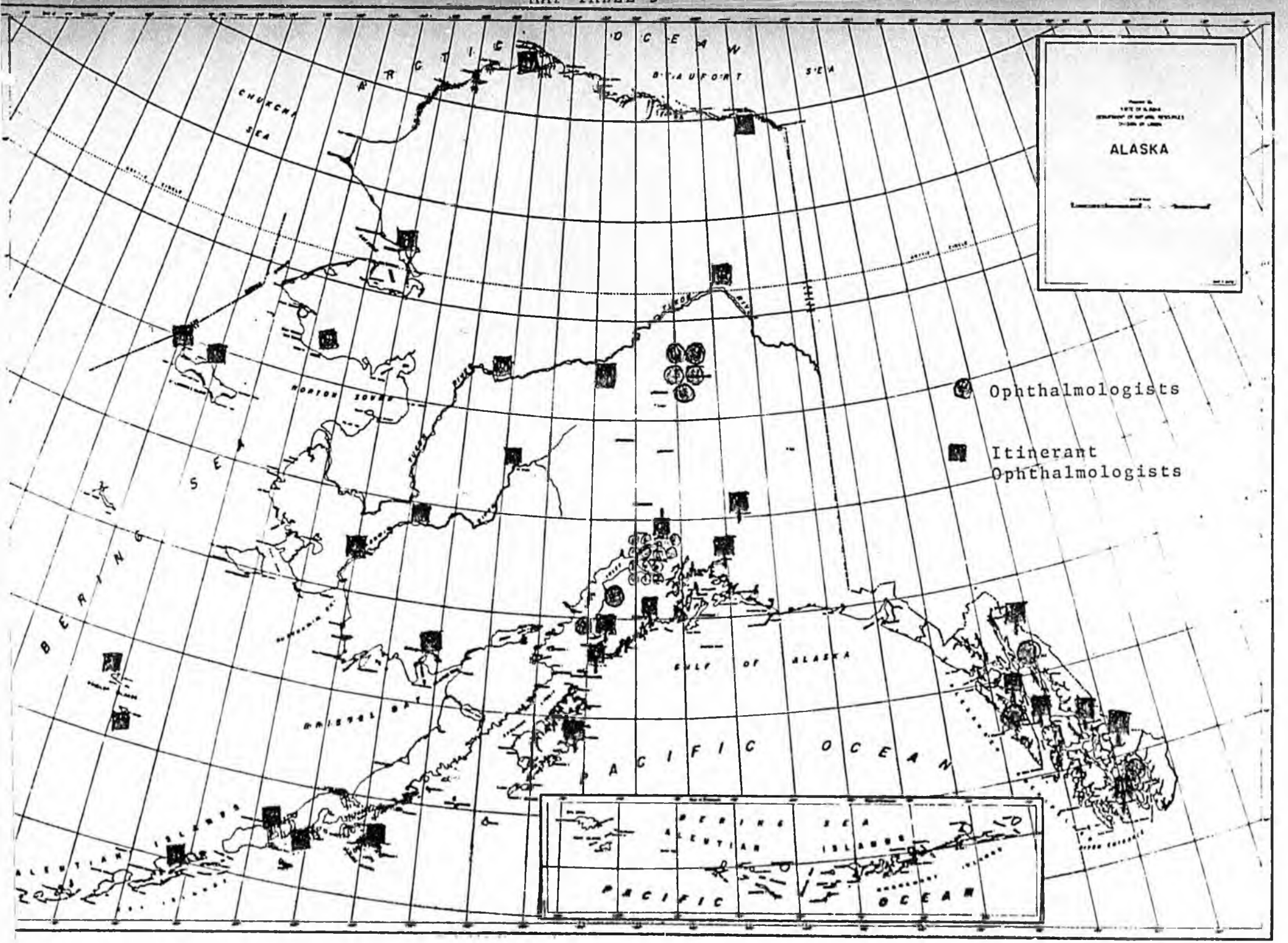
*** Mayo Clinic and Iowa

TABLE 3

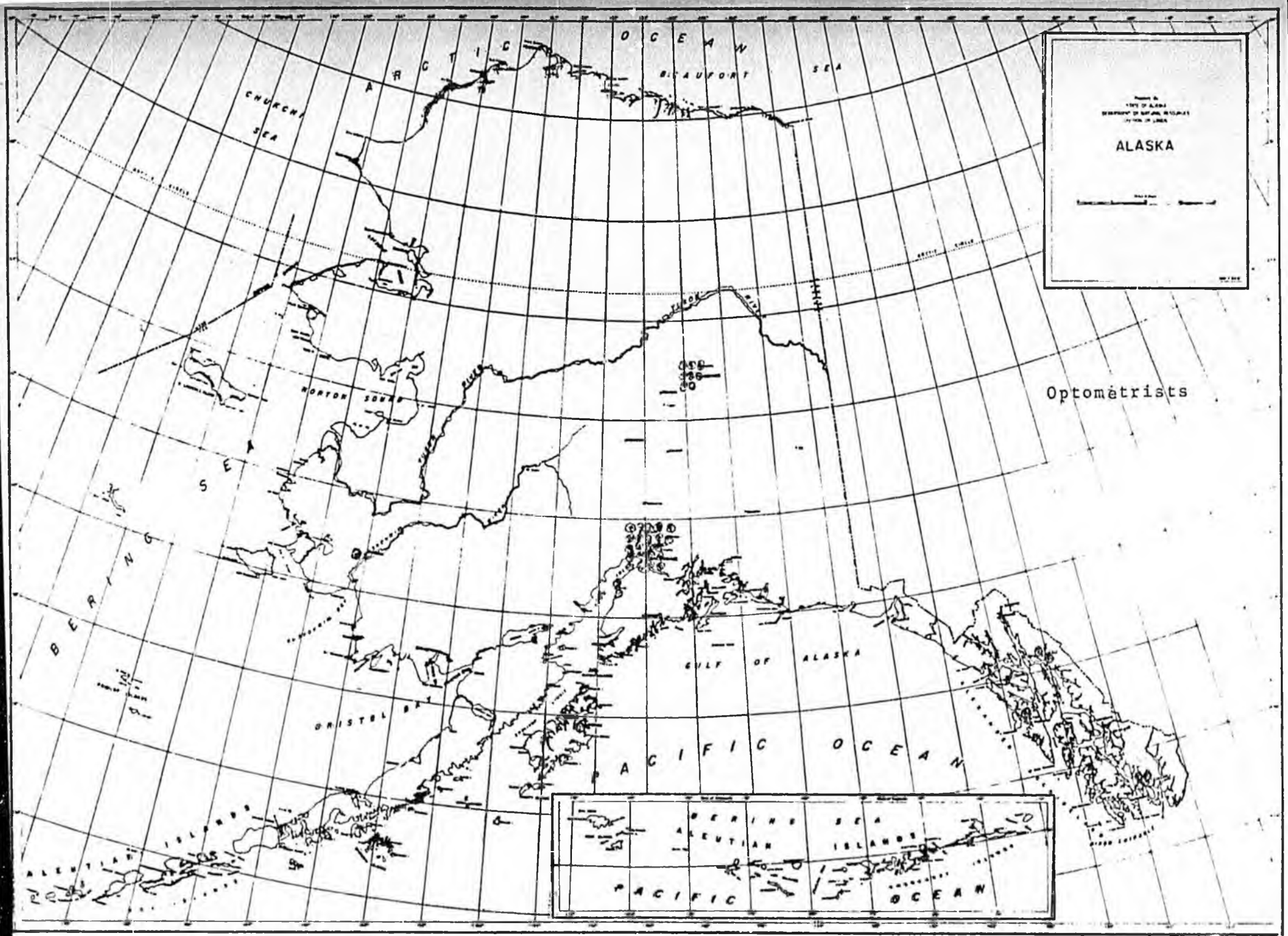
CIVILIAN CONSUMER SPENDING FOR VISION CARE AND SIGHT CORRECTION SERVICES IN 1975

	OFFICES OF OPTOMETRISTS	OFFICES OF OPHTHALMOLOGISTS
A. Expenditures		
General examinations	$525	$510
Medical treatment and therapy	40	500
Ophthalmic Services:		
Corrective Eye glass Lenses	865(49.6%)	180(14%)
Contact Lenses	285	60
Other	30	
	1,745	1,250
		No optical shops No surgery

MAP TABLE 5


ALASKA
Ophthalmologists
Itinerant Ophthalmologists
ARCTIC OCEAN
BEAUFORT SEA
CHUKCHI SEA
BERING SEA
NORTON SOUND
BRISTOL BAY
GULF OF ALASKA
PACIFIC OCEAN
ALEUTIAN ISLANDS

MAP TABLE 6



Optometrists

FOOTNOTES:

1 - Worthen: The Ophthalmologic-Optometric Interface. Transactions of American Academy of Ophthalmology and Otolaryngology *3:OP-155, 1977

2 - Representativ of most ophthalmology residency programs, it is that of the University of Minnesota, Mayo Clinic Graduate School of Medicine. Following graduation from Medical school and a general or specialty internship, the resident enters a program which requires 65 hours a week of ophthalmologic instruction; of this, approximately 8 hours a week is devoted to formal, diadactic lecture, the remainder is clinical or laboratory activity. This weekly schedule continues over a twelve month academic year, for three years. Some of a nine month written home study course administered by the Academy of Ophthalmology. Some programs require an additional one year of ophthalmology. Department of Ophthalmology, University of Minnesota, Mayo Clinic Resident 1974-1977.

3 - Curriculum,University of Minnesota College of Medicine. The basic curriculum required of any candidate for an M.D. degree includes 128 credit hours of 'medical' subjects; this does not includ clinical studies which are specifically directed toward a specialty interest. Although optometrists may agrue that these requirements are not appropriate for them, such an analysis ignores the fact that in expanding their role into the practice of medicine optometrists should be subjected to the same educational requirements. Unfortunately, there is no short-cut to professional competence. This is part'cularly ture in the rapidly expanding and complex field of medicine. The public has a right to demand strict legislative requirements before practitioners are certified as competent.

4 - Worthen, note 1, OP-158, supra.

5 - Trapnell, The Impact of National Health Insurance on the Use and Spending for Sight Correction Service, 1976. (This study was underwritten by the American Optometric Association, and the Optical Manufactures Association.) It reveals that optical device sales represent 66% of the funds expended for optometric services and 19% of funds expended for ophthalmologist services, at Tabel 1 of the Trapwell Study.

6 - This figure includes $920 million spent for optician and $220 spent by institutions. Those categories of service providers are not included in this discussion since they are not involved in patient care.

7 - This economic impact will be divided not only by optometrist and ophthalmologists, but also by opticians and lens/fram/contact lens manufacturers.

8 - Worthen, note , Op-157, supra.

9 - On Blue Shield Survey: In 1975, actuaries for Blue Shield in Connecticut requested of optometrists data necessary to project the cost of insurance covering optometric examinations. One hundred sixty six out of 266 active optometrists responed listing their age, number of years in practice, and number of eye examinations performed each year, and the cost of an eye examination, exclusive of the cost of glasses, so called service charges or visual training. Similar data was gleaned from ophthalmologists, It was concluded that the average optometrist see 23.3 patients per week. Exclusive of patients seen for medical surgical problems or for follow-up care, the average ophthalmologist, of whom there are 160 in Connecticut, sees 56 patients per week for complete eye examinations. Also, if this patients per examiner data is carried over to fit national figures for the number of practicing O.D.'s and ophthalmologists it indicates that about 60% of the primary eye care is rendered by ophthalmologists in the United States right now.

A report prepared for the Optical Manufacturers Association by a consulting actuarial firm (Trapnell Report-1975) presented data based upon national surveys conducted in 1975. The reporters estimated that approximately one-half of 50 million professional eye examinations were done by ophthalmologists and one-half by optometrists. This report dealt only with persons seeking entry into the eye services field for so-called "sight correction" services and did not count all of the services provided by ophthalmologists otherwise for persons who seek out an ophthalmologists otherwise for persons who seek out an ophthalmologist for treatment of medical and surgical problems. (Ophthalmologists obviously do 100% of significant eye surgery and treatment of major eye disease) It is remarkable to note that even though there were approximately 10,000 practicing ophthalmologists, as compared to 20,000 optometrists in the United States, that half of the 50 million so-called "routine eye exams" were performed by ophthalmologists during the year 1976.

10- Department of Commerce and Occupational Licensing

11- Obviously, where ophthalmologists are rare, optometrists see the bulk of patients. However, public education, assistance with payment of medical bills via Medicare and Medicaid, the high mobility of todays population, and the trend toward urban population clustering near ophthalmologists and other specialists certainly influence this bias toward ophthalmologists.

12- R.C.W. 18.53.005 Legislative Declaration: "The legislature finds and declares that the practice of optometry is a learned profession and affects the health, welfare and safety of the people of the this state, and should be regulated in the public interest and limited to qualified persons..." (Amendment 1975)

13 - Ellstad v. Swayze, 15 Wash. 2d281, 130 P2d 354 (1942). See also, Ketchum v. King Co. Medical Service Corp., 81 Wash 2d 565, 502 P2d 1197, 1200 (1973)

14 - Swayze, note 13, 353, supra.

15 - Kelly v. Carroll, 36 Wash 2d 482, 219 P2d 79, 90. (1950)

16 - Campbell v. State, Id., at 462

17 - Gellhorn has recently argued that state licensing statutes are in fact attempts by the profession or occupation involved to control competition by means of restrictive admission to practice. Even Professor Gellhorn would admit that the licensing of health professions is necessary and probably rises above such critisism. Gellhorn, The Abuse of Occupational Licensing, 44 University of Chicago L.R.6, 1976.

18 - Semmler v. Oregon State Dental Examiners, 294, U.S.608, 611, (1934);State v. Wilson, 11 Wn. App. 916, 528 P2d 279 (1974)

19 - R.C.W. 18.53.140

20 - Laughney v. Maybury, 145 Wash. 146, 259 P.17 (1927)

21 - Ellstad v. Swayze, note 47, 353, supra, Accord. Dantzler v. Callison, 230 S.C. 75, 94 WE 2d 177, app. dismd. 352 U.S. 939(1956)

22 - Kelly v. Carroll, note 15, 85, supra.

23 - Art. 20, 2

24 - Ellstad v. Swayze, note 13, 353, supra.

25 - State v. Bonham, 93 Wash 489, 161 P 377, 379 (1916)

26 - Kelly v. Carroll, note 22, supra.

27 - State ex rel Fleming v. Cohn, 12 Wash 2d 425, 121 P2d 954 (1942) Accord, State v Hauk, 32 Wash 2d 68;. 203 P2d 693(1949)

28 - 61 Am Jan 2d, Physicians, Surgeons, and other Healers, 19;86 ALR 623, 624

29 - Ex parte Whitly, 144 Cal. 167, 77 P 879 (1904)

30 - "It is enough that...it might be though that the particular legislative measure was...rational..." Williamson v. Lee Optical Co., 348 U.S. 483, 488 (1955), Douglas, J., majority opinion)

31 - See note 15, supra.

32 - Campbell v. State, note 15, supra.

33 - "A law which reduces or prevents any increase in an ...evil tends to safequard the public welfare..." Id. at 462. (emphasis added).

34 - Williamson v. Lee Optical, note 29, supra.

35 - State v. Houck, note 27, 700, supra.

36 - Worthen, note , Op-160, supra.

37 - "...the legislature was careful to require definite knowledge

38 - West Virginia Statute 30-8-5 requires those optometrists who wish to use drugs to complete those requirements which the board of optometry may see fit to extablish. The board of optometry requires attendance at a pharmacology course similar to that described in note 43, infra.

39 - Ellstad v. Swayze, note 13, supra.

40 - Campbell v. State, note 15, supra.

41 - R.C.W. 18.54070

42 - R.C.W. 18.54.030 - In fact, the statute excludes from board membership any optometrist "...who has any connection with any school...of optometry..." It could be presumed that optometrists teaching at optometric schools would be best qualified to judge the qualifications of optometric candidates and possess the most crrency in clinical information.

43 - A letter from Leon Candenb, O.D., Director Pennsylvania College of Optometry describes the lecture outling in pharmacology used by Kentucky, Florida, Pennsylvania and New Mexico. This course involves participation by the optometrist in six weekend sessions (Saturday and Sunday) and ends with a three hour examination covering the presented material. A letter from Sam A. McConkey,M.D. to the Honorable Charles Parr:

ON OPTOMETRISTS PRACTICING IN THE STATE OF ALASKA

According to figures obtained in February of 1978 from the Department of Commerce, Division of Licensing, there are 40 licensed optometrists in Alaska. Their educational background is as follows:

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

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

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

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

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

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

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

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

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

The maximum number of M.D.'s in even a part-time capacity on the staff of any school attended by 37 of the 40 optometrists in Alaska, is two. From a survey of the Blue Book of Optometry which was last issured in 1976, it appears that the maximum number of members of the State Board of Optometry that even have a bachelors degree from any school is two of the six board members that are listed. It would seem reasonable that there would be an ophthalmologist either in the teaching or in the clinical aspect of optometric education, but it appears from the available evidence, that the maximum number of optometrists currently practicing in Alaska that had any full or part-time instruction, either by lecture or in the clinical setting by an ophthalmologist is zero.

44 - State v. Spino, 61 Wash 2d 246, 377 p2d 868, 870 (1963)

45 - Pennington v. Benelli, 15 Cal App 2d 316, 59 P2d 448

46 - Campbell v. State, note 15, 466, supra.

47 - The AAO Nove-Dec. 1977. "AGREEMENT REACHED ON DEFINITION OF MILITARY OPTOMETRIST- The army, Navy and Air Force have agreed on a common definition limiting the services optometrist may render to military personnel. Prior to the new definition, the three military branches had differing definitions which the AAO mailed to all state ophthalmological societies earlier in the year. On June 15th James W. Foristel, AAO Congressional Liason, met with Robert Smith, M.D., Assistant Defense Secretary for Medicine, who was attempting to have all three of the service's Surgeons General agree on a common definition. In September, they reached agreement on the following single definition.

'The optometric clinic provides optometric patient services under medical supervision. Optometrist examine the eyes and

adnexa to include refraction and other procedures, prescribe lenses to correct refractive errors and imporve vision. They refer patients to physicians for diagnosis and treatment of suspected disease. Optometrists use appropriate drugs to perform optometric procedures. When using these drugs, immediate medical care is available in the event of adverse reaction.'"

Associated Press wirephoto

on can be seen eclipsing the sun in this series of Manitoba, west of Winnipeg.

watch in awe eclipses sun

At Olympia, the Washington state capitol, the clouds broke 10 minutes before total eclipse.

The curious broke out homemade pinhole projectors and makeshift viewers as scientists set up more sophisticated telescopes or conducted experiments in chartered aircraft above the clouds.

But a mattress of clouds several thousand feet thick covered most of the Pacific coast and many had to settle for a televised version.

At Goldendale, Wash., near the Columbia River, more than 1,000 persons had gathered, some from as far away as New England and California.

A cloud bank moved in at the crucil moment of totality, but a muffled cry of awe and joy rippled over the hillside at the small public observatory as the last tiny sliver of sun fell behind the passing moon.

One of those traveling more than 3,000 miles to the snowcovered prairie of northwestern North Dakota was Jim Manning, assistant director of the Morehead Planetarium at Chapel Hill, N.C. He came with a party of eight which drove three days in a van and compact car to get there.

"You feel the awesome power of the laws of nature, how they affect things, and all you can do is sit there and watch," Manning said. "It's a gut feeling of helplessness and you say, 'My God, look what's going on.' It's a mystical experience."

The shadow crossed the earth at speeds over 3,000 miles an hour, beginning on the West Coast near Portland, Ore., and dissolving over Greenland.

Commerce panel urges

'Eliminate 7 health boards'

By ROSEMARY SHINOHARA
Our Juneau Bureau Chief

JUNEAU — A drastic housecleaning that would eliminate 7 of 11 state boards regulating the health professions was proposed Monday by majority members of the House Commerce Committee.

The commerce committee Democrats also propose that two of four health boards dealing with "life and death" professions be required to improve their work within two years, or face death by legislative action.

FRED BROWN, D-Fairbanks, chairman of the committee, presented the plan Monday, but no votes have been taken on it yet. The committee expects to finish considering the fate of the 11 boards audited under the 1977 Sunset Law by Thursday.

Brown said the proposal calls for the state Medical Board, which licenses and polices doctors, to be placed on "one-year probationary status." The committee is expected to recommend that the board hire an executive director to help straighten out its affairs, and return for another "sunset" review in 1980.

A legislative audit of the Medical Board said it had failed to "effectively police" the profession, and neglected to look into consumer complaints. The state Commerce Department's division of occupational licensing, responsible for investigating cases brought to light by the boards, shares the blame, the auditors said.

THE STATE DENTAL Board, meanwhile, should be given two years to shape up, the majority members of the committee suggest.

Unlike the Medical Board, the Dental Board is overly - restrictive in permitting outsiders to set up practice in Alaska, the representatives said.

The committee will recommend that the state boards of nursing and pharmacy, the two other "life and death" boards, be continued for four years, the normal period before another "sunset" review is required. However, significant changes were recommended for the pharmacy board.

Of the other seven health boards, those regulating psychologists, dispensing opticians and nursing home administrators should be phased out over the next year, and four others regulating veterinarians, chiropractors, optometrists and physical therapists should terminate within 1½ years, Brown said.

THE LICENSING functions of boards which terminate would generally be taken over the division of occupational licensing.

The legislative audit division, which prepared reports on all 11 of the health boards, was highly critical of many of them, but recommended that only two, those for nursing home administrators and dispensing opticians, be disbanded. The nursing home administrators agreed with the recommendation, as there are few of them in the state.

Asked to comment on the committee's proposal Monday, legislative audit chief Gerald Wilkerson said, "It would certainly put the fear of God into the rest of the boards."

AAO Program Attracts Residents

Over 150 ophthalmology residents attended a program sponsored by the American Association of Ophthalmology entitled "Tips on Starting Yourself in Practice." The program, as a special service to ophthalmology residents, was held during the Annual Meeting of the AAO in Kansas City, Missouri, and was conducted by George S. Conomikes, President, Conomikes Associates, Inc. Robert J. Crossen, M.D., Chairman, AAO Council on Ways, Means and Finance, opened the program by extending a welcome to the residents.

Conomikes Associates, Inc., a professional medical management consulting firm based in Marina del Rey, California, has worked with all types of medical practices throughout the United States and through the sponsorship of the AAO has conducted an annual series of workshops for ophthalmology residents and ophthalmologists in practice. For a complete schedule of practice management workshops for 1979 see page 14.

The AAO was happy to have served the residents by sponsoring the program in Dallas and hopes that all residents who attended benefited from Mr. Conomikes' expertise in the area of practice management.

U.S. Liable for Failure of Military Optometrist to Refer a Patient

The United States District Court for the District of Alaska (in *Robert K. Steele, etc. v. United States of America,* No. F75-27 Civil) on October 20, 1978, concluded that the failure of a military optometrist to refer a child patient, a medical military dependent, to a medical practitioner "was not a 'judgment call' but a violation of the governing principles of professional standards."

This ruling under the Federal Tort Claims Act [28 U.S.C. 1346 (b)] held that an eight-year-old boy, son of a soldier, who received medical care at the Eye Clinic, Bassett Army Hospital, Ft. Wainwright, Alaska, could recover for the loss of his right eye. The military optometrist examined the child in December, 1973, and in January, 1974, and found "no good reflex" and limited light perception. Eyeglasses were prescribed and the child was instructed to return for follow-up in four months. When seen on June 10, 1974, his right eye had limited eye perception. On June 17, 1974, an ophthalmologist found the child's right eye essentially blind and inflamatory. It was involved with a tumor and a retinal detachment. The eye was later removed as life threatening.

In an 18-page opinion, District Judge James M. Fitzgerald held, "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. 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."

Capt. Blais To Head Navy Eye Care Unit

Navy Captain Bernard R. Blais is the first ophthalmologist assigned to the Navy's Bureau of Medicine and Surgery in the capacity of an ophthalmologist.

Dr. Blais' responsibilities will include coordination of medical and visual eye care for Navy and Marine Corps personnel, plus the design and development of a sight conservation program within the Navy to fulfill the requirements of the Occupational Safety and Health Act (OSHA).

Assigned to the Occupational and Preventive Medicine Division of BUMED, Dr. Blais will serve as project manager of the Sight Conservation Program for active duty Navy and Marine Corps personnel specifically and Civil Service employees generally.

A Professor of Surgery (Ophthalmology) at the Uniformed Services University of Health Sciences, Capt. Blais has been actively involved for many years in the educational and socio-economic aspects of medical eye care.

He earned his M.D. from the College of Medicine of the University of Vermont in 1958 and served his internship at the Naval Hospital, Portsmouth, Va. His residency was in Ophthalmology at the Naval Hospital, Philadelphia, and he also spent a year at the Armed Forces Institute of Pathology in Washington, D.C., under a Fellowship in Ophthalmic Pathology.

Dr. Blais has been certified by the American Board of Ophthalmology since 1966 and is a long-term member of the American Association of Ophthalmology.

AMERICAN ASSOCIATION OF OPHTHALMOLOGY

EXECUTIVE COMMITTEE 1979

President
Whitney G. Sampson, M.D.
Houston, Texas

President-Elect
Byron H. Demorest, M.D.
Sacramento, California

Past-President
Alfonse A. Cinotti, M.D.
Glen Ridge, New Jersey

Speaker of the House
Lawrence A. Winograd, M.D.
Denver, Colorado

Treasurer
Budd Appleton, M.D.
St. Paul, Minnesota

Secretary
Robert J. Crossen, M.D.
Grosse Pointe Woods, Michigan

BOARD OF TRUSTEES

Richard A. Deutsche, M.D., Oakland, California
Thomas S. Edwards, M.D., Jacksonville, Florida
George E. Garcia, M.D., Boston, Massachusetts
Burton M. Krimmer, M.D., Chicago, Illinois
Robert H. Monahan, M.D., St. Paul, Minnesota
Robert D. Reinecke, M.D., Albany, New York
Robert L. Rock, M.D., Austin, Texas
George P. Santos, M.D., Brighton, Massachusetts
Lee H. Trachtenberg, M.D., Munster, Indiana

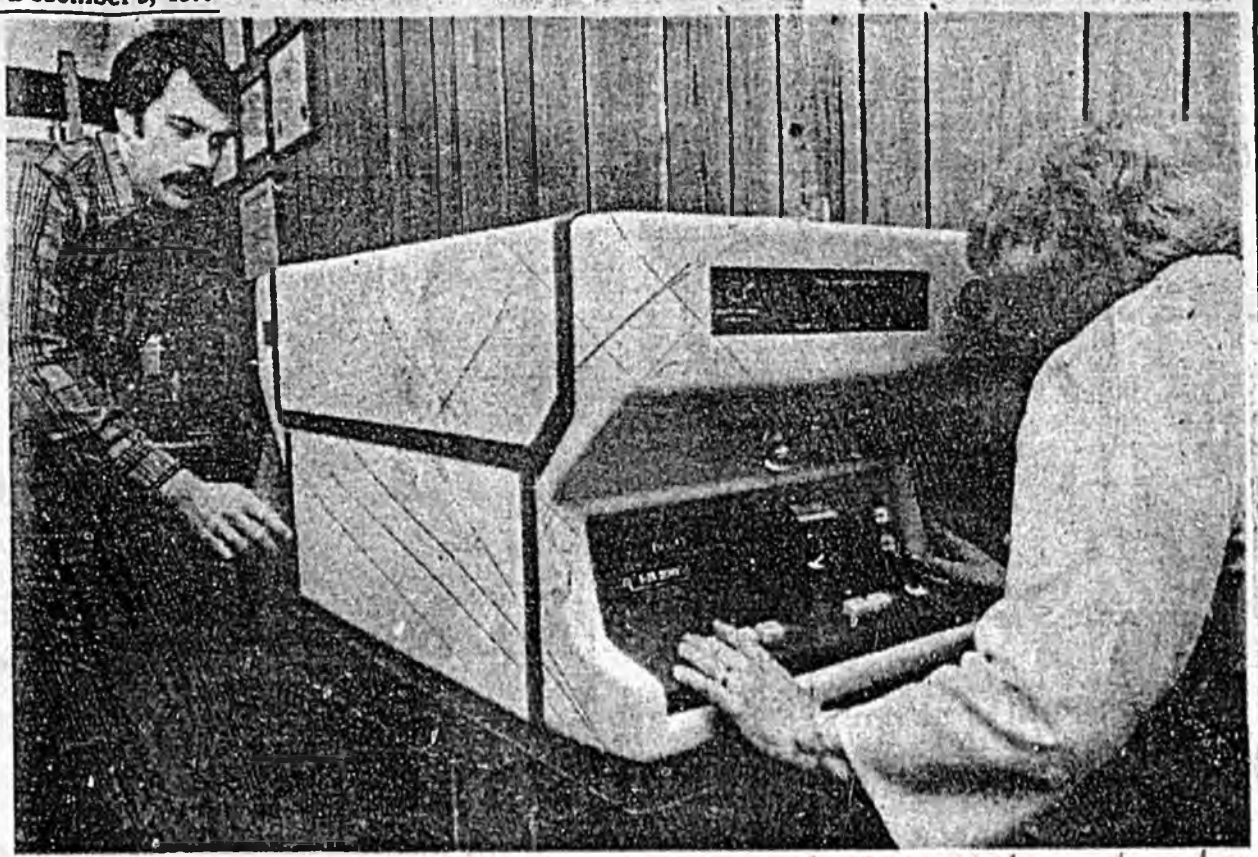
HOUSE OF DELEGATES

Officers
1979

Speaker
Lawrence A. Winograd, M.D.
Denver, Colorado

Vice Speaker
R. Larry Brenner, M.D.
Pasadena, Texas

Clerk
Frank J. Piper, M.D.
Syracuse, New York



MACHINE SIMPLIFIES EYE TESTS

With this space-age computerized device, technicians can have a patient's glasses prescription in hand in about a minute and a half. However, traditional procedures are still followed for much of the examination. At left, Dr. Bill Faulkner adjusts controls for a seated patient. At the other end of the machine optometric technician Carolyn Hazel prepares to take the reading, printed out on a small slip of paper.

Computer Gadget Comes To Town To Help Determine Eyeglass Needs

An automatic vision refractor, born of space-age technology, now is in service in Anchorage.

The computerized machine takes just 90 seconds to establish the correct prescription for eyeglasses. The patient needs no eye drops nor does he need to make decisions as to which correction helps him to see better.

Even if the patient can't speak, the machine will read his eyes and pick out the proper correction, at least to a point.

Installed at the Anchorage Eye Clinic, 1345 E. Ninth Ave., the machine is the only one in Alaska.

Dr. Bill Faulkner, one of the physicians at the center, says that while the instrument "will not replace the traditional refraction techniques, it will prove invaluable in detecting the proper visual prescription. It will also be utilized in contact lens fitting

It can pick up early clues to glaucoma and cataracts by pointing out that not enough light is getting into the patient's eyes.

The computer-based machine was originally developed by the National Aeronautics and Space Administration to test the vision of astronauts.

Another space-age spinoff adapted to ophthalmologists' offices is the tonometer, which screens for glaucoma. Instead of actually touching the eyeball to test inner pressure, the new machine measures and records pressure by blowing a whiff of air into each eye. This device has been in use in local offices for a year or so.

The refraction examination is simple. The patient looks directly into the computer screen, a technician at the opposite end presses a button, and he sees a pale green light, one eye at a time.

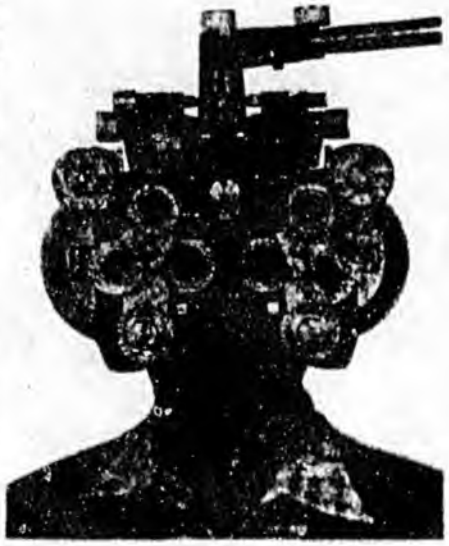
The readout tells the degree of nearsightedness or farsightedness, how much astigmatism is in each eye and where it's located on the eye's axis.

The machine, manufactured by Acuity Systems Inc. of Reston, Va., costs about $28,000. Company technicians are here training clinic staff in use of the machine.

Municipality of Anchorage

Ladies Home Journal

# of 20/20 vision.



This amazing instrument is called a phoropter. It contains almost every possible lens combination. It can help determine which prescription is best for you.

HOW CAN I FIND OUT WHETHER MY EYES ARE WORKING RIGHT OR NOT?

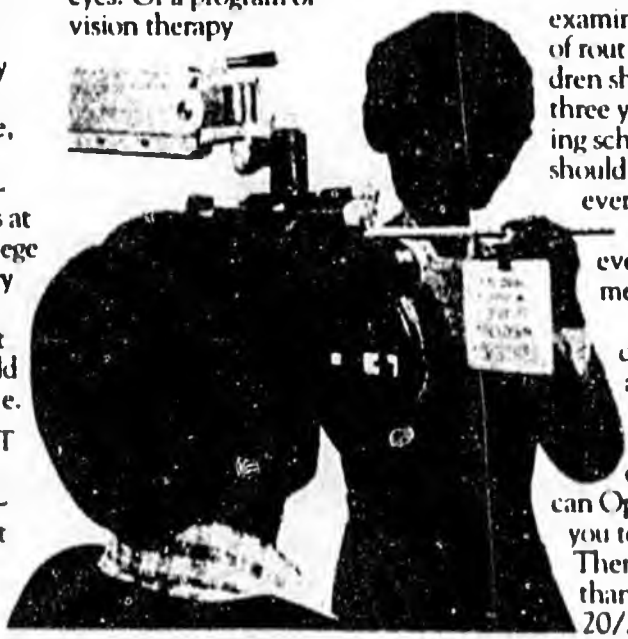
It is important that you receive a thorough examination to determine how well your eyes are doing their job. A member of the American Optometric Association is a highly skilled doctor of optometry.

To become licensed to practice, today's optometrist must have a minimum of two to three years undergraduate college education plus at least four years at a specialized college of optometry. Doctors of optometry who are members of the AOA are totally committed to the ideal that every member of your family should receive the best vision care possible.

WHAT CAN AN OPTOMETRIST DO FOR ME?

Hopefully, the results of your optometric examination will show that you have no need for corrective lenses. If this is the case, suggestions may be made as to how you can practice good visual habits to prevent problems in the future, or keep a minimal vision problem from progressing.

If a vision problem is detected and you are already wearing glasses, your optometrist can update your prescription to make up for the changes that may have taken place in your eyes. If contact lenses are necessary or preferred to glasses, your family optometrist is highly qualified and skilled, through years of education and clinical experience, to provide you with the care and follow-up to ensure a proper fit and healthy eyes. Or a program of vision therapy may be needed or recommended to improve inadequate vision skills.



You should know that besides being able to detect conditions such as glaucoma or cataracts, a doctor of optometry may detect signs of diseases that are not directly related to vision but that show up in the eye. By looking into your eye with a special instrument, an optometrist can see blood vessels and the optic nerve, the only visible part of the nervous system. Among conditions which may be detected by internal eye examination are hypertension and diabetes. When signs or symptoms are discovered you will be referred to your family physician or other health care practitioner if necessary.

WHEN SHOULD I SEE AN OPTOMETRIST?

The American Optometric Association recommends that regular eye examinations be considered a matter of routine preventive care. All children should have examinations by three years of age and regularly during school years. After age 20, you should see an optometrist at least every two years. After age 35 you should have an examination every year, or as often as recommended by your optometrist.

But basically the answer to the question of "when should I see an optometrist?" is "NOW." Your eyes are always changing, and if you haven't had them examined recently, the American Optometric Association urges you to do so as soon as possible. There is a lot more to good vision than just passing an eye chart test. 20/20 vision isn't enough.

Your Family Doctor of Optometry. The person to see. And keep seeing.

American Optometric Association

TM. Trademark of the American Optometric Association

Sen. Hackney;

For your information
from Senator Fillion's
office.

Fill
SB 75

Hns. 2-22

Peninsula Eye Clinic
PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669
TELEPHONE 262-4462

February 18, 1980

Senator Clem Tillion
Pouch V
Juneau, Alaska 99811

The optometrists would have the legislature believe that they simply desire the use of a "little dose of eye drops" in order to serve the public better!

The enclosed page from one of their leading journals clearly portrays their real motives for legislating themselves into the world of eye drops. These people ultimately will be requesting that you create eye surgeons out of them.

The Optometrists have attached their drug bill to their Licensing Board renewal which will be renewed as part of the "sunset legislation" Thus renewal of their board will create drug pushers out of them. This is quite a sly maneuver! I hope the Free Conference Committee sees this and deletes it from their Board renewal bill.

Sincerely,

Peter E. Cannava, M.D.

PEC/bc

OPINION

READERS COMMENTS

More on third parties

To the Editor:

May I clarify a statement in the article, "Third Party Care Comes to Steel Country," which appeared in your December issue?

The article states, "One schedule permits charging the patient the difference between lens and fee benefits and the O.D.'s charge."

It is important that doctors of optometry understand that the difference which they may charge is between the amount of the benefit and a reasonable and customary charge *established by the carrier.*

Although there are a few minor exceptions, the vast majority of the steel programs do *not* permit participating providers to charge the difference between the program benefit and the individual doctor's usual and customary charge. The ceiling is established by the carrier.

Terry O'H. Stark
Harrisburg, Pennsylvania

No time to look back

To the Editor:

Articles in various professional journals vehemently oppose the use of drugs, sphygmomanometry, nutritional counselling and other procedures which are essential to the practice of primary eye care.

The latest of these is a letter by Dr. Harold Friedenberg (Review of Optometry, October 15) who states, "Never has optometry been a profession capable of or trained for the therapeutic aspects of eye care."

I think that Dr. Friedenberg underestimates the capabilities and training of contemporary optometrists. And I am sure that he overestimates the capabilities and training of other doctors who use therapeutic drugs without restriction.

Other disciplines are evidently not as squeamish about expanding their professional scope. Opticians fit soft and hard contact lenses without benefit of formal undergraduate or graduate training. Nurses are expanding their scope of practice considerably with fewer professional prerequisites than are required of optometrists. Dental hygienists and denturists are seeking licensure to practice independently of dentists. Podiatrists and osteopaths practice on a level which is significantly higher than their original concept of practice.

The field of health care is changing and optometry must change with it. The rapid growth of retail optical concerns is a threat to private optometric practice. If our profession is to survive, it must upgrade its scope of services commensurate with that provided by other health care professions.

This is no time to look back at what has been. What will be is our immediate concern.

Vincent P. Lupica, O.D.
Bronx, New York

Coming sooner or later?

To the Editor:

It's time for Dr. Friedenberg to stop practicing 19th century optometry. If he feels he isn't capable of using therapeutic drugs, then he shouldn't.

But, please, let others practice a full scope optometry. We are prepared to treat. And, sooner or later, we will.

Martin A. Malz, O.D.
Philadelphia, Pennsylvania

Courage to stand up

To the Editor:

Congratulations to Harold L. Friedenberg, O.D., who had the courage to stand up and take an "Unpopular Stand" (Opinion, October).

Organized optometry is running scared, and it should be. One year ago I warned our state association president and executive director that our members didn't fully understand or appreciate the reasons for the adoption of the tremendous assessment to fund the National Consumer Communication Program. I predicted that we would lose many members, especially in and around big cities like Chicago.

My warnings were completely ignored and now, one year later, we have the results: Our local society, which had 58 members one year ago, is now down to 39, with the number dropping rapidly.

We can criticize the politicians. We can blame the FTC, Sears and Pearle Vision. But those of us who have a practice large enough to take in a young graduate, and who don't are the real reasons why our profession is going down the drain.

Our future lies with our new graduates. Please make a spot for them in your practice.

Herbert E. Smith, O.D.
Des Plaines, Illinois

O.D.'s: Ready for more

To the Editor:

I hope all the Jimmie Newells and Harold Friedenbergs have said their piece (Opinion, October), because you boys are bringing me and the profession right down.

The legal limitations imposed upon this poor profession frustrate me. And I'm sure they frustrate most other recent and future graduates.

We are intelligent and we are aggressive. We are ready to treat pathological conditions of the eye. And given the opportunity for postgraduate training, we are ready to perform surgery.

I'm sick and tired of referring a routine conjunctivitis or glaucoma patient. I'm sick and tired of giving in to the fancies of the FTC and the propaganda of commercialists.

Let's put ourselves above all this, let's shoot for the top. To do so, we must work to pass more laws that increase the scope of our practice. And we must think seriously of the reality of post-optometric training in the field of ophthalmic surgery and pathology.

To all the Jimmie Newell's of this profession, go cut a few lenses and adjust a few frames. But for God's sake keep quiet and allow this profession to go forward.

Alan Frank, O.D.
Berwick, Pennsylvania

ALASKA VISION CLINIC

DENNIS L. ALBERT, O.D.

THE PROFESSIONAL CENTER
2221 E. NORTHERN LIGHTS - SUITE 206
ANCHORAGE, ALASKA 99504 272-7211

FILE SB75

February 28, 1980

The Honorable Glenn Hackney
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney:

Enclosed is information relating to Georgia's passage of diagnostic pharmaceutical legislation for optometry on Feb. 14, 1980.

There are now 32 states which allow the use of diagnostic drugs in optometry (24 by changes in optometry laws, 8 by existing laws). There is simply no excuse to allow the ophthalmologists to stall passage of the Alaska DPA bill (HB79 and SB75). Is there some compelling reason why this should not be passed, that has not been brought to the attention of the hundreds of legislators in these 32 states?

Respectfully,

Dennis Albert, O.D.

American Optometric Association

BULLETIN
From
OFFICE OF COUNSEL

VOL. XXXVIII, BULLETIN NO. 28 February 19, 1980

TO: O, T, DEC-C, Statutory Definition Advisory Committee, EMS, E, NE, 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, Mrs. Martin, AC, FRC, GC

SUBJECT: Georgia Legislation

FROM: Thomas E. Eichhorst, Counsel

On February 14, 1980, Georgia Governor George D. Busbee, a Democrat, signed into law Senate Bill 31. This law, entitled, "AN ACT To amend Code Chapter 84-11, relating to optometrists, so as to permit the use of pharmaceutical agents for diagnostic purposes by optometrists; to provide for the appointment of an additional member to the Georgia State Board of Examiners in Optometry; to change certain of the provisions relative to the appointment of members; to provide for the confirmation by the Senate of persons appointed as members of the Board; to repeal conflicting laws; and for other purposes", is enclosed.

The bill passed the House on February 4, 1980 by a vote of 121-42. It passed the Senate, as amended, on February 5, 1980, by a vote of 33 to 22.

Georgia is the twenty-fourth (24th) state to enact legislation specifically authorizing optometrists to utilize pharmaceutical agents. Twenty-two (22) 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:

UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

NAME	DATE OF ENACTMENT
Rhode Island	July 16, 1971
Pennsylvania	March 1, 1974
Tennessee	May 3, 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
Georgia	February 14, 1980

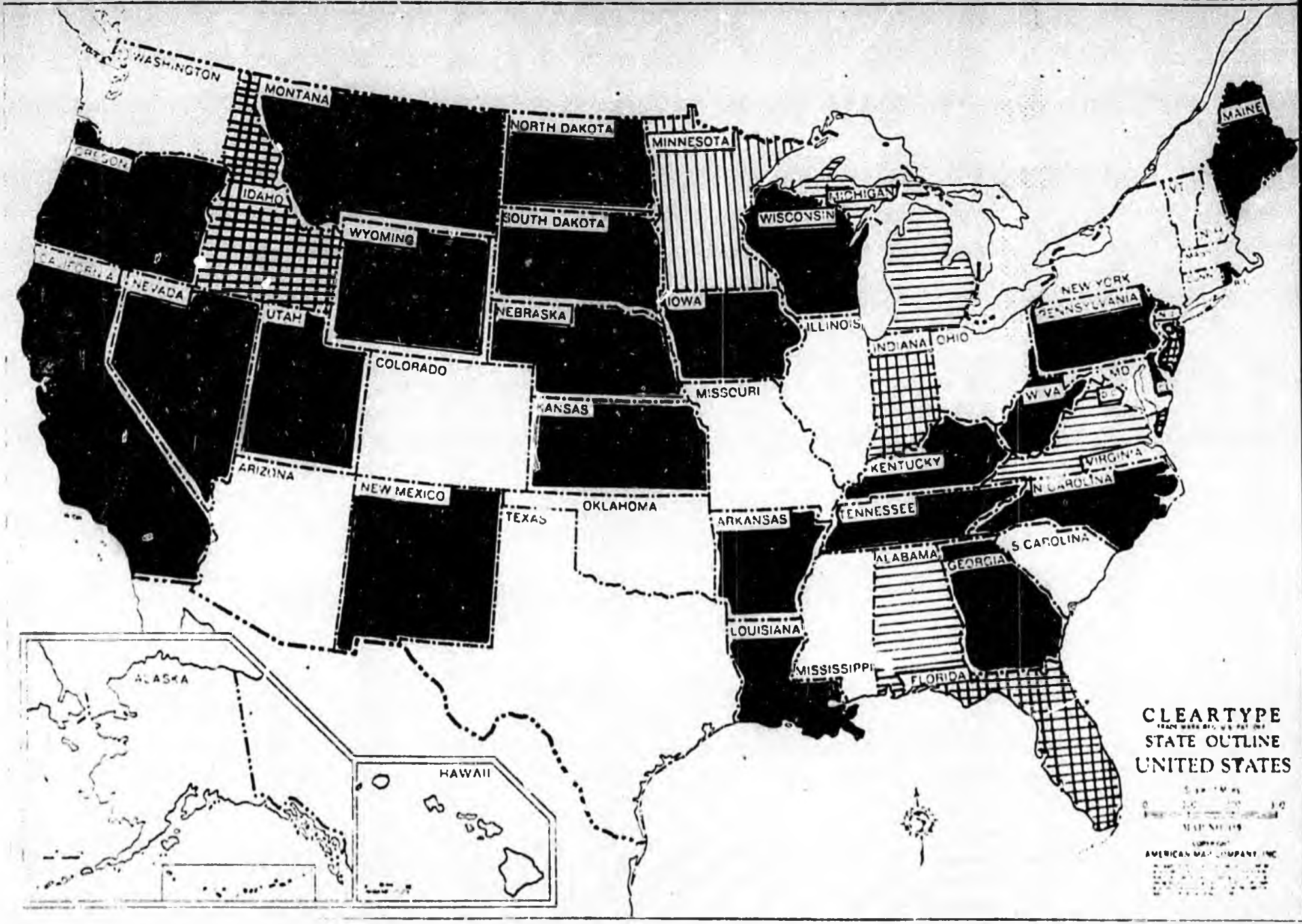
*both diagnostic and therapeutic

[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 (AG-), Minnesota, New Jersey (AG+), Virginia (AG-).]

For your information we are including an updated map showing geographically the utilization of pharmaceutical agents by optometrists.

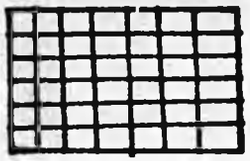
2/14/80

UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

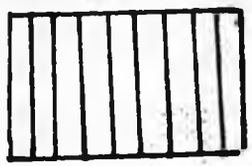


UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

Authorized by Optometrists by Statute



Permitted by Opinion of Attorney General or State Board Secretary



No Statutory Prohibition

No Statutory Prohibition but Negative A.G. Opinion

File

3-15-80

Dear Mr. Hackney,

I would like to ask your support for Bill No. 35. I see no reason why properly trained doctors of optometry should not be permitted to use diagnostic drugs in their field. In other states and in the armed forces optometrists do use diagnostic drugs. Why not in Alaska? I again urge your support for Bill No. 35.

Thank you.

Michael A Lingenfelter
P.O. Box 5433
North Pole AK
99705

TO: Senator Glenn Hackney
Alaska State Senate

Mar. 15, 1980

Dear Mr. Hackney:

I have moved recently to Alaska from the state of Oregon where Optometrists are allowed to use diagnostic drugs. I see no reason why Doctors of Optometry in Alaska should not be given the legal right to use these drugs which tney are trained to use.

Senate Bill No. 75 is a cause which you should support.

Thank You.

Edel J. Laycock

Mrs. Edel J. Laycock
94 Ridgetop Loop
Fairbanks, Alaska 99701

Honorable Glenn Hackney
Alaska State Senate
Pouch V
Juneau, Alaska 99811

March 13,1980

Dear Mr. Hackney;

I would like to urge you to support Senate Bill 75. The bill will promote better eye health care by granting optometrists the right to use diagnostic drugs in their professional field. It will also correct the inequity of current Alaska law chich allows health aids to administer these eye drops while prohibiting their use by a Doctor of Optometry.

Thank you.

Mrs James Sewell

Mrs. James Sewell
S.R.Box 80922
Fairbanks, Ak. 99701

March 20, 1980

Mr. Glenn Hackney
Alaska State Senate
Pouch V,
Juneau AK 99811

Dear Mr. Hackney,

I would like to ask your support for Senate Bill No. 75. Optometrists should be allowed by law to use the diagnostic drugs whicl they are trained to use.

Thank you for your consideration.

Sincerely,

Joseph C. Schmidt

Joseph C. Schmidt

P.O. Box 5451
North Pole, AK 99705

312 - 2th Ave.
Fairbanks, Alaska
March 27, 1980

The Honorable Glenn Hackney
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney:

I am writing to ask your support of Senate Bill #75 which would allow optometrists to use diagnostic eye drops for which they have been trained. This bill is in the best interest of the public health of Alaskans.

Yours truly
Marjorie Swarner
(Mrs. A.M. Swarner)