

S B

136

2/2

COMMITTEE REPORT

SENATE

2/3/81

FURTHER: Judiciary

Date: _____

Mr. President:

HEALTH, EDUCATION AND
SOCIAL SERVICES

The Committee on

has had SB 136

practice of optometry

under consideration and (a majority of the committee) (the committee) reports it back with the following recommendations:

- do pass do not pass
- do pass with attached amendments(s)
- replace with CS for _____ same title
 new title
- and recommends _____
- AND attaches a "Letter of Intent" New Fiscal Note
- reports it back without recommendation
- referred to the _____ Committee

MEMBERS SIGNING
DO PASS

[Handwritten signature]

[Handwritten signature]

[Handwritten signature]

MEMBERS HAVING
OTHER RECOMMENDATIONS:

[Handwritten signature]

CHAIRMAN

Co promise

FEB 25 1968

1. Optometry would be allowed to use proparacaine 0.5% as a topical anesthetic for diagnostic purposes, 1% tropicamide or phenylephrine hydrochloride 2.5% - 5% for dilatation of the pupil for diagnostic purposes.
2. Any changes in this list of medications will be by the combined concurrence of the State Board of Optometry and the State Board of Medical Examiners.
3. A training course will be completed by each optometrist desiring to use drugs prior to any examination. The course shall consist of the following minimum subject matter:
 - A. Clinical pharmacology and drug organ interactions.
 - B. Cardiopulmonary resuscitation and emergency training.
 - C. Techniques of clinical examination.
 - D. Thorough review of clinical signs of fundus, anterior segment, and external disease as well as referral guidelines.

Any practitioner optometrist will take a written examination in the above by test committee comprised of two optometrists and two ophthalmologist, each chosen by their respective professional organizations to assess competency in the above.

When an Optometrist examines any person, he shall inform that person, parent, guardian, or other responsible party, prior to prescribing or providing eyeglasses or other services that examination by a licensed physician ~~specializing in diseases of the eye (or if no such licensed physician is available then by a duly licensed physician)~~ is indicated whenever one or more of the following conditions is present. ~~These conditions fall generally into four categories where there is:~~

1. An abnormality of vision.
2. An abnormality of tissue.
3. An abnormality of motor function.
4. Other.

unless the cause has been medically determined by a physician and is stable or unless there is improvement within two weeks with visual therapy.

- B. A complaint by the individual of a sudden appearance of spots or flashing lights, scintillating images, transient dimming or loss of vision, or distortion in the shape of objects.
- C. A complaint by the individual of temporary or permanent loss of any part of the visual field.
- D. A history of rainbow halos around lights in the absence of contact lens causes.
- E. Diplopia (double vision) of sudden onset.

2. Tissue Abnormalities:

inflammation, infection,

- A. Presence of ~~swelling~~, swelling, mass or ulceration of the eye or its surrounding tissues in the absence of contact lens causes.
- B. Opacities of the cornea, lens or vitreous.
- C. Changes in the appearance of the optic discs.
 - 1. Cupping greater than 0.5 cup-disc ratio (C-D).
 - 2. Difference greater than 0.2 C-D ratio between the two eyes, that is .2 C-D one eye and .5 C-D the other eye.
 - 3. Difference in appearance between the optic discs of each eye.
 - 4. Change in appearance of the optic discs from a previous exam.
 - 5. Suspicion of elevation of the optic nerve head.
- D. Observation of a deviation from the normal appearance of the retina or its vessels.

in straight ahead gaze or gaze in any direction.

~~to correction of refractive error or exercise.~~

- B. A difference in the size of the pupils or failure to constrict with illumination or with near vision.
- C. Ptosis or lag ophthalmus (drooping of the eyelids) with onset within one week of examination.
- D. Nystagmus (rapidly oscillating eye movements).

4. OTHER:

- A. Continuous tearing of longer than 24 hours duration or complaints of watering eyes not associated with visual tasks.
- B. Intraocular tension of 22 or more on any occasion ~~or a family history of~~
~~glaucoma~~
- C. Any other observation or deviation from the usual appearance of the eye and related tissues or any complaint which is not attributable to the refractive state or muscle balance, or which is not amenable to lenses, prisms, or visual training.

Exception to any of the preceding conditions would be previous evaluation by a physician and discharge from medical treatment and followup for that condition.

Failure to comply with the provisions of the Act shall subject the offender to revocation or suspension of his licenses to practice Optometry and this Act shall take effect immediately.

It is completely understood at the outset that there is to be no Grandfather Clause attached to any of the above.

COMMITTEE SUBSTITUTE FOR SENATE BILL NO. 136 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWELFTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to the practice of optometry, and authorizing the use of ophthalmic drugs by optometrists." X

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

* Section 1. AS 08.72.240(3) is amended to read:

(3) advertising professional services in a false or misleading manner, [;] including false representation to the public as something other than an optometrist, which is meant as an optician, eye physician, or by any other designation which would confuse the nature of his licensed practice.

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

Sec. 08.72.280. REFERRAL TO OTHER MEDICAL SPECIALISTS. If, during the course of examining a person, an optometrist determines the possibility of the existence of a pathological condition, the optometrist shall so advise the person and shall refer the person to an appropriate medical specialist for further evaluation.

* Sec. 3. AS 72.300(2) is repealed and reenacted to read:

(2) "optometry" means the employment of any means other than the use of drugs, except the administration

Signature

of diagnostic pharmaceutical agents as authorized in AS 08.72.277, medicine or surgery to examine the human eye, to determine the visual efficiency of the human eye, or to determine the powers or defects of vision; the prescribing, providing, furnishing, adapting, using or employing lenses, prisms, contact lenses, visual training, orthoptics, ocular exercise or any other means or device other than the use of drugs, except diagnostic pharmaceutical agents as authorized in AS 08.72.277, medicine or surgery for the aid, relief or correction of vision.

* Sec. 4. AS 08.72.300(3) is repealed and reenacted to read:

(3) "practicing of optometry" means employing any means other than the use of drugs, except the administration of diagnostic pharmaceutical agents as authorized in AS 08.72.277, medicine or surgery to examine the human eye, to determine the visual efficiency of the human eye, or to determine the powers or defects of vision; the prescribing, providing, furnishing, adapting, using or employing lenses, prisms, contact lenses, visual training, orthoptics, ocular exercise or any other means or device other than the use of drugs, except diagnostic pharmaceutical agents as authorized in AS 08.72.277, medicine or surgery for the aid, relief or correction of vision.

* Sec. 5. AS 08.72.300 is amended by adding subsections to read:

(7) "Commissioner" means the Commissioner of the department of Commerce and Economic Development.

(8) "Committee" means the Alaska State Committee on Optometric Drugs established in AS 08.72.277.

* Sec. 6. AS 98.72 is amended by adding a new section to read:

Sec. 08.72.277. USE OF DRUGS. (a) There is created the Alaska State Committee on Optometric Drugs. The Committee shall consist of five members, including one ophthalmologist from a list of nominees recommended by the Alaska State Medical Board, the Director of the State Division of Public Health, one pharmacist recommended by the Alaska Board of Pharmacy, and two optometrists from a list recommended by the Alaska Board of Examiners in Optometry. All members shall be appointed by the commissioner of the department for three year term. The commissioner shall designate the chairperson of the committee who shall remain chairperson throughout his term. All members shall be voting members. If any member shall cease to act for any reason, prior to the termination of his appointed term, the commissioner shall appoint a new member with the same qualifications as the replaced member and to complete the term of the member ceasing to act. The Committee shall meet at the call of the chairperson, ~~but not less than quarterly.~~

(b) The Committee shall have the following rights and responsibilities:

(1) to approve those diagnostic pharmaceutical agents topically applied to be utilized by optometrists in this state, and the strength thereof. The agents shall be limited to cycloplegics, mydriatics, and topical ^{ANCO} anesthetics;

←
advise
a
comment
to
8

(2) to approve those optometrists who shall be authorized to use those diagnostic pharmaceutical agents approved by the committee, ^N ~~no~~ optometrist~~s~~ shall be approved until he has exhibited his qualifications by passing an examination on the pharmacology of ophthalmic drugs prepared or approved by the committee. Such exam shall consist of written questions designed to test knowledge of the proper listed characteristics of the diagnostic pharmaceutical agents approved by the Committee. Approval shall consist of an endorsement by the Committee to his registration certificate authorizing him to use ophthalmic drugs and specifying restrictions on their use, if any;

(3) to approve educational standards to be used as prerequisites to authorization to use those diagnostic pharmaceutical agents. Provided, however, that no course or courses in pharmacology shall be approved by the Committee unless (a) taught by an institution having facilities for both the classroom and clinical instruction in pharmacology and which is accredited by a regional or professional accrediting organization that is recognized and approved by the Council on Postsecondary Accreditation or the United States Office of Education and (b) transcript credit for the course or courses is certified to the Committee by the institution as being equivalent in both hours and content to those courses in pharmacology required by the other licensing boards in this Chapter whose licensees or registrants are permitted the use of pharmaceutical agents in the course of their professional practice. Such

educational standards shall cover instruction in cardiopulmonary resuscitation and other first aid techniques.

(c) Standards approved by the Committee and adopted in regulation by the department shall be enforced by the Board of Examiners in Optometry. If the Committee, after evidence presented to the Board, finds that clear, cogent and convincing evidence was presented to the Board, but the Board failed to recommend that authority to use diagnostic pharmaceutical agents be withdrawn, then the Committee may withdraw the authority to use pharmaceutical agents from that optometrist.

* Sec. 7. AS 17.15.010 is amended by adding a new subsection to read:

(b) Notwithstanding (a) of this section, diagnostic ophthalmic drug identified by regulation of the State Committee on Ophthalmic Drugs may be sold, given away, bartered, exchanged, or distributed upon the written order or prescription of an optometrist who is authorized to use the drug as provided in AS 08.72.277.

* Sec. 8. AS 17.15.030 is amended by adding a new subsection to read:

(b) AS 17.15.010 and 17.15.020 do not apply to the sale at wholesale by drug jobbers, drug wholesalers and drug manufacturers, or at retail in a pharmacy by a pharmacist, of a diagnostic ophthalmic drug identified by regulation of the Board of Examiners in Optometry to an optometrist who is authorized to use the drug as provided in AS 08.72.277.

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.

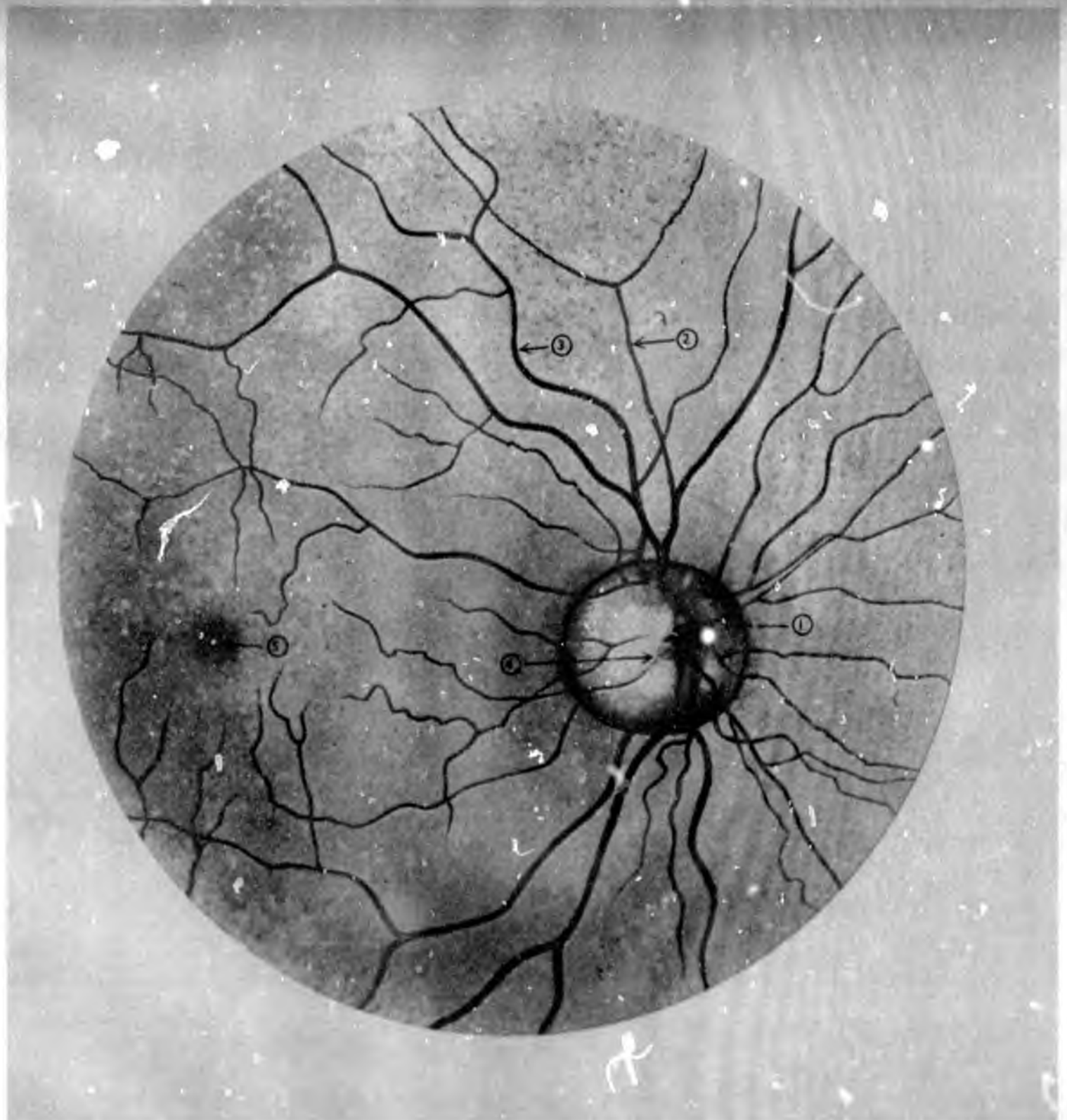
The disc is examined for clarity of outline, color, shape, elevation above or below surrounding tissues.

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



COURSE DESCRIPTIONS

ANATOMY (ANAT.)	PATHOLOGY (PAT.)
BIOCHEMISTRY (BYC.)	PHARMACOLOGY (PHR.)
MICROBIOLOGY (MIC.)	PHYSIOLOGICAL OPTICS (P.O.)
OPTOMETRY (OPT.)	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. (Greenspan, 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. (Greenspan 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: skiascopy, keratometry, visual acuity, subjective refraction, amplitude of accommodation. 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 ophthalmic 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. (Greenspan)

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)

46 / Academic Programs

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

The University of Alabama in Birmingham



SCHOOL OF OPTOMETRY

Bulletin

UAB Bulletin
Vol. 9, No. 27, November 1978

EDITORS: Ms. Darlene Jamison
School of Optometry

Ms. Jerri Beck
UAB Office of Public Affairs

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Dear Representative Parr,

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.

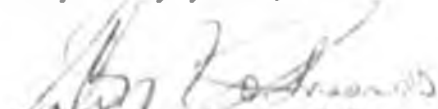
The types of pharmaceutical agents and their uses are described briefly on the second attachment. These are not used routinely with every patient. They are used when needed to adequately examine the eye for pathology.

Doctors of optometry are well qualified to use the 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,


Curtis M. Johnson, O.D.

Copies members
SB 136

E. E. BACH, O.D.
PHILLIP W. BACH, O.D., PH.D.
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March 6, 1981

The Honorable Charles H. Parr
Chairman, Health, Education and
Social Services Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

re: SB 136

Dear Senator Parr:

Thank you for sending me for comment, the compromise proposed by the ophthalmologists. We are willing to make reasonable compromises, and several features of this proposal are acceptable to us.

Here is our response to specific points. I have numbered some paragraphs for reference, corresponding to the numbers below.

1. (Drugs allowed)

The two drugs allowed are a tiny fraction of what the schools prepare undergraduates and existing practitioners to use. Specifying individual drugs in the statute creates an obsolescence problem. We can accept a compromise that specifies certain classes of diagnostic and therapeutic drugs in the statute. We can also accept mandated ophthalmological consultation in determining, by regulation, which drugs within each class may or may not be used. (I would suggest that since this is a detail of implementation, the statute would be less cluttered if the mandate is placed in a letter of intent to accompany the legislation, if this is appropriate for a letter of intent. The Board would follow the directives of the letter of intent.)

2. (Approval of changes in medications by joint concurrence of Optometry and Medical boards)

The Medical Board has opposed drug usage by optometrists in the past. Their involvement would create a 1 to 1 tie, and no change could be made. This is like sending the fox to guard the hen house.

3. (Required training)

Acceptable. One note on cardiopulmonary resuscitation and emergency training: This is taught by many optometry schools even though practitioners are unlikely ever to need it in their practices. I think it is a good thing for every citizen to know. However, graduates who have not had the training should have the

option of taking it in Alaska, such as a Red Cross approved CPR course.

4. (Examination by committee of 2 optometrists and 2 ophthalmologists)

A better system already exists: the schools test the students in their courses. Then the applicant must pass the Board of Examiners in Optometry examination. The Alaska board would use the pharmacology section of the National Boards, an excellent examination constructed from test questions submitted by faculty members of the schools and colleges of optometry, including pharmacologists and ophthalmologists.

5. (Mandatory referral based on single signs and symptoms)

Optometrists in Alaska make literally hundreds of referrals to ophthalmologists and other health care practitioners each year. But this proposal would result in many times that number in needless referrals. Here are some examples:

1A (Less than 20/30 vision for children under 8) - such lower acuity is the norm for preschoolers. Slataper (1950) found the average 5 year old to have 20/32 visual acuity. Weymouth (1963) found 10% of 6 year olds to have 20/36 or less. (Citations available on request). Where visual reduction is due to amblyopia, visual therapy, usually patching, takes up to 3 months or longer to show improvement, not 2 weeks.

1B Spots (floaters) in front of the eyes are normal but often are noticed suddenly, especially by people over 40. They may be pathological (as in uveitis) but this requires corroboration by other signs and symptoms. Scintillating images or flashing lights followed by headache are the classic migraine syndrome. This is untreatable except for possible pain medication.

1E Diplopia after a head blow is not uncommon and usually needs only to be monitored for improvement over the next few days and weeks.

2A Inflammation, injection can easily be treated by the optometrist with antibiotic or anti-inflammatory medications; much of this would not need to be referred if the present bill passes.

2B Corneal opacities can be old foreign body scars, long since forgotten (or never known) by the patient. We see lens opacities in developing cataract years before the cataract becomes dark enough to require removal. We usually make notes but do not always tell the patient so he will not be unduly alarmed.

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 called lamella
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 of gravity
 can occur

CATARACT

A cataract is an opacification of the lens or its capsule. By this definition, almost every adult has cataracts in the sense that some fine opacities are usually visible with the slit lamp in every adult lens. It is advisable, therefore, to restrict the use of the term "cataract" to opacities of the lens that materially interfere with vision. Even in the early stages of cataract, when vision is somewhat interfered with, it is probably wiser to tell the patient that he has lens opacities, rather than use the term cataract. If he asks whether this means that he is going to develop cataracts, he can be told that many times such lens opacities do not progress but remain stationary and occasionally even absorb. If they do progress and cut down his vision further, he can then be told he has a cataract. Many patients go the rest of their lives with slight impairment of vision caused by early cataracts that never increase to the point requiring an operation.

Causes of Opacification of Lens Fibers

Cataract is a loss of transparency of the lens, developing as the result of altered physical and chemical processes in its colloids. Anything which

Francis Head Miles, Textbook of Ophthalmology, Philadelphia: W.B. Saunders Co., 7th Edition, 1962, p. 315

2C A high cup/disc ratio is meaningless as an indicator of the need to begin glaucoma treatment unless it is corroborated by high intraocular pressure or change in the visual fields, both of which are ready optometric test procedures.

4B Tension value of 22 mm is arbitrary and, in my opinion, far too conservative, particularly when the air puff tonometer (which tends to read high) is used. Other factors, such as family history, optic cup appearance, diurnal variation and visual fields must be taken into account before deciding whether this level of tension is even marginally significant.

I hope the fallacy of requiring referral on the basis of single symptoms is readily apparent from this. To reach a diagnosis, final or even tentative, usually requires that several factors be considered in combination. One item alone is rarely meaningful. Not only would this proposal result in great numbers

of unnecessary referrals, but it would rob the highly trained professional person of his judgment. This is the real motive of ophthalmology in proposing this as a feature of a "compromise". For if they get the law to strip optometry of its professional judgment, they can begin to bring optometry under their control and eventually eliminate it as an independent profession.

Such a mandatory referral proposal has not passed in any state, though the ophthalmologists have tried. (Utah does have one that comes uncomfortably close to this). One of our ODs said in all seriousness that if this proposal should become law he would leave Alaska. If by some chance it passed, we would probably resort to the courts.

Virtually the same document was proposed by the ophthalmologists last year. They are not truly negotiating when they introduce completely new considerations that they know we cannot possibly accept, then say, "See, they aren't willing to compromise." A compromise cannot be one step forward and two steps backward.

However since I know you are all under pressure, we have developed a wording for a mandatory referral clause that we can live with, and can use as a compromise if necessary:

All optometrists licensed under this chapter shall assist their patients in whatever manner possible in obtaining further care when in the professional judgment of the optometrist, the services of another health care practitioner are required. The practitioner to whom the patient is referred shall return the patient to the referring doctor with a detailed report of his findings and treatment.

This is not palatable, because it implies that we have done something wrong which requires such a statement. But at least it preserves the practitioner's discretion as to when and to whom he refers his patients. As a logical extension, it should be made to apply to general physicians as well, since they know far less about the eye and its diseases than optometrists do (see attached copy of Dr. Maumenee's remarks and the optometry-medical school comparisons in a booklet previously submitted).

Very truly yours,

Phillip W. Bach
Phillip W. Bach, O.D., Ph.D.
Co-Chairman, Legislative Committee,
Alaska Optometric Association
Member, Board of Examiners

PWJ/lr

Attachment

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may be protected by copyright
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Chairman's Address

The Educational and Political Structure of Ophthalmology in America

A. Edw. J. Munnice, MD, Baltimore

THE SOCIOECONOMIC structure under which medicine is now practiced is in the process of one of its greatest changes in the history of our country. In this connection, a few items of particular interest to ophthalmologists are: the medical school curriculum and the place of ophthalmology in it; the National Eye Institute; Medicare; the Hart Bill now before the Senate; and our relationship to optometry, and its effect on Resolution 77 of the American Medical Association. It is not my intent to discuss these specific problems, but rather to outline the educational and political structure of ophthalmology in this country and to offer a few suggestions regarding the management of these conditions so that we may seek the most effective avenues to voice our opinion on these matters.

The educational aspects of this discussion are included because the faculty of our medical schools exert a major influence on the development and administration of new programs. This is particularly true today, when government agencies frequently seek the ad-

vice of academicians in establishing policies in medical aid and care.

Ophthalmology is a minor specialty in undergraduate teaching. According to Duane,¹ ophthalmology has subdepartmental (division) status in over 50% of the medical schools in the United States. The time allocated to the teaching of this specialty, even when it has departmental status, is extremely short. Thus, in most schools, only 60 to 100 hours are devoted to ophthalmology during the entire four years, as compared to 300 to 900 hours in the fields of obstetrics and gynecology, pediatrics, psychiatry, surgery, and medicine. In postgraduate education, however, ophthalmology assumes much greater importance, for the three to five years spent in residency training are comparable to those of other specialties. At present, about 10% of all outpatients and inpatients seek aid because of ocular complaints.

The role of ophthalmology in postgraduate teaching will probably increase greatly in the immediate future because of Medicare. An analysis of the patients over 65 years of age who received medical attention at The Johns Hopkins Hospital showed that 20% sought assistance because of ocular problems. A review of all discharge diagnoses at Hopkins on patients of any age revealed that cataract discharges were the

Submitted for publication June 20, 1967.
From the Wilmer Institute, Johns Hopkins Hospital, Baltimore.

Chairman's Address read before the Section on Ophthalmology at the 115th Annual Convention of the American Medical Association, Chicago, June 26-30, 1967.

Reprint requests to the Johns Hopkins Hospital, 601 N Broadway, Baltimore 21205 (Dr. Munnice).

Compromise

FEB 23 1968

1. Optometry would be allowed to use proparacaine 0.5% as a topical anesthetic for diagnostic purposes, 1% tropicamide or phenylephrine hydrochloride 2.5% - 5% for dilatation of the pupil for diagnostic purposes.
2. Any changes in this list of medications will be by the combined concurrence of the State Board of Optometry and the State Board of Medical Examiners.
3. A training course will be completed by each optometrist desiring to use drugs prior to any examination. The course shall consist of the following minimum subject matter:
 - A. Clinical pharmacology and drug organ interactions.
 - B. Cardiopulmonary resuscitation and emergency training.
 - C. Techniques of clinical examination.
 - D. Thorough review of clinical signs of fundus, anterior segment, and external disease as well as referral guidelines.
4. Any practitioner optometrist will take a written examination in the above by test committee comprised of two optometrists and two ophthalmologist, each chosen by their respective professional organizations to assess competency in the above.
5. When an Optometrist examines any person, he shall inform that person, parent, guardian, or other responsible party, prior to prescribing or providing eyeglasses or other services that examination by a licensed physician ~~specializing in disease of the eye (or if no such licensed physician is available then by a duly licensed physician)~~ is indicated whenever one or more of the following conditions is present. ~~These conditions fall generally into four categories where there is:~~
 1. An abnormality of vision.
 2. An abnormality of tissue.
 3. An abnormality of motor function.
 4. Other.

...in children under 8 years of age by refractive correction by lenses, unless the cause has been medically determined by a physician and is stable or unless there is improvement within two weeks with visual therapy.

- B. A complaint by the individual of a sudden appearance of spots or flashing lights, scintillating images, transient dimming or loss of vision, or distortion in the shape of objects.
- C. A complaint by the individual of temporary or permanent loss of any part of the visual field.
- D. A history of rainbow halos around lights in the absence of contact lens causes.
- E. Diplopia (double vision) of sudden onset.

2. Tissue Abnormalities:

Inflammation, infection,

- A. Presence of ~~swelling~~, swelling, mass or ulceration of the eye or its surrounding tissues in the absence of contact lens causes.
- B. Opacities of the cornea, lens or vitreous.
- C. Changes in the appearance of the optic discs.
 - 1. Cupping greater than 0.5 cup-disc ratio (C-D).
 - 2. Difference greater than 0.2 C-D ratio between the two eyes, that is .2 C-D one eye and .5 C-D the other eye.
 - 3. Difference in appearance between the optic discs of each eye.
 - 4. Change in appearance of the optic discs from a previous exam.
 - 5. Suspicion of elevation of the optic nerve head.
- D. Observation of a deviation from the normal appearance of the retina or its vessels.

in straight ahead gaze or gaze in any direction.

~~to correction of refractive error or exercise.~~

3. A difference in the size of the pupils or failure to constrict with illumination or with near vision.
2. Ptosis or lag ophthalmus (drooping of the eyelids) with onset within one week of examination.
3. Nystagmus (rapidly oscillating eye movements).
4. OTHER:
 - A. Continuous tearing of longer than 24 hours duration or complaints of watering eyes not associated with visual tasks.
 - B. Intraocular tension of 22 or more on any occasion ~~or a family history of~~
~~glaucoma~~
 - C. Any other observation or deviation from the usual appearance of the eye and related tissues or any complaint which is not attributable to the refractive state or muscle balance, or which is not amenable to lenses, prisms, or visual training.

Exception to any of the preceding conditions would be previous evaluation by a physician and discharge from medical treatment and followup for that condition.

Failure to comply with the provisions of the Act shall subject the offender to revocation or suspension of his licenses to practice Optometry and this Act shall take effect immediately.

It is completely understood at the close that there is to be no Grandfather Clause attached to any of the above.

W. Swarner
SB 136

Dennis A. Swarner, O.D.
Robert D. O'Connell, O.D.

Doctors of Optometry
Drawer 4370
Kenai, Alaska 99611

Telephone (907) 283-7575

March 3, 1981

Mr. Charlie Parr
Pouch V
Juneau, Ak 99801

Dear Mr. Parr,

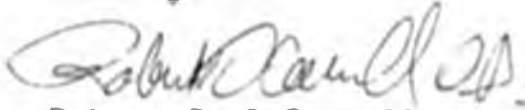
I am writing in support of Senate Bill #136. I hope you will judge this bill on it's own merits as well as the needs of the Alaskan citizens.

As a practicing Alaska Optometrist I could fill reams of paper in support of this bill but I'm sure that you are just as tired reading about the pros and cons of this bill as I am tiring of writing in it's support!!

I have a very simple solution to the problem. There are three states (Florida, North Carolina and West Virginia) that have allowed Optometrists to use the full range of Ophthalmic Drugs for several years. Look at the Optometric record relative to drug use in those states and judge accordingly.

I'm not sure how many of you folks are aware of the enormous amount of money generated by insurance companies, they usually have things pretty well figured out. Malpractice insurance for Optometrists went down nationwide last year. I'm sure not too many other professions experienced a similar reduction.

Thank you


Robert D. O'Connell, O.D.

RO/mw



Member
American Optometric Association

MEMBERSHIP
515 136

The
ALASKA OPTOMETRIC ASSOCIATION

AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

PRESIDENT
George Hall O.D.

PROFESSIONAL PERSPECTIVES

No. 1

SEC. TREAS.
Dennis Swanner O.D.

LEGISLATIVE COMM.
Maynard Falconer O.D.
Philip Bach O.D. Ph.D.

AETNA REDUCES ANNUAL PREMIUM FOR INSURED AOA MEMBERS

Hartford, CT--More than two years of efforts between the American Optometric Association and Aetna Life & Casulty Co. have prompted the Hartford based insurance firm to REDUCE PROFESSIONAL LIABILITY RATES FOR AOA MEMBERS BY 18 PERCENT. The high quality of professional vision care which AOA optometrists are providing has warranted this reduction. Fear expressed by ophthalmologists, in those states which allowed optometrists to use ophthalmic drugs, was unfounded. Optometry has been the ONLY major health care profession to have its liability insurance rates reduced.



March 10, 1981

Charlie Parr
Chairman Senate HESS Committee
Alaska Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

I had the opportunity to sit in on some of the testimony during the teleconference in regards to Senate Bill '86. There are a few points that might not have been brought forth, that I would like to address.

First, many people go to Optometrists for vision care solely because of their expertise in evaluating and solving problems of the visual system. Optometry and Ophthalmology have vastly different approaches to interpreting the visual system. This would follow in line of our educational background; Ophthalmology stresses the medical aspect of the eye (infection and disease) with much less depth in visual problems, whereas, Optometry is just the opposite. There was reference by some Ophthalmologists at the teleconference who wanted Optometrists to categorically state to their patients that they are not eye physicians. This is as absurd as mandating Ophthalmologists to state that they are not Optometrists and implying that their approach to vision care is not up to a certain standard.

The second point I wish to make is that Ophthalmology is not the only medical discipline that Optometry refers to. I have personally referred to Internists, Neurologists, Dermatologists, General Practitioners and of course Ophthalmologists. This is an illustration that Optometry is a primary entry point into the health care system. Many people, especially in the 40-70 age bracket, have their eyes checked more frequently than a general medical check, therefore, it is essential to evaluate the eye system and the surrounding structures as thoroughly as possible not only to help detect an eye health problem but a general health problem and to refer to the proper medical discipline. This is best accomplished, in some instances, by the use of Ophthalmic drugs.

Thirdly, it doesn't make sense that an Optometrist would not refer a patient who has need of further health care. The patients that we see are often, figuratively and literally our neighbors. Talk of mandatory referral with specialized forms and check lists is strictly a device by

page 2
March 10, 1981



Member
American Optometric Association

Ophthalmology to enhance their own position at the expense of Optometry as a disciplined profession. Referral is a professional judgement based on educational and clinical experience. Nowhere in the health care system is referral mandated based on criteria set by one discipline over another. This destroys the independent professional judgement and since, referral is 'mandated' by our code of ethics and our professionalism this idea by Ophthalmology is completely unnecessary.

Finally, in regards to our educational background for the use of Ophthalmic drugs, it has to be emphasized that there are several groups of people in the state of Alaska i.e., Community Health Aides, Nurse Practitioners, Physicians Assistants, that use these drugs with far less training than Optometrists. Are they having a detrimental affect on the people they serve? I think not or there would be a demand for discontinuing their use. The real issue comes down not to whether Optometry or Ophthalmology will gain or lose because of this legislation but what will be the best for the people of Alaska. If this is truly kept in mind I believe this legislation will be passed. Thank you.

Sincerely,

Jeffrey G. Keene, O.D.

JGK/zmt

cc: Senate HESS Committee

WILLARD E. ANDREWS, M.D.

A PROFESSIONAL CORPORATION
3200 HOSPITAL DR. SUITE 203
3200 GLACIER HWY.
JUNEAU, ALASKA 99801
(907) 586-3264

MARCH 9, 1981

SENATOR CHARLES PARR,
CHAIRMAN, SENATE HESS COMMITTEE
POUCH V
JUNEAU, ALASKA 99811

DEAR SENATOR PARR,

I WISH TO EXPRESS MY OPPOSITION TO SENATE BILL 136 AND HOUSE BILL 111, UNDER WHICH OPTOMETRISTS' PRACTICE PRIVILEGES WOULD BE EXTENDED TO DIAGNOSIS AND TREATMENT OF EYE DISEASE. I AM A GENERAL SURGEON PRACTICING IN JUNEAU, AND WHILE MY PRACTICE DOES NOT INVOLVE THE TREATMENT OF EYE CONDITIONS I FEEL AN OBLIGATION TO COMMENT ON BEHALF OF THE BEST MEDICAL INTERESTS OF THE PEOPLE OF ALASKA. WHILE SCHOOLS OF OPTOMETRY MAY PROVIDE SATISFACTORY TRAINING IN THEIR TRADITIONAL FIELD OF REFRACTION AND FITTING OF CORRECTIVE LENSES, THEY DO NOT PROVIDE COMPETENCE IN DIAGNOSIS AND TREATMENT OF DISEASE. THE PHARMACEUTICAL AGENTS WHICH PASSAGE OF THESE BILLS WOULD PLACE AT THE DISPOSAL OF OPTOMETRISTS CAN HAVE SYSTEMIC AS WELL AS LOCAL EFFECTS, AND THEIR USE BY ANYONE WHO IS NOT UNDER A PHYSICIAN'S SUPERVISION IS EXTREMELY QUESTIONABLE. THE PHRASE "MINOR" EYE DISEASES AS IT APPEARS IN THE BILLS TENDS TO BE MISLEADING. FIRST, NO DISEASE IS MINOR WHEN IT'S YOURS. SECOND, IT IMPLIES THE ABILITY OF THE OPTOMETRIST TO DISCRIMINATE BETWEEN A MINOR AND MAJOR EYE PROBLEM, AND TO APPROPRIATELY REFER THE MAJOR PROBLEMS. THIS PLACES THE BURDEN OF DIAGNOSIS OF MAJOR EYE PROBLEMS UPON THE OPTOMETRISTS, WHOSE COMPETENCE TO DIAGNOSE MINOR PROBLEMS IS ALREADY IN QUESTION.

THE PUBLIC AT LARGE, WHEN CONFRONTED WITH THE TERMS OPTOMETRIST AND OPHTHALMOLOGIST, HAS LITTLE APPRECIATION OF THE DIFFERENCES BETWEEN THEM IN TERMS OF TRAINING AND COMPETENCE. FOR BETTER OR WORSE, IT HAS ALWAYS BEEN A LEGISLATIVE DECISION OF WHICH ONE IS ALLOWED TO DO WHAT THAT DETERMINES WHERE THE PATIENT GOES. I WOULD URGE YOU AND YOUR COLLEAGUES NOT TO MISLEAD THE PUBLIC BY ATTEMPTING TO LEGISLATE INTO BEING A COMPETENCE WHICH WAS NOT ATTAINED BY APPROPRIATE EDUCATION. WHILE YOU AND YOUR COLLEAGUES ARE CONSIDERING THESE BILLS PLEASE ASK YOURSELVES THE FOLLOWING QUESTION: WHAT KIND OF TRAINING AND EXPERIENCE WOULD YOU DEMAND OF ONE ENTRUSTED TO TREAT YOUR OWN EYES, OR THE EYES OF YOUR FAMILY?

SINCERELY,



W.E. ANDREWS M.D.

WEA/BJS

YUKON-KUSKOKWIM HEALTH CORPORATION

P. O. Box 528
Bethel, Alaska 99559
(907) 543-0821

The Honorable Charles H. Parr
Alaska State Senate
Pouch V
Juneau, Alaska 99811

March 18, 1981

Dear Senator Parr:

This letter is to indicate Yukon-Kuskokwim Health Corporation's support of Senate Bill No. 136, "an act relating to the practice of optometry and authorizing the use of ophthalmic drugs by optometrists." The reasons for supporting the bill are as follows:

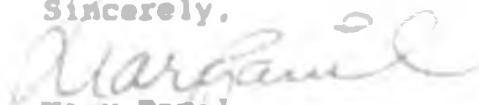
For more than two years YKHC's optometrist has been using diagnostic and therapeutic drugs under standing orders from the Indian Health Service physicians. There have been no negative reactions to this.

The fact is that the use of ophthalmic drugs has enabled the optometrist to do a more thorough examination and to detect certain eye pathologies, such as narrow angle glaucoma and retinal detachments, then make referrals to the ophthalmologist for appropriate therapy. If the optometrist had not used ophthalmic drugs, certain pathologies probably would have gone undetected.

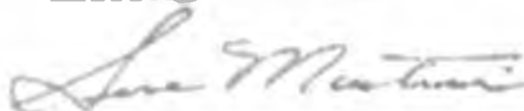
We believe that all optometrists, those in private practice and those not in private practice, should be able to use certain diagnostic and therapeutic drugs. In our opinion, this would redound to the benefit of the patient and, also, would allow optometrists to maximize the use of their training and skills.

We urge your support of Senate Bill No. 136.

Sincerely,



Mary Fayil
Executive Director



Sue Martin
Assistant Health Director

MP/SM/to

cc: Senator George Hohman
Representative Tony Vaska
Jim Martin
Sue Martin
John Demske, O.D.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1977



SENATE BILL 424*
Second Edition Engrossed 5/24/77

Short Title: Redefine Optometry.

(Public)

Sponsors: Senators Hardison; Kincaid, Combs, Mathis, Raylor,
Popkin, Lawing, Webster, Scott, Alexander.

Referred to: Judiciary II.

April 6, 1977

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A BILL TO BE ENTITLED

AN ACT TO REDEFINE THE PRACTICE OF OPTOMETRY CONSISTENT WITH
MODERN ADVANCES IN SCIENCE AND OPTOMETRY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-114 as the same appears in the 1975
Replacement Volume 2C of the General Statutes is hereby amended
and rewritten to read as follows:

"§ 90-114. Optometry defined.--Any one or any combination of
the following practices shall constitute the practice of
optometry:

(1) the examination of the human eye by any method, other than
surgery, to diagnose, to treat, or to refer for consultation or
treatment any abnormal condition of the human eye and its adnexa;
or

(2) the employment of instruments, devices, pharmaceutical
agents and procedures, other than surgery, intended for the
purposes of investigating, examining, treating, diagnosing or
correcting visual defects or abnormal conditions of the human eye
or its adnexa; or

1 (3) the prescribing and application of lenses, devices
2 containing lenses, prisms, contact lenses, orthoptics, vision
3 training, pharmaceutical agents, and prosthetic devices to
4 correct, relieve, or treat defects or abnormal conditions of the
5 human eye or its adnexa.

6 Provided, however, in using or prescribing pharmaceutical
7 agents, other than topical pharmaceutical agents within the
8 definition hereinabove set out which are used for the purpose of
9 examining the eye, the optometrist so using or prescribing shall
10 communicate and collaborate with a physician duly licensed to
11 practice medicine in North Carolina designated or agreed to by
12 the patient. "

13 Sec. 2. G.S. 90-118 as the same appears in the 1975
14 Replacement Volume 2C of the General Statutes and in the 1975
15 Cumulative Supplement thereto is hereby amended by adding at the
16 end thereof a new subsection (e) to read as follows:

17 "(e) The board shall not license any person to practice
18 optometry in the State of North Carolina beyond the scope of the
19 person's educational training as determined by the board. No
20 optometrist presently licensed in this State shall prescribe and
21 use pharmaceutical agents in the practice of optometry unless and
22 until he (i) has submitted to the board evidence of satisfactory
23 completion of all educational requirements established by the
24 board to prescribe and use pharmaceutical agents in the practice
25 of optometry and (ii) has been certified by the board as
26 educationally qualified to prescribe and use pharmaceutical
27 agents.

28 Provided, however, that no course or courses in pharmacology

1 shall be approved by the board unless (i) taught by an
2 institution having facilities for both the didactic and clinical
3 instruction in pharmacology and which is accredited by a regional
4 or professional accrediting organization that is recognized and
5 approved by the Council on Postsecondary Accreditation or the
6 United States Office of Education and (ii) transcript
7 credit for the course or courses is certified to the board by the
8 institution as being equivalent in both hours and content to
9 those courses in pharmacology required by the other licensing
10 boards in this Chapter whose licensees or registrants are
11 permitted the use of pharmaceutical agents in the course of their
12 professional practice."

13 Sec. 3. G.S. 90-118.10 as the same appears in the 1975
14 Replacement Volume 2C of the General Statutes is hereby amended
15 by adding at the end thereof a new paragraph to read as follows:

16 "In issuing a certificate of renewal, the board shall expressly
17 state whether such person, otherwise licensed in the practice of
18 optometry, has been certified to prescribe and use pharmaceutical
19 agents."

20 Sec. 4. G.S. 90-118.11 as the same appears in the 1975
21 Replacement Volume 2C of the General Statutes is hereby amended
22 by inserting in line 8 thereof immediately following the word
23 "refused" and before the semicolon the words:

24 "; or shall practice or attempt to practice optometry by means
25 or methods that the board has determined is beyond the scope of
26 the person's educational training".

27 Sec. 5. Article 6 of Chapter 90 of the General Statutes
28 is hereby amended by inserting therein a new section G.S. 90-

1 |25.| to read as follows:

2 "§ 90-|25.|. Filling prescriptions.--Legally licensed
3 druggists of this State may fill prescriptions of optometrists
4 duly licensed by the North Carolina State Board of Examiners in
5 Optometry to prescribe, apply or use pharmaceutical agents."

6 Sec. 6. G.S. 90-87(22) (a) as the same appears in the
7 1975 Replacement Volume 2C of the General Statutes is hereby
8 amended by inserting in line | thereof immediately following the
9 word "dentist," and preceding the word "veterinarian" the word
10 "optometrist,".

11 . Sec. 7. The provisions of this act are applicable only
12 to those individuals licensed pursuant thereto and

13 shall not] restrict, expand, or otherwise alter
14 those other practices or acts governed by Chapter 90 of the
15 General Statutes.

16 Sec. 8. This act shall become effective on and after
17 July 1, 1977.

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BULLETIN
from
OFFICE OF COUNSEL

VOLUME XXXV, BULLETIN NO. 84

June 6, 1977

TO: O, T, DEC-C, EMS, E, NE, GC, State Association Presidents, Executives, Legal-Legislative Chairmen, Attorneys, Legislative Counsel, Optometric Legislators, IAB-EC, State Board Presidents, Secretaries, Attorneys, Administrative Heads of Schools and Colleges, COE-ES, CCOC-ES, Drs. Rhodes, Rush

FROM: Thomas E. Eichhorst, Counsel

SUBJECT: North Carolina Legislation

The General Assembly of North Carolina has enacted into law Senate Bill 424, as amended. This law permits optometrists to utilize pharmaceutical agents "to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa. Provided, however, in using or prescribing pharmaceutical agents, other than topical pharmaceutical agents within the definition hereinabove set out which are used for the purpose of examining the eye, the optometrist so using or prescribing shall communicate and collaborate with a physician duly licensed to practice medicine in North Carolina designated or agreed to by the patient."

A copy of this bill, as enacted, is enclosed. The bill in its final form passed the Senate on May 24, 1977 by a vote of 46 to 4, and the House of Representatives on June 3, 1977 by a vote of 93 to 4. In North Carolina, the Governor has no veto power, so enactment by both houses of the legislature is final.

North Carolina is the fourteenth state to enact legislation authorizing optometrists to utilize pharmaceutical agents. Twelve other states authorize optometrists to utilize diagnostic pharmaceutical agents; the dates of the enactment of these laws are 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), California (July 9, 1976), Wyoming (February 17, 1977), New Mexico (March 4, 1977), Montana (April 12, 1977 at 10:10 a.m.), and Kansas (April 12, 1977 at 2:00 p.m.). On March 4, 1976, the West Virginia Legislature authorized the use of drugs for diagnostic or therapeutic purposes by optometrists who meet educational requirements set by the optometry board.

[In addition, there are eight 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, Indiana (AG+), Minnesota, Nevada (State Board Statement +), New Jersey (AG+), Virginia (AG-).]



Official Business

Alaska State Legislature

Senate

Committee on State Affairs

Pouch V
State Capitol
Juneau, Alaska 99811

M E M O R A N D U M

TO: SENATOR CHARLIE PARR
FROM: SENATOR VIC FISCHER *VF*
DATE: FEB. 19, 1981
RE: SB 136 Relating to the practice of optometry

Charlie---I've had quite a few people talk to me about this legislation, both optometrists and ophthalmologists. For whatever it's worth, here are my current thoughts.

Some legislation appears justified. At the same time, vague language and inadequate distinctions between what optometrists and ophthalmologists do should be avoided. Aside from making sure that language is specific and clear, we might well consider bringing in some clear definition of ophthalmology, of the turf upon which optometrists do not transcend.

Thanks for your attention.

sent unauthorized medical practices in future. Id.

Given power of Board of Nurse Examiners to suspend or revoke a nurse's license, Board had authority, although not specifically authorized by statute, to formally reprimand nurse for willful violation of its regulation prohibiting administration of anesthetic in absence of a directing physician. *McCarl v. Com., State Bd. of Nurse Examiners, 395 A.2d 800, 39 Pa.Cmwith, 628, 1979.*

Nurse, who was reprimanded by Board of Nurse Examiners for willful violation of its regulations, failed to demonstrate nature and extent to which he was prejudiced by oral and written notification of scheduling of further hearing which was scheduled in order to permit him to introduce evidence on his behalf. Id.

Nurse, who was reprimanded by Board of Nurse Examiners for willful violation of its regulations, was not denied license by virtue of fact that several of Board members who participated in hearing were not actually present at hearing. Id.

Substantial evidence supported determination of Board of Nurse Examiners that nurse willfully violated one of its regulations by administering an anesthetic in absence of a directing physician when that another physician was present at time did not remove nurse's conduct from that proscribed in regulations had back to nurse and that he was aware of what had occurred.

As used in this section of regulations of Board of Nurse Examiners, willful violations connotes an intentional or conscious act. Id.

That laches could be asserted as a defense to administrative action of State Board of Nurse Examiners in suspending her license as a nurse for a period of one year could not be imputed by the Board in investigating absence of a showing as to whether she was harmed by delay. *State Bd. of Nurse Examiners v. Com., 41 Pa.Cmwith, 204, 1979.*

To establish that delay of two years from time of suspension and issuance of citation for nursing law prohibited in the citation or that such petition for reinstatement of license according to regulations of State Board of Nurse Examiners was barred, nurse must show that she was harmed by delay. *State Bd. of Nurse Examiners v. Com., 41 Pa.Cmwith, 204, 1979.*

State Board of Nurse Examiners' action in suspending her license for one year was not inapplicable. *State Bd. of Nurse Examiners v. Com., 397 A.2d 1261, 41 Pa.Cmwith, 204, 1979.*

Administrative finding of willful violation of regulations with respect to unauthorized medical practices and denial of license were not inconsistent and do not.

Penn

§ 225. Suspensions and revocations, how made; notice, hearing, adjudication and appeal; reissuance of license

1. Construction and application

State board of nurse examiners committed prejudicial error in disciplinary hearing by sustaining objections of board counsel to cross-examination of complaining witness concerning pending civil suits she had instituted against registered nurse and hospital based on incident which was subject of disciplinary hearing. *Leukhardt v. Com., State Bd. of Nurse Examiners, Bureau of Professional & Occupational Affairs, 403 A.2d 645, Cmwith, 1979.*

Board after a full and fair hearing before the Board, does not require all members of the Board to be present at hearings in order to constitute a "body" of the Board, but merely dictates that the decisions and actions of the Board be adopted by the full Board. *Ulio v. Com., State Bd. of Nurse Examiners, 399 A.2d 744, 41 Pa.Cmwith, 204, 1979.*

Phrase "after a full and fair hearing before the Board," within provision of this section that all suspensions and revocations shall be made only in accordance with regulations of Board and only by majority vote of members of the

Absence of certain members of the State Board of Nurse Examiners during taking of certain testimony in respect to suspension of petitioner's license as a registered nurse did not serve to invalidate subsequent suspension order where a quorum was present at time Board convened and determined to suspend petitioner. Id.

CHAPTER 8.—OPTOMETRISTS

Rules and Regulations

State board of optometrical examiners, see 49 Pa.Code § 29.1 et seq.

§ 231. "Optometry" defined

That the practice of optometry is hereby defined to be the employment of any means or methods, other than the use of surgery, or drugs, except diagnostic pharmaceutical agents known generically as cycloplegics, mydriatics, topical anesthetics and miotics which are administered topically for the examination of the human eye and the analysis of ocular functions, or the prescribing, providing, furnishing, adapting or employing any or all kinds and types of lenses and prisms, visual training orthoptics, ocular exercises, and any and all preventive and corrective methods for the aid, correction or relief of the human eye, its associated structures, appendages and functions, other than the use of drugs or surgery. The Secretary of Health shall designate the specific agents to be used under the above generic classification: Provided, however, That with respect to optometrists licensed at the time of the effective date of this amendatory act, only such licensed optometrists who (i) have satisfactorily completed a course in pharmacology, as it applies to optometry, by an institution accredited by a regional or professional accreditation organization which is recognized or approved by the National Commission on Accrediting or the United States Commissioner of Education, with particular emphasis on the topical application of diagnostic pharmaceutical agents to the eye for the purpose of examination of the human eye and the analysis of ocular functions, approved by the State Board of Optometrical Examiners, and (ii) who upon successful completion of such course shall be permitted by the State Board of Optometrical Examiners in Optometry to use diagnostic pharmaceutical agents topically in the practice of optometry. Whenever an optometrist during the course of his examination of a person shall determine the probability of the existence of a pathological condition he shall advise the person of such opinion and refer such person to a physician for further evaluation.

The term "optometrist" means a person who practices optometry in accordance with the provisions of this act.

As amended 1974, March 1, P.L. 120, No. 39, § 1.

1974 Amendment: Insert the section.

Supplementary Index to Notes

Cross References
Child protective services, see § 23.1 et seq.

Acupuncture 2.5

Medical Practice Act, applicability, see section 231.17 of this title.

Osteopathic Medical Practice Act, application to optometry, see § 231.17 of this title.

Peer review protection, health care professionals, see sections 425.1 to 425.4 of this title.

2. Construction and application

The Optometry Law of 1917 (this section et seq) only authorizes the State Board of Optometrical Examiners to regulate the registration of optometrists and the conduct of examinations and not the practice of optometry. State Bd. of Op-

tommetrical Examiners v. Campbell, 90 Dauph. 92, 1968.

The regulation of optometry is within the police power of the state but the manner of regulation must be reasonable and must have a substantial relation to the end to be attained. The true exercise of the police power can and must

concern itself with the safety and well-being of the public in general and the patients of optometrists in particular.

2.5 Acupuncture
Optometrists may not engage in practice of acupuncture. 1974 Op. Atty. Gen. No. 29.

§ 232. Practice without license unlawful; penalties

Supplementary Index to Notes
Injunction. 3

1. Validity

Provision of this section forbidding the practice of optometry by unlicensed persons, constitutes a reasonable and lawful exercise of the state's powers to protect the health, safety and welfare of the people, and is therefore not violative either of the Fourteenth Amendment of the United States Constitution (U.S.C. A. Const. Amend. 14) or Const. Art. 1, § 9. Neill v. Wall and Ocha, Inc., 68 D. & C.2d 429, 1973.

2. Construction and application

Although defendant sometimes works in a capacity ancillary to an ophthalmologist, he is not entitled to the protection

of the exemption granted by the act to physicians and surgeons. Pennsylvania Optometric Ass'n, Inc. v. DiGiovanni, 45 D. & C.2d 345, 1968.

3. Injunction

In an action by licensed optometrists in their own behalf and as members of an optometric association to enjoin defendant, an optician, from practicing optometry where it appears defendant examined the human eye, analyzed its functions, prescribed contact lenses for his customers and provided and adapted the lenses to aid and correct their vision, such acts constituted the unlicensed practice of optometry in violation of section 231 of this title and defendant would be enjoined from continuing the practice. Pennsylvania Optometric Ass'n, Inc. v. DiGiovanni, 45 D. & C.2d 345, 1968.

§ 233. Examinations, eligibility of applicants

Every person desiring to commence the practice of optometry, or, if now in practice, to continue the practice thereof after January first, one thousand nine hundred and eighteen, except as herein otherwise provided, shall take the examination provided in this act, and satisfy the other requirements hereof as here provided. Any person who has been engaged in the practice of optometry in this Commonwealth for two full years prior to the passage of this act, or for one year in this and for the year preceding it in another State, and is of good character, shall be entitled to take a limited examination covering the following only:

- (a) The limitation of the sphere of optometry.
- (b) The necessary scientific instruments used.
- (c) The form and power of lenses used.
- (d) A correct method of measuring presbyopia, hypermetropia, myopia, and astigmatism.

(e) The writing of formulae or prescriptions for the adaptation of lenses in aid of vision.

The board shall also permit the taking of limited examinations by, and the license, of any person who shall apply therefor before the first day of January, one thousand nine hundred and twenty-two, who, at the time of the passage of the act to which this is an amendment or the time when the limited examinations under said act were held, was unavoidably absent from this State on account of service in the army or navy of the United States, or who was at such time or times otherwise unavoidably absent from this State, or was physically handicapped and unable to take such examination. Provided, however, That any such person shall have engaged in the practice of optometry in this Commonwealth for two full years prior to the passage of the act to which this is an amendment, or for one year in this Commonwealth and one year in another State, and shall be of good character.

Any person who, at the time of the passage of the act to which this is an amendment, was unavoidably absent from this State on account of service in the army or navy of the United States, or who was otherwise unavoidably absent from this State, or was physically handicapped and unable to take the examination, and who was actually engaged in the practice of optometry, but who had engaged in such practice less than two years; and any person over the age of twenty-one years, of good

moral character, years of the course one thousand nine hundred and eighteen, shall be ascertained from a school of Education and Examiners, on not less than three years of standard examination in physiological anatomy and practice as they apply to optometry at the standard examination of moral character and narcotic drugs. As amended 1974 Amendment of education of public instruction

§ 234. Filing certificate

2. Branch office
office
All that the Optometrist an office and the to that office. optometrist main office which has supervision and ity to require proved by it or physical layout where it shall be

§ 235. Fees of

Section 234
Fees for (title), representative with

Cross Reference
Fees, see section

§ 237. Refusal

Supplemental
Review 4

2. Construction
Where there is an optometrist at another of complete that optician or a physician faintly describes metrical professional examiners commercial had a representation. Optometrical Board of the Commonwealth

West Virginia

ENROLLED
COMMITTEE SUBSTITUTE
FOR
H. B. 1005

(By Mr. SOMMERVILLE,

(Originating in the House Committee on the Judiciary.)

(Passed February 20, 1976; in effect ninety days from passage.)

AN ACT to amend and reenact section one, article five, and sections two, four and five, article eight, all of chapter thirty of the code of West Virginia, one thousand nine hundred thirty-one, as amended, relating to the profession of optometry; adding, within the definition of "prescription," optometrist to the license of professionals who order drugs or medicines or combinations or mixtures thereof in certain cases; providing for the redefinition of the practice of optometry, exempting the practice of osteopathy from the provisions of law regulating the practice of optometry; accreditation of schools and colleges of optometry and the qualifications, education, examination and certification of applicants to practice optometry.

Be it enacted by the Legislature of West Virginia:

That section one, article five, and sections two, four and five, article eight, all of chapter thirty of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted to read as follows:

ARTICLE 5. PHARMACISTS, ASSISTANT PHARMACISTS AND DRUG-STORES.

§30-5-1. Definitions.

1 The following words and phrases as used in this article,
2 shall have the following meanings, unless the context other-
3 wise requires

4 (1) The term "drug" means (a) articles in the official United
5 States Pharmacopoeia, or official National Formulary, or any
6 other supplement to either of them, which are intended for use
7 in the diagnosis, cure, mitigation, treatment or prevention of
8 disease in man or other animals, and (b) all other articles in-
9 tended for use in the diagnosis, cure, mitigation, treatment, or
10 prevention of disease in man or other animals, and (c) articles,
11 other than food, intended to affect the structure or any func-
12 tion of the body of man or other animals and (d) articles in-
13 tended for use as a component of any articles specified in
14 clause (a), (b), or (c).

15 (2) The term "poisonous drug" means any drug likely to
16 be destructive to adult human life in quantities of five grains
17 or less.

18 (3) The term "deleterious drug" means any drug likely to
19 be destructive to adult human life in quantities of sixty grains
20 or less.

21 (4) The term "habit-forming drug" means any drug which
22 has been or may be designated as habit forming under the
23 regulations promulgated in accordance with Section 502 (d)
24 of the Federal Food, Drug and Cosmetic Act of June twenty-
25 fifth, nineteen hundred and thirty-eight.

26 (5) The term "pharmacy" or "drugstore" or "apothecary"
27 shall be held to mean and include every store or shop or
28 other place (a) where drugs are dispensed, or sold at retail,
29 or displayed for sale at retail, or (b) where physicians'
30 prescriptions are compounded, or (c) which has upon it or
31 displayed within it, or affixed to or used in connection with
32 it, a sign bearing the word or words "pharmacy," "pharma-
33 cists," "apothecary," "drugstore," "drugs," "druggists," "medi-
34 cine," "medicine store," "drug sundries," "remedies," or any

35 word or words of similar or like import; or (d) any store
36 or shop or other place, with respect to which any of the
37 above words are used in any advertisement.

38 (6) The term "prescription" shall be held to mean an
39 order for drugs or medicines or combinations or mixtures
40 thereof, written or signed by a duly licensed physician,
41 dentist, optometrist, as authorized by section two, article
42 eight of this chapter, veterinarian or other medical practi-
43 tioner licensed to write prescriptions intended for the treat-
44 ment or prevention of disease of man or animals. The
45 term "prescription" shall also include orders for drugs or
46 medicines or combinations or mixtures thereof transmitted
47 to the pharmacist by word of mouth, telephone or other means
48 of communication by a duly licensed physician, dentist,
49 optometrist, veterinarian or other medical practitioner licensed
50 to write prescriptions intended for treatment or prevention of
51 disease of man or animals, and such prescriptions received
52 by word of mouth, telephone or other means of communication
53 shall be recorded in writing by the pharmacist and the record
54 so made by the pharmacist shall constitute the original prescrip-
55 tion to be filed by the pharmacist. All such prescriptions shall
56 be preserved on file for a period of five years, subject to in-
57 spection by the proper officer of the law. The above shall apply
58 except for narcotic prescriptions, when all narcotic laws and
59 regulations must be complied with.

60 (7) The term "cosmetic," which shall be held to include
61 "dentifrice" and "toilet article," means (a) articles intended
62 to be rubbed, poured, sprinkled, or sprayed on, introduced
63 into, or otherwise applied to the human body, or any part
64 thereof for cleansing, beautifying, promoting attractiveness, or
65 altering the appearance, and (b) articles intended for use
66 as a component of any such articles, except that such term
67 shall not include soap.

ARTICLE 8. OPTOMETRISTS.

§30-8-2. Practice of optometry defined.

- 1 Any one or any combination of the following practices
- 2 shall constitute the practice of optometry:
- 3 (a) The examination of the human eye, with or without

4 the use of drugs prescribable for the human eye, which drugs
5 may be used for diagnostic or therapeutic purposes for topical
6 application to the anterior segment of the human eye only, and,
7 by any method other than surgery, to diagnose, to treat or to
8 refer for consultation or treatment any abnormal condition of
9 the human eye or its appendages;

10 (h) The employment without the use of surgery of any in-
11 strument, device, method or diagnostic or therapeutic drug
12 for topical application to the anterior segment of the human
13 eye intended for the purpose of investigating, examining, treat-
14 ing, diagnosing, improving or correcting any visual defect or
15 abnormal condition of the human eye or its appendages;

16 (c) The prescribing and application or the replacement or
17 duplication of lenses, prisms, contact lenses, orthoptics, vision
18 training, vision rehabilitation, diagnostic or therapeutic drugs
19 for topical application to the anterior segment of the human
20 eye, or the furnishing or providing of any prosthetic device,
21 or any other method other than surgery necessary to correct
22 or relieve any defects or abnormal conditions of the human
23 eye or its appendages.

24 Nothing in this section shall be construed to permit an
25 optometrist to perform surgery, use drugs by injection or to
26 use or prescribe any drug for other than the specific purposes
27 authorized by this section.

**§10-8-4. Registration prerequisite to practice of optometry; excep-
tions.**

1 No person shall practice or offer to practice optometry in
2 this state without first applying for and obtaining a certificate of
3 registration for such purpose from the West Virginia board of
4 optometry, but the following persons, firms and corporations
5 are exempt from the operation of this article, except as
6 hereinafter provided:

7 (a) Persons who have heretofore been registered as op-
8 tometrists in this state, or who were engaged in the practice
9 of optometry in this state before the passage of any law by
10 this state regulating such practice, and who have heretofore
11 received from the board of examiners certificates of exemption
12 from examination.

13 (b) Persons authorized under the laws of this state to prac-
14 tice medicine and surgery or osteopathy;

15 (c) Persons, firms and corporations who sell eyeglasses
16 or spectacles in a store, shop or other permanently established
17 place of business on prescriptions from persons authorized
18 under the laws of this state to practice either optometry or
19 medicine and surgery;

20 (d) Persons, firms and corporations who manufacture or
21 deal in eyeglasses or spectacles in a store, shop or other
22 permanently established place of business, and who neither
23 practice nor attempt to practice optometry.

§30-8-5. Qualifications of applicant for registration, examination.

1 An applicant for registration shall present satisfactory
2 evidence that he is at least eighteen years of age, of good
3 moral character and temperate habits, and has graduated from
4 a high school or secondary school, or has completed an equiva-
5 lent course of study approved by the West Virginia board of
6 optometry, has satisfactorily completed all preoptometry or
7 premedical college requirements and has graduated from a
8 school or college of optometry approved by said board. No
9 school or college of optometry shall be approved by the West
10 Virginia board of optometry unless at first it has been
11 accredited by a regional or professional accreditation organiza-
12 tion which is recognized by the national commission on ac-
13 creditation or the United States commission of education. Each
14 applicant shall submit to and be examined in all phases of
15 optometry as is provided by the school or college of optometry
16 and shall include, but not be limited to, anatomy and phy-
17 siology of the human eye, the use of instruments such as the
18 ophthalmoscope, retinoscope, tonometer, slit lamp biomicro-
19 scope, the general laws of optics and refraction, general and
20 ocular pharmacology, general and ocular pathology and other
21 such subjects or instrumentation as the board of optometry
22 may deem necessary.

23 The West Virginia board of optometry shall be responsible
24 to determine the educational training received by the applicant
25 from the schools and colleges of optometry, the educational
26 qualifications of each applicant and the administering of the

27 examination and certifications of each applicant commensurate
28 with his education. No optometrist shall be registered or
29 certified to practice optometry in the state of West Virginia
30 in any area that is beyond the scope of his educational train-
31 ing as determined by the West Virginia board of optometry;
32 Provided, That any optometrist presently registered in the state
33 of West Virginia and who desires to employ the use of pharma-
34 ceutical agents must submit to the West Virginia board of
35 optometry evidence of satisfactory completion of all necessary
36 educational requirements as made mandatory by the West Vir-
37 ginia board of optometry; Provided further, That the West
38 Virginia board of optometry shall provide for continuing edu-
39 cational requirements to be completed from time to time by all
40 optometrists desiring to employ the use of pharmaceutical
41 agents.



BULLETIN

'from

COUNSEL

VOLUME XXXIV, BULLETIN NO. 62

March 8, 1976

TO: State Association Presidents, Legal-Legislative Chairmen, Attorneys, Executives

FROM: Thomas E. Eichhorst, J.D., Counsel; AOA, St. Louis

SUBJECT: West Virginia Legislation

DIST: O, T, Drs. Rhodes, Rush, Division Executive, Committee Chairmen, ED, WOD, GC, C, AA, Division Directors, E, NE, Administrative Heads of Schools and Colleges

The West Virginia Legislature has enacted Committee Substitute for H.B. 1005 (as amended). The West Virginia House of Delegates (the lower house) on Monday, February 16, 1976 passed the bill by a vote of 58 to 39. On Friday, February 20, 1976 the state Senate passed the bill by a vote of 27 to 4. Governor Arch A. Moore, Jr., vetoed the bill on Saturday, February 28, 1976.

On Tuesday, March 2, 1976 the House considered the measure again. An amendment was proposed to strike therapeutics and treatment from the bill. This amendment was defeated 53 to 44. Then the House voted to override the Governor's veto by a vote of 59 to 39. (In West Virginia, unlike most states, there is no 2/3 vote requirement to override; only a 51% of the elected membership is needed.) On Thursday, March 4, 1976 the Senate defeated by a voice and standing vote the amendment to strike therapeutics and treatment. Then the Senate voted to override the veto by a vote of 27 to 6.

A copy of this new law is attached. The notations (on pages 6 and 10) indicate amendments made by the House of Delegates before the initial passage of the bill.

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.

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 13, 1981

The Honorable Charles H. Parr
Chairman, Senate Health, Education
and Social Services Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

I am concerned that if the legislation embodied in SB 136 is not to be obsolete the moment it is written, it should recognize the full scope of present education in optometry. This includes the use of chemotherapeutic agents like antibiotics.

At present, two optometry schools serving the "therapeutic" states have well established clinical programs in ocular therapeutics. By this I mean student clinicians are actually using drugs therapeutically in the clinic. These schools are the Pennsylvania College of Optometry in Philadelphia and the Southern College of Optometry in Memphis. Other therapeutic programs are in various stages of development in the other optometry schools. Pennsylvania and Southern both offer this training in postgraduate form to existing practitioners, so Alaskan optometrists can avail themselves of it. I would envision the Board of Examiners endorsing ODs' certificates for diagnostic and therapeutic or diagnostic only, depending on the training they have completed.

This training is far superior to that given the undergraduate medical student. The postgraduate course offered by Pennsylvania in drugs alone comprises 105 curriculum (clock) hours of instruction and application. By contrast, a recently published survey of medical schools (attached) indicates that total required instruction in ophthalmology averages 22 hours, and many of those are taken up with learning basic anatomy, physiology and pathology of the eye, areas occupying multiple courses in optometry school. Yet medical school graduates can and do use the drugs we are seeking to use.

At the same time, I am aware that compromises in our bill may have to be achieved. I have suggested to Senator Colletta at his request, a possible constraint upon the Board of Examiners as to whom it consults in the process of implementing the legislation. A copy of that letter is attached.

There are additional limitations on statutory authority that could be imposed upon the board without significantly impairing the primary care services that will be of most benefit to the people of Alaska. In regard to therapeutics, the categories of drugs allowed are not as important as the three principal routes of administration, for the latter correspond to three levels of sophistication in the treatment of eye diseases. Those, in turn, relate to the location and severity of infections or inflammations of the eye. The routes, with commentary, are:

1. Topical application (eye drops and ointments)

Useful for "pink eye" (conjunctivitis), superficial infections of the cornea, irritation due to allergy, lid inflammations, prevention of infection in scratched eye. Most cases of simple glaucoma also respond well to drops. Topical treatment is well within the capability of optometrists trained in therapeutics.

2. Oral (tablets, capsules)

Primarily antibiotics. Often necessary as an adjunct to topical in deep or severe corneal infections. Usually necessary in infections deeper in the eye. While dentists use systemic antibiotics routinely and safely to clear up abscesses, I believe that optometrists are best advised at the present time to refer such cases to the specialist. While the board would probably exclude orals by regulation, they could also be excluded by statute without impairing the viability of the primary care concept.

3. Injection (intramuscular, intravenous, retrobulbar, subconjunctival, rarely intraocular)

These are also used for deep infections where topical application cannot deliver a sufficient quantity of antibiotic to the site of infection to be effective or where the effective oral dose would create undesirable side effects. This is definitely beyond the scope of present training in optometry and should be excluded.

Of the three therapeutic states, Florida and North Carolina do not restrict the route of administration by statute; discretion in this area is exercised by the boards. West Virginia specifies topical application.

While we would like to see the board free to run its own show, a statute adequate for some time to come would limit drug utilization to corneal anesthetics, mydriatics (pupil dilators), miotics (pupil constrictors), cycloplegics (ocular focus held constant) and topical therapeutic agents. A possible wording is circled in the enclosed West Virginia law (p. 4).

Senator Parr
March 13, 1981

3

Bach

Another restriction might be the specification in statute that anyone who has graduated or last used drugs more than three years before applying for endorsement under this act must re-take the required pharmacology training. This would be slightly unfair to a number of the younger graduates who have had the training, but it could be argued that their skills have gotten rusty in the interim. It would also get the board off the hook as to where to draw the line.

Other possible amendments include:

1. Directing the board to specify continuing education requirements, as in the West Virginia law (p. 6, line 37).
2. Specifying the Pharmacology section of the National Board Examination in Optometry as the board's examination.
3. Requiring the board to report to the legislature in 3 to 5 years, detailing drug usage, side effects reported, etc.
4. Requiring training in cardiopulmonary resuscitation (CPR).
5. Mandatory referral statement from my letter of March 6.

Very truly yours,



Phillip W. Bach, O.D., Ph.D.
Member, Board of Examiners
in Optometry
Co-Chairman, Legislative Committee,
Alaska Optometric Association

PWB/lr

3 enclosures

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notion and has emphasized to trainees that the hospital does not endorse them as being competent to engage in family practice. However, since state laws permit an M.D. licensee to do any type of practice he wishes, it is the feeling of the director that the public would be better served by potential family practitioners having some rather than no additional training. Since there are a number of physicians seeking some training to change their specialty, consideration should be given to longer hospital training periods or a return to specially designed preceptorships to accommodate them.

With respect to those family doctors in retraining, the program would be improved by a more specific set of goals and more careful monitoring of achievements than has as yet been accomplished. The author is aware of two other programs offering similar training. At Creighton University School of Medicine rural family doctors are trained in a specific area, for

example, cardiology techniques such as Swan-Ganz catheter insertion. At the Medical College of Pennsylvania inactive physicians or physicians in administrative positions are being trained in primary care.

Conclusions

A pilot miniresidency in family practice has been in operation at Santa Monica Hospital Medical Center since 1979. Many of the applicants were practicing in other specialties and seeking to make a change to family practice. It is unrealistic to expect that the available two-to six-week period can accomplish this objective, and there is a need for a different kind of program to accommodate such circumstances. Training goals for family doctor residency refresher training must be more specific and evaluations more formal than is now the case in the Santa Monica experience.

Ophthalmology Teaching in Medical Schools

Robert E. Kalina, M.D., Henry J. L. Van Dyk, M.D.,
and George W. Weinstein, M.D.

The Association of University Professors of Ophthalmology (AUPO) was founded in 1965 and is made up of the chairmen of all departments or divisions of ophthalmology in U.S. medical schools (1). A major interest of the body, individually and collectively, is medical student education.

Some members of the AUPO believe that recent medical school graduates are less well

prepared in ophthalmology than those of the more distant past. Also reduced familiarity with ophthalmology by physicians in future generations has been cited as a potential problem in the legislative and legal arena (2).

The results of two AUPO surveys of ophthalmology teaching are reported here.

Survey Techniques

Questionnaires were mailed in 1974 and again in 1979 to the members of the AUPO. Each member was asked to complete the form or to forward it to the individual in his unit most responsible for medical student education. Confidentiality was optional and was elected by some.

The survey document used in 1979 duplicated the questions of 1974 and in addition

This survey was supported in part by a grant to the University of Washington from Research to Prevent Blindness, Inc.

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inquired about the usage and usefulness of the *Ophthalmology Study Guide for Students and Practitioners of Medicine*, a joint publication of the AUPO and the American Academy of Ophthalmology and Otolaryngology (AAOO) which first appeared in 1976 and now is in its third edition (3). This guide is based upon seven objective areas thought to represent essential knowledge requirements for all physicians. These objectives were developed as a result of a survey of 1,600 respondents representing medicine at undergraduate and graduate levels of general and specialty orientation (4, 5).

Results

Responses were received from 74 of 102 member schools in 1974 (73 percent) and from 81 of 110 schools in 1979 (74 percent) (Figure 1). There was a decline in mean required curriculum hours from 25 in 1974 to 22 in 1979, while the median declined from 18 to 15. Hours actually assigned to the department or division of ophthalmology decreased proportionately from a mean of 22 in 1974 to 20 in 1979. Assigned hours were used most frequently for lectures or demonstrations.

All responding institutions offered medical student electives in ophthalmology in 1979, but only a minority of students chose them (mean 25 percent, median 15 percent). Use of audiovisual self-instruction units rose from 66 percent in 1974 to 82 percent in 1979.

The study guide, not available in 1974, had been adopted as a syllabus by 58 percent of institutions in 1979, while 28 percent used another syllabus, usually prepared locally. In most cases the study guide was purchased by the student and used for self-instruction as a supplement to lectures. The microfilm demonstrations, newly added in the 1978 edition (1978), had been found useful by 67 percent of schools using the study guide.

Discussion

The surveys reported here were prompted in part by suspicion among the AUPO members that curriculum time devoted to ophthalmology had suffered during the widespread curriculum revisions which have taken place in U.S. medical schools during recent years.

Although data are not available from the preceding era, the results of the study reported here indicate that currently assigned time for

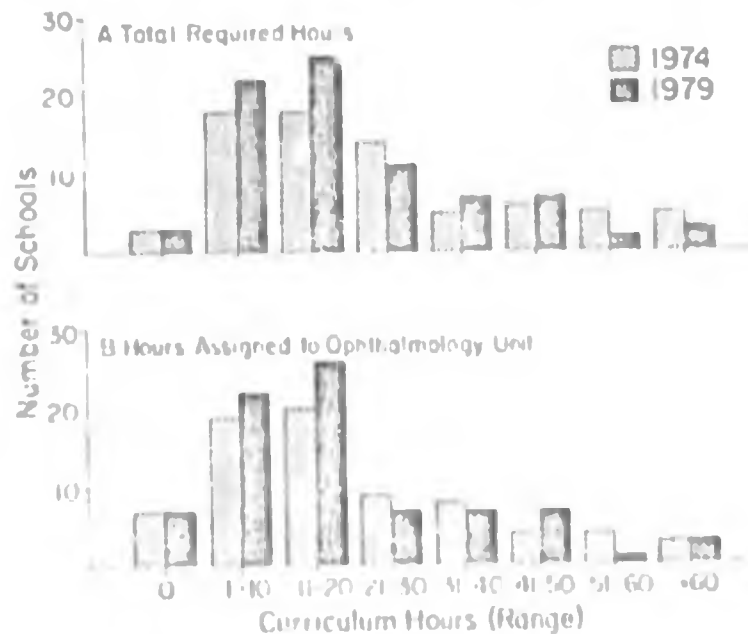


FIGURE 1
Minimum requirements for ophthalmology in U.S. medical schools

teaching ophthalmology is limited and gradually declining. One logical extension might be a declining ability for appropriate diagnosis, management, or referral of patients with eye disorders, who form a significant segment of those seeking primary care.

The results of these surveys may not include ophthalmology teaching done in the primary care clinical setting. It seems likely that such on-site instruction would be effective and appear relevant to students in that the patient-problem-teacher loop is shortest there; but the authors believe that such teaching events are rare, often unscheduled, and likely to be the first to suffer from time constraints.

Knowledge that curriculum time was limited and that competition for it was keen was one of the prime motivating factors for the development of the AAOO/AUPO study guide. Standardization of objectives to be achieved was presumed then as now to be a laudatory goal. However, the availability of clearly defined objectives has coincided with apparent reduced national curricular emphasis upon ophthalmology.

Not only is the curricular time available to ophthalmology small, but also surprisingly few

students (25 percent) choose ophthalmology electives. The reasons for limited elective participation may range from the influence of counselors to lack of available electives. Whatever the cause, the effect must be negative upon student appreciation for what the specialty offers. In view of the excess of candidates for the limited number of ophthalmology residency positions, a main concern is that students who will practice other specialties, especially primary care, learn proper diagnosis and treatment of some ophthalmic disorders so that they may avoid inappropriate referral to medical or nonmedical practitioners.

References

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2. WINGGRAD, L. A. What's Happening in Medical School? *Ophthalmologist*, March-April, 1978
3. *Ophthalmology Study Guide* (Third Edition). San Francisco: American Academy of Ophthalmology, 1978
4. SPIVEY, B. E. A Technique To Determine Curriculum Content for Medical Students. *J. Med. Educ.*, 46:269-274, 1971
5. SPIVEY, B. E. Ophthalmology for Medical Students: Content and Comment. *Arch Ophthalmol.*, 84:368-375, 1970



OFFICE OF THE
PRESIDENT
Freda J. Slaymaker, O.D.
P.O. Box 663
Charleston, West Virginia 25323
(304)342-3536

January 22, 1980

Dear Legislator:

This letter is an integral part of a report to you concerning the functioning of the 1976 updating of the West Virginia Optometry Law through H.B. 1005 which among other changes included diagnostic and therapeutic drug use by qualified optometrists.

To those of you who are "seasoned" legislators some of this is material of which you will perhaps be well aware. To those of you who have been recently elected, I will endeavor to provide you with as much pertinent material as possible without undue composition.

This law (H.B. 1005) has now been in effect since 1976 and has been functioning in the satisfactory manner as was intended by the legislature.

Optometrists have for over three and a half years been providing diagnosis and treatment to the many patients who live in the smaller towns in rural areas where no other eye care practitioners are available except the local optometrist. He, along with his colleagues, has administered drugs to Thirty Thousand Six Hundred Forty-Nine (30,649) patients with a savings of Four Hundred Fifty Thousand (450,000) miles (greater details enclosed for the term involved in this report).

Educational courses are being made available to the optometrists of West Virginia on a continuing basis providing them with newer diagnostic and therapeutic methods of treatment as they occur.

The inclusion of the use of drugs by optometrists is still a major bone of contention by a number of ophthalmologists who, through their efforts and financing have been sending what has been referred to as a "poisonous pen" letter (prepared by a public relations firm) to legislators of which you no doubt will be a recipient.

The enclosed letter from Dr. Butterfield contains results of the most recent survey conducted by the West Virginia Board of Optometry of those optometrists currently certified to use pharmaceuticals. This will provide you with greater details of the functioning of the law from the standpoint of drugs used and treatment instituted with far less travel time of which many indigent patients would not have the means and, thus, could not otherwise have received proper

THE WEST VIRGINIA OPTOMETRIC ASSOCIATION



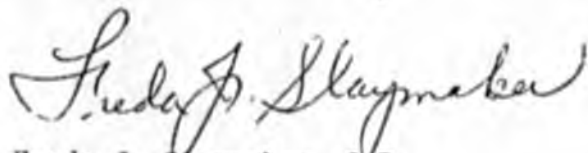
Affiliated with American Optometric Association

West Virginia Legislators
January 22, 1980
Page Two

treatment.

In submitting this report to you on behalf of the optometrists of the State of West Virginia we hope it will provide you with a better understanding of the results of your labor by supplying a means whereas the people of West Virginia are delivered an improved system of health care services.

Respectfully yours,



Freda J. Slaymaker, O.D.
President
West Virginia Optometric Association

FJS/scp

WEST VIRGINIA BOARD OF OPTOMETRY

J. GORDON BUTTERFIELD, O.D.

SECRETARY TREASURER

WEST VIRGINIA BOARD OF OPTOMETRY

111 BROOKS STREET

CHARLESTON, WEST VIRGINIA 25301



January 22, 1980

The Honorable W. T. Brotherton, Jr.
President, Senate of West Virginia
State Capitol Building
Charleston, West Virginia 25305

The Honorable Clyde M. See, Jr.
Speaker, West Virginia House of Delegates
State Capitol Building
Charleston, West Virginia 25305

RE: Report on Enrolled H.B. 1005 of 1976

Dear President Brotherton and Speaker See:

The purpose of this letter is to report to each of you and your respective bodies on the Enrolled H.B. 1005 enacted on February 20, 1976 by the Sixty-Second Session of the West Virginia legislature. As you may recall, this law expanded the statutory definition of "optometry" to include, among other things, the limited use of drugs prescribable for the human eye for both diagnosis and treatment, under carefully prescribed certification authority delegated to the West Virginia Board of Optometry. This Board has endeavored continuously and faithfully to both certify and monitor the use of drugs by optometrists practicing under the registration of this Board.

Recent information compiled from the one hundred seventeen (117) West Virginia registered optometrists now certified by this Board for drug usage is as follows:

a. A total of sixty-three (63) different drugs prescribable for the human eye have been employed by these West Virginia certified optometrists since the law was enacted.

b. Thirty Thousand Six Hundred Forty-Nine (30,649) individual patients have been seen by these optometrists and conditions such as infectious or allergic conjunctivitis, corneal abrasions and blepharitis (granulated eye lids) have been treated by those certified in the compilation.

c. The distance those patients who otherwise would have had to travel to geographical locations other than those of the treating optometrists for treatment by ophthalmologists or appropriate medical specialists to whom they formally were referred would have required that over 450,000 aggregate miles be traveled by the 30,649 patients.

The Honorable W. T. Brotherton
The Honorable Clyde M. See, Jr.
January 22, 1980
Page Two

J. Forty-six (46) different pathological conditions have been diagnosed and treated by these West Virginia certified optometrists.

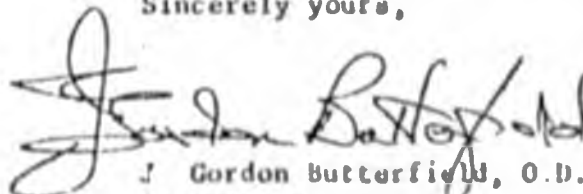
Those 117 West Virginia optometrists who have been certified are widely dispersed throughout our state and are now faithfully and well providing expanded eye health care benefits to the people of West Virginia. IT SHOULD BE ADDITIONALLY NOTED THAT THERE HAS BEEN NO REPORT TO THIS BOARD OF ANY ADVERSE REACTION IN THE DIAGNOSIS AND TREATMENT RENDERED TO PATIENTS INVOLVED BY ANY WEST VIRGINIA CERTIFIED OPTOMETRIST.

There have been reports in the newspapers during the past few months of adverse reactions allegedly caused by optometrists. These alleged reports have all been made by one ophthalmologist.

Registered letters sent to him by this Board seeking his cooperation in helping to identify and fulfill this Board's responsibility have been met with only silence. This Board, therefore, considers his alleged complaints to be just that.

Please be advised that this Board is quite aware of the full responsibility placed upon it by the legislature in the enactment of this law Enrolled H.B. 1005. This data was compiled in a continuing effort to support the trust which has been reposed in it. Each of you is encouraged to call upon this Board for any additional information which may be helpful.

Sincerely yours,


J. Gordon Butterfield, O.D.
Secretary-Treasurer

JCB/scp

COMPARATIVE PHARMACOLOGICAL INSTRUCTION FOR
HEALTH CARE PROFESSIONS

<u>PROFESSION</u>	<u>SCHOOL</u>	<u>PHARMACOLOGY HOURS OF INSTRUCTION</u>	<u>REFERENCE</u>	<u>RESTRICTION ON DRUG USE IN WEST VIRGINIA</u>
Optometry	Southern College of Optometry	Total = 204 Lecture = 156 hours (Ocular & Systemic) Lab = 48 hours Plus 696 hours Clinical use of FDA Classified Drugs. Plus 180 hours of Elec- tive Seminars attended by 80% of students.	Catalog of Southern College of Optometry 1979-80	Topically applied Ophthalmic Drugs as permitted in Enrolled H.B. 1005 March 1976
Dentistry	University of Tennessee Center for Health Sciences/ Memphis	Total = 70 hours Lecture = 40 hours Lab = 30 hours Plus Clinical use of drugs	General Catalog The University of Tennessee Center for Health Sciences/ Memphis 1978-79	NONE
Medicine	University of Tennessee Medical Units/ Memphis	Total = 187 hours Lecture = 88 hours Lab = 99 hours Plus Clinical use of drugs for 17 months *Clinical use of ocular drugs probably less than 25 of other drugs since Ophthalmology represents only 1.1% of total cur- riculum	General Catalog The University of Tennessee Medical Units/ Memphis 1973-74	NONE
Podiatry	Pennsylvania College of Podiatric Medicine	Total = 176 hours	Pennsylvania College of Podiatric Medicine 1977-79	NONE
Osteopathy	Philadelphia College of Osteopathic Medicine	Total = 156	Bulletin of Philadelphia College of Osteopathic Medicine 1978-79	NONE

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

March 13, 1981

The Honorable Mike Colletta
Health, Education and Social
Services Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Colletta:

In response to your request that I develop items of possible compromise regarding SB 136, the following provision is suggested as an addition to the bill. It relates to the power of the board to adopt regulations, which subject was the main topic of our discussion on March 11.

* Sec. 4. AS 08.72.050(4) is amended to read:

(4) necessary to govern the practice of optometry [;] subject to the following provision: regulations defining and specifying ophthalmic drugs which may be used by optometrists shall be adopted in consultation with the Director of Public Health of the Alaska Department of Health and Social Services;

This would insure continuing input and monitoring by this branch of the Administration during the course of implementing the legislation.

I would have no objection to the type of board proposed by Deborah Behr for the Department of Health and Social Services, if the board is advisory in nature. However I think such a board is undesirable, for several reasons:

1. The legislature and Governor currently show little enthusiasm for the creation of additional boards and commissions.
2. It is difficult to recruit lay or "ou side" members to serve on boards of this type.
3. The board as proposed would not have expertise in the critical area: Knowledge of the education and training of optometrists vis a vis drug usage.

Senator Colletta
March 13, 1981

2

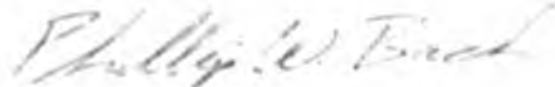
Bach

4. The board composition as proposed includes members (ophthalmologist, Department representative) who represent groups that have testified in favor of legislation far more restrictive than would seem necessary, considering the educational background of optometrists and the track record of boards and practitioners in other states (copy of West Virginia report attached). Thus the board's deliberations would more likely be political than technical in nature.

On the other hand, I can see considerable merit in the proposal given above. The Director of Public Health could use such consulting resources as he deemed valuable. For its part, the Board of Examiners would consult with the deans and certain faculty members of the optometry schools, for they are the only ones who really know what is going on in optometric education!

I am sending to Chairman Parr this date, other possible restrictive amendments which we would regard as compromise positions. You might wish to consider them along with those suggested in this letter. Once again, I appreciate your efforts to achieve an equitable compromise, though I fear the two sides are so far apart that this will not be possible.

Very truly yours,



Phillip W. Bach, O.D., Ph.D.
Member, Board of Examiners
in Optometry
Co-Chairman, Legislative Committee,
Alaska Optometric Association

PWB/lr

enclosure

cc: Senator Charles H. Parr

E. E. BACH, O.D.
PHILLIP W. BACH, O.D., Ph.D.
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ANCHORAGE, ALASKA 99503

March 13, 1981

Ms. Rocky Weller
Legislative Assistant to
Senator Charles Parr
Alaska State Senate
Pouch V
Juneau, Alaska 99811

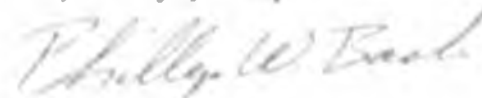
Dear Ms. Weller:

Representative Don Clocksin told me on March 11 that he
would like to attend the markup session for SB 136.

Perhaps you could check to see whether he has been
informed of the date.

Thank you.

Very truly yours,



Phillip W. Bach, O.D.

copy memo 2
SB 136

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 6, 1981

The Honorable Charles H. Parr
Chairman, Health, Education and
Social Services Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

re: SB 136

Dear Senator Parr:

Thank you for sending me for comment, the compromise proposed by the ophthalmologists. We are willing to make reasonable compromises, and several features of this proposal are acceptable to us.

Here is our response to specific points. I have numbered some paragraphs for reference, corresponding to the numbers below.

1. (Drugs allowed)

The two drugs allowed are a tiny fraction of what the schools prepare undergraduates and existing practitioners to use. Specifying individual drugs in the statute creates an obsolescence problem.

[REDACTED]

...which drugs within each class may or may not be used. (I would suggest that since this is a detail of implementation, the statute would be less cluttered if the mandate is placed in a letter of intent to accompany the legislation, if this is appropriate for a letter of intent. The Board would follow the directives of the letter of intent.)

2. (Approval of changes in medications by joint concurrence of Optometry and Medical boards)

The Medical Board has opposed drug usage by optometrists in the past. Their involvement would create a 1 to 1 tie, and no change could be made. This is like sending the fox to guard the hen house.

3. (Required training)

Acceptable. One note on cardiopulmonary resuscitation and emergency training: This is taught by many optometry schools even though practitioners are unlikely ever to need it in their practices. I think it is a good thing for every citizen to know. However, graduates who have not had the training should have the

option of taking it in Alaska, such as a Red Cross approved CPR course.

4. (Examination by committee of 2 optometrists and 2 ophthalmologists)

A better system already exists: the schools test the students in their courses. Then the applicant must pass the Board of Examiners in Optometry examination. The Alaska board would use the pharmacology section of the National Boards, an excellent examination constructed from test questions submitted by faculty members of the schools and colleges of optometry, including pharmacologists and ophthalmologists.

5. (Mandatory referral based on single signs and symptoms)

Optometrists in Alaska make literally hundreds of referrals to ophthalmologists and other health care practitioners each year. But this proposal would result in many times that number in needless referrals. Here are some examples:

1A (Less than 20/30 vision for children under 8) - such lower acuity is the norm for preschoolers. Slataper (1950) found the average 5 year old to have 20/32 visual acuity. Weymouth (1963) found 10% of 6 year olds to have 20/36 or less. (Citations available on request). Where visual reduction is due to amblyopia, visual therapy, usually patching, takes up to 3 months or longer to show improvement, not 2 weeks.

1B Spots (floaters) in front of the eyes are normal but often are noticed suddenly, especially by people over 40. They may be pathological (as in uveitis) but this requires corroboration by other signs and symptoms. Scintillating images or flashing lights followed by headache are the classic migraine syndrome. This is untreatable except for possible pain medication.

1E Diplopia after a head blow is not uncommon and usually needs only to be monitored for improvement over the next few days and weeks.

2A Inflammation, injection can easily be treated by the optometrist with antibiotic or anti-inflammatory medications; much of this would not need to be referred if the present bill passes.

2B Corneal opacities can be old foreign body scars, long since forgotten (or never known) by the patient. We see lens opacities in developing cataract years before the cataract becomes dark enough to require removal. We usually make notes but do not always tell the patient so he will not be unduly alarmed.

CATARACT

A cataract is an opacification of the lens or its capsule. By this definition, almost every adult has cataracts in the sense that some fine opacities are usually visible with the slit lamp in every adult lens. It is advisable, therefore, to restrict the use of the term "cataract" to opacities of the lens that materially interfere with vision. Even in the early stages of cataract, when vision is somewhat interfered with, it is probably wiser to tell the patient that he has lens opacities, rather than use the term cataract. If he asks whether this means that he is going to develop cataracts, he can be told that many times such lens opacities do not progress but remain stationary and occasionally even absorb. If they do progress and cut down his vision further, he can then be told he has a cataract. Many patients go the rest of their lives with slight impairment of vision caused by early cataracts that never increase to the point requiring an operation.

Causes of Opacification of Lens Fibers

Cataract is a loss of transparency of the lens, developing as the result of altered physical and chemical processes in its colloids. Anything which

*Francis Head Miles, Textbook of Ophthalmology, Philadelphia -
W. B. Saunders Co., 7th ed. 1942, p. 315*

2C A high cup/disc ratio is meaningless as an indicator of the need to begin glaucoma treatment unless it is corroborated by high intraocular pressure or change in the visual fields, both of which are ready optometric test procedures.

4B Tension value of 22 mm is arbitrary and, in my opinion, far too conservative, particularly when the air puff tonometer (which tends to read high) is used. Other factors, such as family history, optic cup appearance, diurnal variation and visual fields must be taken into account before deciding whether this level of tension is even marginally significant.

I hope the fallacy of requiring referral on the basis of single symptoms is readily apparent from this. To reach a diagnosis, final or even tentative, usually requires that several factors be considered in combination. One item alone is rarely meaningful. Not only would this proposal result in a great numbers

of unnecessary referrals, but it would rob the highly trained professional person of his judgment. This is the real motive of ophthalmology in proposing this as a feature of a "compromise". For if they get the law to strip optometry of its professional judgment, they can begin to bring optometry under their control and eventually eliminate it as an independent profession.

Such a mandatory referral proposal has not passed in any state, though the ophthalmologists have tried. (Utah does have one that comes uncomfortably close to this). One of our ODs said in all seriousness that if this proposal should become law he would leave Alaska. If by some chance it passed, we would probably resort to the courts.

Virtually the same document was proposed by the ophthalmologists last year. They are not truly negotiating when they introduce completely new considerations that they know we cannot possibly accept, then say, "See, they aren't willing to compromise." A compromise cannot be one step forward and two steps backward.

However since I know you are all under pressure, we have developed a wording for a mandatory referral clause that we can live with, and can use as a compromise if necessary:

All optometrists licensed under this chapter shall assist their patients in whatever manner possible in obtaining further care when in the professional judgment of the optometrist, the services of another health care practitioner are required. The practitioner to whom the patient is referred shall return the patient to the referring doctor with a detailed report of his findings and treatment.

This is not palatable, because it implies that we have done something wrong which requires such a statement. But at least it preserves the practitioner's discretion as to when and to whom he refers his patients. As a logical extension, it should be made to apply to general physicians as well, since they know far less about the eye and its diseases than optometrists do (see attached copy of Dr. Maumenee's remarks and the optometry-medical school comparisons in a booklet previously submitted).

Very truly yours,

Phillip W. Bach
Phillip W. Bach, O.D., Ph.D.
Co-Chairman, Legislative Committee,
Alaska Optometric Association
Member, Board of Examiners

PLB/lr

Attachment

NOTICE: This Material
may be protected by copyright
law. (Title 17 US. Code)

Chairman's Address

The Educational and Political Structure of Ophthalmology in America

A. Edward Maumenee, MD, Baltimore

THE SOCIOECONOMIC structure under which medicine is now practiced is in the process of one of its greatest changes in the history of our country. In this connection, a few items of particular interest to ophthalmologists are: the medical school curriculum and the place of ophthalmology in it; the National Eye Institute; Medicare; the Hart Bill now before the Senate; and our relationship to optometry, and its effect on Resolution 77 of the American Medical Association. It is not my intent to discuss these specific problems, but rather to outline the educational and political structure of ophthalmology in this country and to offer a few suggestions regarding the management of these conditions so that we may seek the most effective avenues to voice our opinion on these matters.

The educational aspects of this discussion are included because the faculty of our medical schools exert a major influence on the development and administration of new programs. This is particularly true today, when government agencies frequently seek the ad-

vice of academicians in establishing policies in medical aid and care.

Ophthalmology is a minor specialty in undergraduate teaching. According to Duane,¹ ophthalmology has subdepartmental (division) status in over 50% of the medical schools in the United States. The time allocated to the teaching of this specialty, even when it has departmental status, is extremely short. Thus, in most schools, only 60 to 100 hours are devoted to ophthalmology during the entire four years, as compared to 300 to 900 hours in the fields of obstetrics and gynecology, pediatrics, psychiatry, surgery, and medicine. In postgraduate education, however, ophthalmology assumes much greater importance, for the three to five years spent in residency training are comparable to those of other specialties. At present, about 10% of all outpatients and inpatients seek aid because of ocular complaints.

The role of ophthalmology in postgraduate teaching will probably increase greatly in the immediate future because of Medicare. An analysis of the patients over 65 years of age who received medical attention at The Johns Hopkins Hospital showed that 30% sought assistance because of ocular problems. A review of all discharge diagnoses at Hopkins on patients of any age revealed that cataract discharges were the

Submitted for publication June 29, 1966.
From the Wilmer Institute, Johns Hopkins Hospital, Baltimore.

Chairman's Address read before the Section on Ophthalmology at the 115th Annual Convention of the American Medical Association, Chicago, June 26-30, 1964.

Reprint requests to the Johns Hopkins Hospital, 601 N Broadway, Baltimore 21205 (Dr. Maumenee).

copy member SB 136

**Dennis A. Swarner, O.D.
Robert D. O'Connell, O.D.**

Doctors of Optometry
Drawer 4370
Kenai, Alaska 99611

Telephone (907) 283-7575

March 3, 1981

Mr. Charlie Parr
Pouch V
Juneau, Ak 99801

Dear Mr. Parr,

I am writing in support of Senate Bill #136. I hope you will judge this bill on it's own merits as well as the needs of the Alaskan citizens.

As a practicing Alaska Optometrist I could fill reams of paper in support of this bill but I'm sure that you are just as tired reading about the pros and cons of this bill as I am tiring of writing in it's support!!

I have a very simple solution to the problem. There are three states (Florida, North Carolina and West Virginia) that have allowed Optometrists to use the full range of Ophthalmic Drugs for several years. Look at the Optometric record relative to drug use in those states and judge accordingly.

I'm not sure how many of you folks are aware of the enormous amount of money generated by insurance companies, they usually have things pretty well figured out. Malpractice insurance for Optometrists went down nationwide last year. I'm sure not too many other professions experienced a similar reduction.

Thank you

Robert D. O'Connell
Robert D. O'Connell, O.D.

RO/mw

March 5, 1981

Representative Fred Zharoff,

I support the optometry bill # 136. Having practiced dentistry in Kodiak for seven years, it would seem helpful to the public to have minor eye problems treated by the optometrist. We have no resident ophthalmologist here and the optometrists may be as well qualified to treat some problems topically, as are the local physicians. I particularly support the use of topical diagnostic drugs by the optometrist.

Sincerely,



Knox N. Christie D.D.S.

C.C. Senator Charles Parr ✓
Representative Don Clockain
Senator Bob Mulcahy

members files
SB 136

The
ALASKA OPTOMETRIC ASSOCIATION

AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

PRESIDENT
George Hall O.D.

PROFESSIONAL PERSPECTIVES

No. 1

SEC-TREAS
Dennis Swamer O.D.

LEGISLATIVE COMM.
Maynard Falconer O.D.
Phillip Bach O.D. Ph.D.

AETNA REDUCES ANNUAL PREMIUM FOR INSURED AOA MEMBERS

Hartford, CT--More than two years of efforts between the American Optometric Association and Aetna Life & Casualty Co. have prompted the Hartford based insurance firm to REDUCE PROFESSIONAL LIABILITY RATES FOR AOA MEMBERS BY 18 PERCENT. The high quality of professional vision care which AOA optometrists are providing has warranted this reduction. Fear expressed by ophthalmologists, in those states which allowed optometrists to use ophthalmic drugs, was unfounded. Optometry has been the ONLY major health care profession to have its liability insurance rates reduced.

March 5, 1981

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Knox N. Christie D.D.S.

C.C. Representative Fred Zharoff
Representative Don Clocksin
Senator Bob Mulcahy

Copies members
SB 136

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 6, 1981

The Honorable Charles H. Parr
Chairman, Health, Education and
Social Services Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

re: SB 136

Dear Senator Parr:

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Here is our response to specific points. I have numbered some paragraphs for reference, corresponding to the numbers below.

1. (Drugs allowed)

The two drugs allowed are a tiny fraction of what the schools prepare undergraduates and existing practitioners to use. Specifying individual drugs in the statute creates an obsolescence problem. We can accept a compromise that specifies certain classes of diagnostic and therapeutic drugs in the statute. We can also accept mandated ophthalmological consultation in determining, by regulation, which drugs within each class may or may not be used. (I would suggest that since this is a detail of implementation, the statute would be less cluttered if the mandate is placed in a letter of intent to accompany the legislation, if this is appropriate for a letter of intent. The Board would follow the directives of the letter of intent.)

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1B Spots (floaters) in front of the eyes are normal but often are noticed suddenly, especially by people over 40. They may be pathological (as in uveitis) but this requires corroboration by other signs and symptoms. Scintillating images or flashing lights followed by headache are the classic migraine syndrome. This is untreatable except for possible pain medication.

1E Diplopia after a head blow is not uncommon and usually needs only to be monitored for improvement over the next few days and weeks.

2A Inflammation, injection can easily be treated by the optometrist with antibiotic or anti-inflammatory medications; much of this would not need to be referred if the present bill passes.

2B Corneal opacities can be old foreign body scars, long since forgotten (or never known) by the patient. We see lens opacities in developing cataract years before the cataract becomes dark enough to require removal. We usually make notes but do not always tell the patient so he will not be unduly alarmed.

CATARACT

A cataract is an opacification of the lens or its capsule. By this definition, almost every adult has cataracts in the sense that some fine opacities are usually visible with the slit lamp in every adult lens. It is advisable, therefore, to restrict the use of the term "cataract" to opacities of the lens that materially interfere with vision. Even in the early stages of cataract, when vision is somewhat interfered with, it is probably wiser to tell the patient that he has lens opacities, rather than use the term cataract. If he asks whether this means that he is going to develop cataracts, he can be told that many times such lens opacities do not progress but remain stationary and occasionally even absorb. If they do progress and cut down his vision further, he can then be told he has a cataract. Many patients go the rest of their lives with slight impairment of vision caused by early cataracts that never increase to the point requiring an operation.

Causes of Opacification of Lens Fibers

Cataract is a loss of transparency of the lens, developing as the result of altered physical and chemical processes in its colloids. Anything which

Excerpt from book "The Eye" by Dr. J. J. Moore, Philadelphia, 1920

2C A high cup/disc ratio is meaningless as an indicator of the need to begin glaucoma treatment unless it is corroborated by high intraocular pressure or change in the visual fields, both of which are ready optometric test procedures.

4B Tension value of 22 mm is arbitrary and, in my opinion, far too conservative, particularly when the air puff tonometer (which tends to read high) is used. Other factors, such as family history, optic cup appearance, diurnal variation and visual fields must be taken into account before deciding whether this level of tension is even marginally significant.

I hope the fallacy of requiring referral on the basis of single symptoms is readily apparent from this. To reach a diagnosis, final or even tentative, usually requires that several factors be considered in combination. One item alone is rarely meaningful. Not only would this proposal result in great numbers

of unnecessary referrals, but it would rob the highly trained professional person of his judgment. This is the real motive of ophthalmology in proposing this as a feature of a "compromise". For if they get the law to strip optometry of its professional judgment, they can begin to bring optometry under their control and eventually eliminate it as an independent profession.

Such a mandatory referral proposal has not passed in any state, though the ophthalmologists have tried. (Utah does have one that comes uncomfortably close to this). One of our ODs said in all seriousness that if this proposal should become law he would leave Alaska. If by some chance it passed, we would probably resort to the courts.

Virtually the same document was proposed by the ophthalmologists last year. They are not truly negotiating when they introduce completely new considerations that they know we cannot possibly accept, then say, "See, they aren't willing to compromise." A compromise cannot be one step forward and two steps backward.

However since I know you are all under pressure, we have developed a wording for a mandatory referral clause that we can live with, and can use as a compromise if necessary:

All optometrists licensed under this chapter shall assist their patients in whatever manner possible in obtaining further care when in the professional judgment of the optometrist, the services of another health care practitioner are required. The practitioner to whom the patient is referred shall return the patient to the referring doctor with a detailed report of his findings and treatment.

This is not palatable, because it implies that we have done something wrong which requires such a statement. But at least it preserves the practitioner's discretion as to when and to whom he refers his patients. As a logical extension, it should be made to apply to general physicians as well, since they know far less about the eye and its diseases than optometrists do (see attached copy of Dr. Maumenee's remarks and the optometry-medical school comparisons in a booklet previously submitted).

Very truly yours,

Phillip W. Bach
Phillip W. Bach, O.D., Ph.D.
Co-Chairman, Legislative Committee,
Alaska Optometric Association
Member, Board of Examiners

PWB/lr

Attachment

*Cops members
SB 136*

**Dennis A. Swarner, O.D.
Robert D. O'Connell, O.D.**

Doctors of Optometry
Drawer 4370
Kenai, Alaska 99611

Telephone (907) 283-7575

March 3, 1981

Mr. Charlie Parr
Pouch V
Juneau, Ak 99801

Dear Mr. Parr,

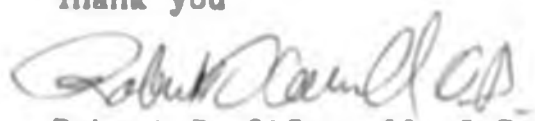
I am writing in support of Senate Bill #136. I hope you will judge this bill on it's own merits as well as the needs of the Alaskan citizens.

As a practicing Alaska Optometrist I could fill reams of paper in support of this bill but I'm sure that you are just as tired reading about the pros and cons of this bill as I am tiring of writing in it's support!!

I have a very simple solution to the problem. There are three states (Florida, North Carolina and West Virginia) that have allowed Optometrists to use the full range of Ophthalmic Drugs for several years. Look at the Optometric record relative to drug use in those states and judge accordingly.

I'm not sure how many of you folks are aware of the enormous amount of money generated by insurance companies, they usually have things pretty well figured out. Malpractice insurance for Optometrists went down nationwide last year. I'm sure not too many other professions experienced a similar reduction.

Thank you



Robert D. O'Connell, O.D.

RO/mw

Copy 2, memo
5/5 136

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 4, 1981

The Honorable Charles H. Parr
Chairman, Senate Health, Education
and Social Services Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

In accordance with your request at the February 27 hearing on SB 136, I am enclosing a list of the types of ophthalmic drugs that optometrists believe should be permitted under SB 136. The list represents those categories of drugs whose clinical use is taught by the Pennsylvania College of Optometry.

When contacted about the preparation of this list, the Academic Dean of Pennsylvania College indicated that a full listing of drugs under each category would be unduly long and cumbersome, and he suggested instead that a few examples of each category be included; this they have done. I might note that the examples given are generic names and that two or more companies may market the same generic product under different brand names. A comprehensive listing of drugs in each category is available in the Physicians Desk Reference for Ophthalmology. I can provide this information on request.

Since drugs are constantly changing and improving, it appears that writing specific drugs into the statute would subject the statute to rapid obsolescence. We would prefer to have the Board of Examiners authorize drugs by regulation, using such consulting resources as it deems necessary. However an acceptable intermediate position would be to specify in the legislation, categories of drugs, which are unlikely to change with time.

Very truly yours,



Phillip W. Bach, O.D., Ph.D.
Member, Board of Examiners
in Optometry

PWB/lr

Enclosure



1200 West Godfrey Avenue
Philadelphia, Pa. 19141
215 424 5900

Office of Academic Affairs

**Pennsylvania College
of Optometry**

March 3, 1981

The Eye Institute
1201 West Spencer Street
Philadelphia, Pa. 19141
215 276 6000

Phillip W. Bach, O.D., Ph.D.
Suite 204
Denali Professional Center
3401 Denali Street
Anchorage, Alaska 99503

Dear Doctor Bach:

In response to your request, I have formulated a list of pharmaceutical agents which may be helpful in preparing your legislation. The current graduating class from the Pennsylvania College of Optometry has developed competency in utilizing pharmaceutical agents in the various categories and classifications listed below.

Currently the students at the College develop a theoretical knowledge of these pharmaceutical agents through various didactic courses, and expertise in the clinical utilization of these drugs through a variety of clinical experiences. These clinical experiences occur in various settings such as The Eye Institute of the Pennsylvania College of Optometry, Veterans Administration Medical Centers, Health Maintenance Organizations, Armed Forces Hospitals, and private practice settings.

A major emphasis of the curriculum at the College is the differential diagnosis of ocular diseases and systemic diseases with ocular complications. We feel the critical step in the management of ocular and visual disorders is the specific differential diagnosis. The application of pharmaceutical agents is simply one of the competencies necessary in the continuum of the diagnosis and management of ocular diseases.

Listed below are the major classifications and categories of pharmaceutical agents commonly utilized in the patient care setting of the College. Examples are given of different drugs in each category. This is not to be interpreted that other drugs within these categories are not utilized when specifically needed, based on the professional judgements of the clinician.

- I. Topical Anesthetics
Example: Proparacaine
Benoxinate
- II. Mydriatics
 - A. Sympathomimetics
Example: Phenylephrine
 - B. Parasympatholytics
Example: Atropine group
- III. Cycloplegics
 - A. Parasympatholytics
Examples: Atropine group
Cyclopentolate
- IV. Miotics
 - A. Examples: Pilocarpine
Anticholinesterases
- V. Antimicrobials
 - A. Antibiotics
Examples: Tetracycline
Erythromycin
Gentamicin
Chloramphenicol
Bacitracin
Cephalosporins
 - B. Antibacterial
Example: Sulfonamides
 - C. Antiviral
Example: Idoxuridine
 - D. Antifungal
Example: Natamycin
- VI. Anti-inflammatory
Example: Corticosteroids
- VII. Anti-glaucoma
 - A. Sympathomimetics
Example: Epinephrine
 - B. Sympatholytic
Example: Timolol Maleate
 - C. Parasympathomimetics
Examples: Pilocarpine
Anticholinesterases
 - D. Carbonic Anhydrase Inhibitors
Example: Acetazolamide

VIII. Antihistamines

Examples: Diphenhydramine
Antazoline

IX. Miscellaneous Legend Drugs

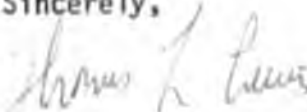
Example: Hyperosmotic Agents

X. Over-the-counter Drugs

Example: Dyes
Ocular Lubricants
Decongestants

I hope this list is of some help to you in constructing your new legislation. The Pennsylvania College of Optometry stands prepared to assist you educationally in meeting the visual care needs of the people of Alaska.

Sincerely,



Thomas L. Lewis, O.D., Ph.D.
Dean of Academic Affairs

TLL:dmf

NORTH PACIFIC MEDICAL CENTER

P. O. BOX 948
KODIAK, AK 99615

TELEPHONE (907) 486-4183

LOREN HALTER, D. O. (D.A.B.F.P.)
FAMILY MEDICINE

GARY HURLBURT, PA-C

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

March 6, 1981

The Honorable Charles H. Parr
Health, Education and Social
Services Committee
Pouch U
Juneau, Alaska 99811

Dear Senator Parr,

The passage of Senate Bill 136 (House Bill III) will help to provide better and more prompt health care for the population of Alaska.

We often use our local optometrist for consultation, diagnosis, and treatment of eye related problems. Many times he is called into the hospital for consultation. It is more effective to use his knowledge and instrumentation to determine whether a patient has a minor eye disease or something more serious. He is better equipped to handle their problem, and to treat those problems within his realm of expertise, and give the necessary follow-up care.

It is an unnecessary expense and inconvenient for the patient to go back and forth from one office to the other, when these problems can be handled by the optometrist.

Also, here in Kodiak, there is a close relationship (because of our distance from a large referral center) between ourselves and the optometrist, in order that we may give better medical care.

NORTH PACIFIC MEDICAL CENTER

LOREN J. HALTER, D.O.

RON BROCKMAN, D.O.

GARY HURLBURT, PA-C

RICHARD HOLYOKE, PA-C

cc: Rep. D. Clocksin Chairman House HESS
Rep. Fred Zharoff
Sen. Bob Mulcahy

TELEGRAM

ALASCOM, INC.
PHONE: 986-6442
JUNEAU, AK 99802

*Copies member
SB 136*

APR 10 11 3 35

02151 ANCHORAGE ALASKA 70 03-10 1245P AST

PMS SENATOR CHARLES PARR, CHAIRMAN HESS COMMITTEE

ALASKA STATE SENATE ROOM 209 BEHRENS BLDG

JUNEAU AK 99811 920

URGE YOU NOT USE DEPARTMENT OF HEALTH AND SOCIAL SERVICES PROPOSED
SUBSTITUTE FOR SB136 AS THE VEHICLE FOR MARKUP. IT PERMANENTLY
REMOVES ALL CONTROL OF DRUGS FROM THE BOARD OF EXAMINERS, ALLOWS
FOR NO POSSIBILITY OF THERAPEUTIC USAGE, NOW OR IN THE FUTURE, AND
EVEN REMOVES THE WORD DIAGNOSIS FROM THE EXISTING DEFINITION OF
OPTOMETRY. WITH THE ORIGINAL BILL THERE IS ROOM FOR COMPROMISE IF
NEED BE.

PHILLIP W BACH, O.D.

COCHAIRMAN LEGISLATIVE COMMITTEE

ALASKA OPTOMETRIC ASSOCIATION

Copy number
1
SB 136

DR. CURTIS M. JOHNSON
OPTOMETRIST
330 SEVENTH AVENUE
FAIRBANKS, ALASKA 99701
Telephone 456-4010

March 6, 1981

Senator Charlie Parr
Pouch V
Juneau, Alaska 99811

Dear Senator Parr;

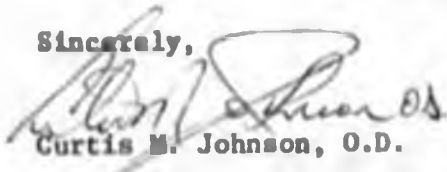
This is in response to a proposed compromise substitute for SB 136.

This is no compromise at all, it is all take and no give, more commonly known as R & R (rape and run).

1. Drug list offered is too restrictive with too many strings attached and too cumbersome to change as new and better drugs appear.
2. It would result in massive needless referrals as most conditions listed are not pathological and the ones that may be are presently referred already. It would destroy the professional judgement of the optometrist.
3. It appears a clever ploy to prevent further development of our profession. If something like this were to pass their next step would be legislation to require all patients to have ophthalmological evaluation for pathology before they could be seen by an optometrist. This would wipe out our profession which is really what they want, despite their protestations.
4. This would set a dangerous precedent for other professions such as dentistry, psychology, etc.
- 5.. The general MD would be exempt from these provisions and most everyone seems to agree that the optometrist knows more about the eye than the general practitioner.

If a true and sincere compromise were offered maybe something could be worked out but this is a sham and smokescreen.

Sincerely,



Curtis M. Johnson, O.D.

memory



March 6, 1981

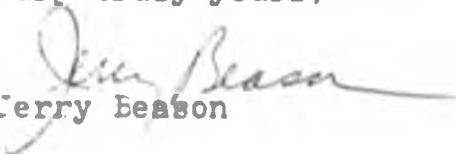
The Honorable Charles H. Farr
Chairman, Senate Health, Education
and Social Services Committee
Alaska State Senate
Fouch V
Juneau, Alaska 99811

Dear Senator Farr:

I seek your committee's support for Senate Bill 136.

It is my understanding that optometrists cannot so much as treat a pink eye because ophthalmologists wish to protect themselves from every shred of competition. This can only result in higher costs and longer times waiting for an appointment.

Recently an optometrist sent me to an ophthalmologist for an internal condition of my eye so I am familiar with both professions. We, the public, cannot benefit if one group is not allowed to fully use its skills and knowledge.

Very truly yours,

Jerry Beason

cc: Senator Bill Ray

EYE, EAR, NOSE & THROAT CLINIC

1919 LATHROP

FAIRBANKS, ALASKA 99707

PHONE: 456-7767

MESSAGE

REPLY

TO: Mrs. Kree Fanning
Pouch V

Juneau, AK 99811
Optometric Logics DATE 2/15/81

Thanks for the latest literature
by optometry - Mrs. are 5 quick
ruses from W.Va.
The real sad thing is no one
knows the real number of
missed diagnoses and improper
treatment percentages.
Thanks again

BY

[Signature]

DATE: 2/29

Sam -
Thanks so
much for your
response - I'll
make certain the info
gets to the right folks -
In preparing you a
rather lengthy correspondence
on the overall issue -
appreciate your
patience & cooperation -

FOLD

BY

[Signature]

ADDRESSEE: Keep this Copy for your files

The
ALASKA OPTOMETRIC ASSOCIATION

AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

FEB 10 1981

FEB 19 1981

PRESIDENT
George Hall O.D.

PROFESSIONAL PERSPECTIVE YES

No. 2

SEC. TREAS.
Dennis Swamer O.D.

LEGISLATIVE COMM.
Maynard Falconer O.D.
Philip Bach O.D. Ph.D.

OPHTHALMIC DRUG USE REPORT BY WEST VIRGINIA

Since 1976 certified optometrists in West Virginia have administered ophthalmic drugs for diagnostic and therapeutic use. A total of sixty-three (63) different drugs prescribable for the human eye have been employed since H.B. 1005 was enacted. Thirty thousand six hundred forty-nine (30,649) individual patients have been seen by certified optometrists. The distance those patients saved by not having to travel to sparsely located ophthalmologists to whom they formally were referred was over 450,000 aggravated miles.

Forty-six (46) different pathological conditions have been diagnosed and treated by these certified optometrists. IT SHOULD BE ADDITIONALLY NOTED THAT THERE HAS BEEN NO REPORT OF ANY ADVERSE REACTION IN THE DIAGNOSIS AND TREATMENT RENDERED TO PATIENTS INVOLVED BY ANY WEST VIRGINIA CERTIFIED OPTOMETRIST.

CRAP!
Sm.

PATIENT — (Confidential file)
STATE — West Virginia
REPORTING SOURCE — Physician (M.D.)
INFORMATION SOURCE —
 Ralph W. Ryan, M.D., Morgantown, West
 Virginia, (THE PEN, Vol. 2, No. 4,
 February 15, 1978).

HISTORY — (Synopsis)
 A 63-year-old female patient went to an op-
 tometrist complaining of decreased vision and
 watering in the right eye. Treatment in the form
 of drops was given.

Patient's family physician became aware of
 her vision loss in the right eye and referred her
 to an ophthalmologist. An easily seen retinal de-
 tachment was found in the right eye. Delay in
 necessary retinal surgery is believed to be the
 cause of a patient's statutory blindness in the af-
 fected eye.

CASE CLASSIFICATION— Optometric
 mismanagement and failure to refer.

PATIENT — (Confidential file)
STATE — West Virginia
REPORTING SOURCE — Physician (M.D.)
INFORMATION SOURCE —
 Ralph W. Ryan, M.D., Morgantown,
 West Virginia, (THE PEN, Vol. 2, No. 4,
 February 15, 1978).

HISTORY — (Synopsis)
 A registered nurse working on her Master's
 degree, felt the reading involved had caused ex-
 cessive strain on her eyes and visited an optome-
 trist. He advised the patient that she had a
 malignant melanoma of the iris in the left eye. The
 patient was advised that some 13% of the optome-
 trist's patients had these tumors.

Greatly alarmed, the patient consulted an oph-
 thalmologist. Examination revealed some need for
 eyeglasses and "freckles" in the iris of both eyes.
 None of the brown spots showed any indication
 of malignancy.

CASE CLASSIFICATION— Optometric
 mismanagement and failure to refer.

PATIENT — Mrs. Laura Dent
STATE — West Virginia
REPORTING SOURCE — Patient
INFORMATION SOURCE —
 Richard Rashid, M.D., South Charleston,
 W. Virginia, (THE PEN, Vol. 3 - No. 2 - 1979)
HISTORY — (Synopsis)

A female supermarket cashier visited an optometrist in May, 1975 for a general eye examination. She was advised that there were no signs of glaucoma or other eye diseases, and new glasses were prescribed. Within two weeks, the patient's vision became distorted. She contacted the optometrist, who again examined the patient, advising that the distortion was caused by astigmatism which would be corrected by continuing to wear the glasses he prescribed.

When the condition failed to improve, the patient visited her family physician, who found serious deterioration in both eyes. She was immediately referred to an ophthalmologist. Doctors Rashid and Toma, both ophthalmologists, examined the patient and found she was suffering from histoplasmosis (a disease caused by fungus). It was found that the disease had been present for a long period of time.

After six months of treatment, the laser was used to arrest the disease. Central vision in the left eye has been destroyed and vision is limited in the right eye. She was placed on continuing observation and treatment.

**CASE CLASSIFICATION— Optometric
 mismanagement and failure to refer.**

PATIENT — D. J. Denkins
STATE — West Virginia
REPORTING SOURCE — Patient
INFORMATION SOURCE —
 Richard Rashid, M.D., South Charleston,
 W. Virginia, (THE PEN, Vol. 3 - No. 7
 April 1, 1979)
HISTORY — (Synopsis)

A businessman reports that he visited an optometrist after developing a vision problem. Patient was told by the optometrist that he had a detached retina, a loss of sight for which nothing could be done.

Several months later, the patient suffering excruciating pain in his damaged eye called on an ophthalmologist who discovered a tumor that required surgery and removal of the patient's eye. Failure to refer early cost the patient the loss of an eye and possibly endangered his life.

**CASE CLASSIFICATION— Optometric
 mismanagement and failure to refer.**

PATIENT — Ina Browning
STATE — West Virginia
REPORTING SOURCE — Physician (M.D.)
INFORMATION SOURCE —

Richard C. Rashid, M.D., Charleston, W. Va.
HISTORY — (Synopsis)

A 74-year-old female patient experiencing a problem with her left eye, saw an optometrist in August of 1977. He placed the patient under treatment using a salve which the patient said, "liked to put my eye out". The medication was changed and changed again on August 10, 1978, when Vasocidin was administered. Following treatment, the eye became rapidly worse with excruciating pain. On August 24, 1978, the patient saw Dr. David W. Mullins, an ophthalmologist. He found a damaged left eye, which had perforated, but brought the condition under fair control with intensive treatment.

For other medical problems, the patient was later seen by an internist at a hospital in Charleston, West Virginia, some 60 miles from her hometown. The internist there recognized a serious eye problem and called Dr. Richard C. Rashid, a Charleston ophthalmologist, to the hospital. The damaged left eye had ruptured, and the patient was immediately admitted to the hospital. Every effort was made to control infection and to find an eye donor so that a piece of cornea might be obtained to patch and possibly save the damaged eye. Surgery was undertaken on November 27, and a corneal transplant was done for therapeutic purposes. At the time this report was submitted, it appeared unlikely that vision in the patient's damaged left eye could be restored. Improper diagnosis, drug use and treatment, as well as failure to refer, caused the patient to lose sight in her left eye.

CASE CLASSIFICATION — Optometric mismanagement and failure to refer.

John - Ken says hold

FEB 17 1981

**The
ALASKA OPTOMETRIC ASSOCIATION**

AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

PRESIDENT
George Hall O.D.

SEC-TREAS
Dennis Swamer O.D.

LEGISLATIVE COMM.
Maynard Falconer O.D.
Phillip Bach O.D. Ph.D.

February 12, 1981

Honorable Kenneth J. Fanning
Alaska State House of Representatives
Pouch V
Juneau, AK 99811

Dear Representative Fanning:

Enclosed is the optometric drug bill HB 111 as it emerged from drafting. It differs slightly from the wording of the proposed bill in the booklet we sent you. It tightens the revision language in the pharmaceuticals statute (A.S. 17.15) to relate more closely to the existing paragraphs.

Your staff can use the bill number for filing the booklet.

Very truly yours,

Maynard Falconer, O.D.
Phillip Bach, O.D., Ph.D.
Legislative Committee

1/30/51

TELEPHONE CONVERSATION WITH DR. SAM MCCONKEY, PH # 456-7760

McConkey is an Md. physician, 12 years education after high school.

Optometry school is not a medical school. Requires only two to four years additional schooling after high school. There is not one full-time M.D. on staff at ANY school of optometry in the US.

Study done which has stated that optometry schools are simply "make work" schools. They are not associated with any medical school.

Optometrists declared themselves a profession in 1951. Now they are trying to legislate themselves into the medical profession. They are trained to fit and prescribe glasses, not make diagnosis re: drugs, etc.

Last year, Dr. McConkey met with Sen. Hackney and Coletta and two optometrists to work out a compromise in order to protect the patient. The compromise allowed optometrists to prescribe drugs, however there were safeguards. (about six or seven different points - Dr. McConkey is mailing us a copy)

The compromise was agreed to by all there. But there was no further response from the optometrists. McConkey called Falconer, who told him that there would be no compromise - "If we wait long enough, we'll get exactly what we want" (Exact quote, according to Dr. McConkey)

About 1/2 of the States now allow optometrists to prescribe drugs. However McConkey cited several examples of poor results - one boy lost his eye because after the optometrist discovered the problem which he couldn't diagnose, he would not refer him to an ophthalmologist. \$250,000 settlement in process now.

Other countries have not found it safe to let optometrists diagnose these problems and treat them. In Great Britain - mandatory referra if vision is worse than 20/40. In Israel an optometrist is not allowed to treat anyone over 50 or under 10. In Italy - no one over 40 or under 10. Greece does NOT allow optometry.

McConkey repeatedly stated that his concern was not to keep business from the optometrists (he has enough business!), but to protect the patient and make him aware of the differences between an ophthalmologist and an optometrist.

OPHTHALMOLOGIST

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

OPTOMETRIST

ROBERT P. HAMMOND, O.D.

OTOLOGYNGOLOGIST

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

AUDIOLOGIST

PHYLLIS K. CASHER, M.A.C.C.C.

PLASTIC AND RECONSTRUCTIVE SURGEON

WILLIAM W. WENNEN, M.D., F.A.C.S.
RICHARD G. PARRY, M.D.

ORAL AND MAXILLOFACIAL SURGEON

ROBERT L. HASTINGS, D.M.D.
DENNIS W. JEFFERS, D.D.S.

ADMINISTRATOR

NICHOLAS J. NOEL



1/29/61

- Gail,
- ① The first paper is rough draft of my testimony I plan to give this year.
 - ② The second is a synopsis letter of 2 years ago to Sam Ziegler
 - ③ The third was my ^{with} presentation to 1979 session
 - ④ The four " " oral presentation " "
 - ⑤ This paper is one I talked to you about
optometric training
 - ⑥ Va Medical - This is how family practice people do it. Optoms can do the same without drops.
 - ⑦ An independent study on eye drops + use in Alaska
 - ⑧ The compromise we came up with in Sam Collett's office that Falconer refused to comply with
 - ⑨ PEN paper - Timothy Steels, the Alaska Assoc. Sec. finally by my partner, Bruce Wolf.

Thomson

Ken, This is rough draft of what I plan
to say @ committee hearings this session.
FEB 2 1981
sh

OPTOMETRIC LEGISLATION - 1981

Ladies and Gentlemen:

Optometry has an unyielding determination to substitute legislation for medical education. If you, as the guardians of the citizen's welfare in the State of Alaska, feel this type of legislation indeed is warranted, the least you can do is offer the citizens some safeguards. After all, it is their sight and in some cases their lives we are talking about.

For the fourth year, we meet again. The question of drug use by non-physicians was well on its way toward a compromise solution last year when the representatives of the non-physician group (Roy Box and James Matson) met with myself, Robert Page, Peter Carava, and Ron Tokar, all M.D. ophthalmologists, as well as Rick Urion, who was then the Optometric Lobbyist, and Jeff Landry, the Alaska State Medical Lobbyist.

We met in good faith at the request of Senators Coletta and Hackney to find a fair and reasonable compromise to this legislative bag of worms. The compromise was reached and agreed to by all, with the understanding that the participants spoke for their respective groups. After all of us had a typed copy of our agreement, I had no further response from the Optometrists. I called Falconer, the optometric power in Anchorage, and was told that there was no way they would agree to any compromise, at which time he stated, "All we have to do is wait long enough and we will get everything we want". As you might imagine, that was the end of any negotiating. It was certainly disappointing to have the group who initially put this type of legislation before you, say with such finality that they were not interested in any compromise. The Optometric motives must be questioned.

It has been repeatedly stated to previous committee members that the optometric intent is not to eventually practice medicine, but only to increase the capacity to diagnose eye problems because of their legal liability. If that is so, then why does the most prominent optometric spokesman, Henry Peters, O.D. have his stationery headed by the words "Optometric Medicine" "General Practice" and why does the group which Dr. Peters heads call itself the "American College of Optometric Physicians" and why have he and the dean of the Southern College of Optometry taken it upon themselves to redefine optometrists as: " a physician who practices optometry" and why do they redefine optometry as: "that branch of the science and art of medicine dealing with the treatment and prevention of disorders and maintenance of health of the human eye and visual system" and why are they promoting the title "doctor of optometric medicine". The truth is that prior to 1951, there was not even an O.D. degree (Dr. of Optometry) known to man and the optometrists conferred this degree upon themselves.

If the intent is not to practice medicine, then why do they hold "seminars" in the management of ocular emergencies, management of specific neuro-ophthalmic disorders, the management of peripheral retinal disorders. Some of these conditions are purely in the realm of the neurologist - neurosurgeon and are not in the purvue of even eye physicians and surgeons.

At this juncture, it serves no useful purpose to go back and rehash all the previous arguments relating to the inappropriateness of this type of legislation (to make someone a pseudophysician by legislative fiat, the hazards of drug use, any drug use, and most especially the general overall lack of training needed to be a diagnostician as concerns the visual apparatus).

There is no conceivable way that optometry approaches the intensity, duration, exposure, or depth that is required in medical training.

Recent publications (Optometric Management, December 1980) recommend withholding referrals from an ophthalmologist if politically the physician does not support this optometric intrusion into medicine. This is abhorrent to me.

The first rule of medicine is "Do no harm". Withholding appropriate care to any deserving patient demonstrates an appalling lack of moral and professional ethics and will not be tolerated by the public under any circumstances.

Any group who participates in such a conspiracy does not only not deserve to be called "doctor" of anything, but should not be allowed access to the public.

The governments of several countries have taken steps to see this sort of thing does not endanger their citizens. Recently, the Ministry of Health of Israel³⁶ signed an order which prohibits optometrists from examining anyone under the age of 10 or over the age of 50 without an ophthalmology referral. Italy's law is similar. Optometrists can only examine anyone between the age of 10 and 40 without ophthalmologic referral. In Greece, the practice has been outlawed totally.

The picture is now in perspective.

I am tired of coming back here year after year.

I am tired of taking up your time with an issue that should not even be before you.

I am embarrassed that I have become involved with this debasing, and degrading, unethical group of non-physicians.

4

I am disilluisioned with the lack of ethics on the part of this group who have distorted and mis-represented themselves.

I have not been impressed with the attitude of the lower house of the legislature when considering this question. Turf bill, indeed - What shallow thinking!

I am a professional. I have spent too many years being educated so that I can provide an ethical, professionally rewarding, and morally fulfilling service to my patients to continue this.

The minimum safeguards acceptable, in my opinion, would be those outlined in the previously accepted compromise. This gives Optometry more legal safeguards than they should ever expect and certainly more than any real physician in real medicine could ever hope to obtain. As a physician at risk every time I see a patient, I would certainly like to be absolved of all responsibility if all I had to do was follow the suggested criteria. However, I am not so naive as to think this will ever come to pass. I accept the responsibility. My training and experience gives me that confidence, not the conferring of some quasi-medical degree by a State legislature.

FEB 2 1978

OPHTHALMOLOGIST

OTOLARYNGOLOGIST

PLASTIC AND RECONSTRUCTIVE SURGEON

WILLIAM F KINN MD
BRUCE WOLF MD
SAMUEL A MCCONKEY MD

RONALD E TINSLEY MD
RICHARD F RAUGUST MD
BRUCE G WHIPPLE MD

WILLIAM W WENNER MD



May 22, 1978

Senator Robert Ziegler
Capitol Room 211
Juneau, Alaska 99811

Dear Senator Ziegler:

I understand that House Bill 664, an act relating to optometry, that recently passed the House with a three vote margin has been referred to your committee. I hope you can take a few moments to read this brief summary of what I feel are the important points to consider in this legislation.

This bill, if passed, would give optometrists (nonphysicians) the power to use "diagnostic drops" in the eyes of their customers. This legislation that you have before you is part of a nationwide effort on the part of organized optometry to introduce themselves into the field of medicine. Early on, optometry passed this bill in eight states before the medical profession was aware of their concerted efforts. However, the second year that this was introduced, this legislation was defeated in 14 states and only passed in four. In 1978, the legislation has been defeated in ten states and has only passed in two. The trend is clear, and that is, that once an informed legislature and public are aware of this type of legislation, it has been defeated overwhelmingly in legislatures across the country. The bill is not good for the public welfare and, in fact, endangers them at the hands of nonphysicians. Allow me to make several points then, and they are as follows:

1. As concerns "diagnostic drops." The general nomenclature is certainly a misnomer. These drugs are only called "diagnostic drops" by optometrists and not by physicians. Drops do not diagnose, people diagnose, and only people with the proper education, training, and experience to make these determinations should be allowed to use them. Currently, physicians who have completed their academic and clinical training have this ability and optometrists have minimal classroom training and no clinical experience with patients in the use of these medications.
2. Dilating the eye is not a prerequisite to making a diagnosis of eye disease, dilating drops are not a prerequisite to supplying children with the proper glasses correction, and anesthetic drops are not needed for anesthesia or the presumptive diagnosis of glaucoma.
3. It has been said in several states that have passed this legislation that because of the maldistribution between optometrists and ophthalmologists (physicians) that optometry could provide care where no other care was available. The status in Alaska is that there is no maldistribution between those that have the concern for providing eye care to our residents. The state is equally well covered by both optometry and ophthalmology.

4. Alaska is a unique state in that there is a high incidence of narrow angle glaucoma in the residents in Alaska, particularly among the native population. Narrow angle glaucoma is a severe high pressure in the eye that is caused by dilating the eye, specifically caused by the drops that the optometrists want to be able to use. This is a surgical disease, and the potential for inducing this problem should not be legislated on nonphysicians.
5. It's quite important that anyone involved with the use of medications in any fashion be capable of handling any systemic or local reactions to the medication, no matter how uncommon they may be. Optometrists have absolutely no training or preparation in the management of these potentially serious and, in some cases, life threatening reactions that happen occasionally with the use of these drops.
6. It should be mentioned that ophthalmology has no financial interest in this type of legislation and, as a matter of fact, this is not special interest legislation in any sense of the word. Ophthalmology is responding because we are the best qualified people to ask for an opinion and because we feel it is absolutely detrimental to the public's welfare.
7. Consumer protection is quite prominent in all of our considerations. It's evident from the efforts in other parts of the United States that optometry is lobbying both in the public sphere and in the legislatures across the country to be the primary eye care provider across the United States. It's my contention that this further confuses the public as to who they are seeing for their eye care. This does not give them any advantage. I can substantiate several cases of patients thinking they were being seen by an eye physician and, in truth, were being seen by an optometrist which, in some cases, has resulted in malpractice suits against optometrists for delays of diagnosis of potentially quite serious disease.
8. It would seem that of all the people available for comment, it would be those people who are both optometrists and ophthalmologists. I refer you to Dr. Roger L. Hiatt, M.D., who is a former optometrist and now a physician, Chairman of the Department of Ophthalmology at the University of Tennessee College of Medicine in Memphis. He is adamantly opposed to this type of legislation, having been through both training programs.

Thank you very much for your time in reading this brief summary. I would hope that you will have an opportunity to peruse other material and copies of data that have been sent to the HESS Committee in the House.

Sincerely,

Sen. A. McConkey, M.D.

SAM:ls

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 20/50 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.

FEB 2 1981

Outline Comments for Senate Meeting with Optometry

February 11, 1980

I. INTRODUCTION

Once again, for the third year in a row, I am embarrassed to be here. I do not think this is the proper forum for a discussion of this topic. The Legislature has been placed in an untenable position trying to decide on professional standards and it is unfortunate indeed that you have been forced to go through this procedure. I must say that we have tried on numerous other occasions to meet with some of the responsible members of Optometry to discuss this question, and those attempts were to no avail. Unfortunately, here we are again forcing you to waste time on a subject that should not even be presented to you. I honestly feel that the Legislature and its members have more important questions before them that decide the future of our state, not only financially but philosophically, and that your time should not be spent on what is considered by many of the legislators to be a turf bill. The truth is that Ophthalmology did not introduce this legislation, Optometry did, to further their own interests in lieu of the accepted mechanisms for raising ones position in the medical community, i.e. by being medically educated by qualified instructors to insure that the public will be protected.

*As recently as 1978
eye is the majority
in Sen. Culler's
office. Dr. Bon
approached re
re: meeting
to set up some
committee
for a better
status the
year to
2/11*

Unfortunately, Optometry has elected not to pursue this path but would prefer, by legislative fiat, to enjoy the benefits of being a physician without the appropriate background and training. Dr. Roger Hyatt, Chairman of the Department of Ophthalmology at the University of Tennessee is also an Optometrist who elected to go to Medical School and become an ophthalmologist. I would like to present his comments briefly, and I quote:

Optometry's arguments (in this sort of legislative effort) overlook two great dangers. First, the public in general associates the use of drugs with medically trained people, which Optometrists are not. Accordingly, when one applies medicine to the eye and attempts to prevent to the patient the ability to diagnose disease, he is putting himself legally, ethically, morally, and educationally in a position he is unable to assume as an Optometrist. Not only are Optometrists incapable of using equipment necessary to study disease, but they are unable to interpret what they might see. No one without proper medical training, including medical school, internship, and residency, can set himself up as an eye specialist capable of diagnosing disease. In fact, diagnosis is the practice of medicine. Diagnosis, not therapy, is the most difficult task facing the eye specialist today. When, as a practicing Optometrist I used an ophthalmoscope, I realized that the full burden of responsibility was on me, the practitioner, looking into the patient's eye. I realized that with the limited training I had in disease detection, a guess was the best I could do. A guess is just not good enough when it comes to the issue of blinding eye disease. Guesswork will just not do when the precious element of sight is involved. Therefore, it is the practitioner on the other end of the instrument that becomes more important than the instruments, drugs, or whatever is being used.

This approach to legislating the non-physician to physician status was assumed by the National Optometric Organization several years ago as a way to increase their share of the eye care market. Two years ago, the GAO instituted a study that demonstrated there were more optometrist being produced than there was market for their services: you see the reason for this type of maneuvering.

II. OPTOMETRY'S FUNCTION

Optometry provides a useful function in our society. They are exceptionally well trained in those areas in which they have historically excelled. Ophthalmology, in general, harbors no antagonism towards Optometry as long as they maintain themselves within the bounds of their training. In that regard, I might have you note that my group of Ophthalmologists in the Eye, Ear, Nose and Throat Clinic in Fairbanks employs an Optometrist who does an exceptional job on those areas for which he was employed, i.e. within the bound of optometric training and management. As an aside, I might point out that our Optometrist has had numerous problems with the State Optometric Society because of his association with us. Optometry has historically never been expected to be more than vision deficiency evaluators, that is prescribe and dispense glasses for vision problems, and evaluate eye muscle problems. As such, Optometry is properly limited by state statutes to stay out of the practice of medicine. Alaska Statute 08.72.300 (2 and 3) state "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. Practicing Optometry means the diagnosis of, 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." It is apparent and quite clear that the intent of this statute, as it is now in the Alaska State Statutes, is not the diagnosis of disease, not the practice of medicine, nor even the responsibility to diagnose disease, but to correct optical deficiencies, and visual or muscular anomalies the prescription of lenses, prisms, or ocular exercises and to refer those patients who do not fall in this sphere.

In a landmark case decided in Alaska, the U.S. Government was found liable for \$250,000 for the loss of an eye in a 4 year old child because of failure of timely referral by an Army optometrist.

From Judge James Fitzgerald's opinion:

An Optometrist should not attempt to complete a definitive diagnosis but recognize this responsibility as part of the practice of medicine. This principle is clearly stated in "The Optometric Profession".

The bill you have before you, and have had in the past, is only part of the continued effort on the part of Alaskan Optometrists to comply with their nationwide effort of organized Optometry to place itself higher on the medical ladder and hold themselves up as medically trained and qualified to diagnose and otherwise be capable of using medications in the eye.

III. OPTOMETRIC EDUCATIONAL REQUIREMENTS

A review of the Optometric educational requirements as compared with those of physician ophthalmologist document some of the comments I have made. A recent evaluation shows that Optometry has no hours in any of its training where they are under the supervision of a medical practitioner in the practice of general medicine, internal medicine, general surgery, or primary care. They have had no hours of formal education in the supervised practice of medicine and surgery of the eye. The training hours per year for Optometry is 412 and for Ophthalmology is 1677. The conclusion is that an Ophthalmologist gets more hours of training each year in his program than an Optometrist receives in his entire four year curriculum.

The truth is that after reviewing the State Division of Occupational Licensing data, I have documented that not one Optometrist in Alaska has had any pharmacology training from any M.D. or Ph.D. in pharmacology. Not one Optometrist in Alaska has had any instruction in anything from a full time M.D. on the staff, and not one Optometrist in Alaska has had any full or part time instruction either in class or in a clinical setting by an Ophthalmologist who is a physician trained in the diagnosis and treatment of eye disease.

The bill before you is unreasonable in assuming that a hurry-up course in pharmacology can render an Optometrist capable of using drugs. Especially since the bill gives the Board of Optometry the right to determine the education and professional competence of its own practitioners. How can the members of a Board, who themselves have never had any training in the use of drugs and the diagnosis of disease, be given the power to pass on the qualifications of their own people in these medical areas.

IV. PREDISPOSITION OF ALASKA NATIVES TO NARROW ANGLE GLAUCOMA

There are approximately 35,000 native Alaskans residing in Alaska. It has been documented by the Alaska Native Health Service, as well as by independent United States and foreign researchers, that there is an extremely high incidence of narrow angle glaucoma in Alaska. Dr. Roy Box, at one of the committee hearing in 1978, said that he had dilated probably 10,000 Natives and never seen a case of near-angle glaucoma. I submit that no one in Alaska, have Milo Fritz, M.D. with his some 30 years experience could have had this type of exposure to our Native residents. I also submit that if Dr. Box did not have any case of narrow angle glaucoma with dilating 10,000 Natives, he has missed some cases of narrow angle glaucoma. Optometry says that the incidence is 1 in 18,400. The truth is in Alaska native adults the incidence is 1 in 1,900. At the Alaska Native Health Service hospital in Anchorage, there are not three operations per year or month, but three operations per week for narrow angle glaucoma. It is further documented by the Alaska Native Health Service that the incidence of this problem in Alaska natives is 18 times that of caucasians. Dilating drops cause narrow angle glaucoma attacks. Even Optometry agrees with this.

DIAGNOSTIC DROPS

This bill is commonly called a Diagnostic Drug Bill. Let me rank on to you that this is a gross misnomer. Diagnostic Drugs is a buzz word. Drugs do not diagnose. People diagnose. You have heard that this bill does not enlarge the scope of Optometric practice, but allows better and more efficient use of existing procedures, such as glaucoma testing and vision analysis in children. Dilating the eye is not a prerequisite to making a diagnosis of eye disease. The truth is that general practitioners and family practice physicians across the country as well as specialists in other fields routinely evaluate eyes for visual acuity and pathology without using any dilating drops whatever, and do a quite satisfactory job. Dilating drops are not a prerequisite for supplying children with the proper glasses correction. For years, Optometry has prided itself on non-drop methods of refraction, that is prescribing the correct glasses in children without any medications at all. One of the more common techniques is called "fogging". Anesthetic drops are not needed for the diagnosis or presumptive diagnosis of glaucoma. There are several non-contact air tonometers on the market today that are quite accurate. They are the Muckay-Mark tonometer and the American Optical air

tonometer which compare quite favorably with applanation tonometry for the measurement of intraocular pressure. In addition to the illogical arguments for the use of drops is the quite important factor of competently dealing with systemic or local reactions to these medications, no matter how uncommon they may be. Optometrists have absolutely no training or preparation in the management of these potentially serious and in some cases life-threatening untoward reactions that happen occasionally with the use of these medications. How many people have to be blinded, injured, or killed before someone realizes that the camel has his head in the tent?

VI. CONCLUSION

In conclusion, I think it is grossly unfair of Optometry, through the introduction of this type of legislation to force our representatives into a position of having to pass on the medical qualifications of a non-physician group and therefore assume the responsibility for their actions. There are other arenas to decide this question more appropriately.

I would like to say that my wish is for cooperation and not competition in the health professions. Optometrists do not need to use drops to practice good Optometry. You, as legislators, are charged with guarding the public welfare for there can be no compromise in the quality of medical care to which Alaskan's are entitled. The role of the Optometrist is a vital one and can be expanded through the use of new optics technology and ideally by working as members of the eye care team. This is working in large teaching institutions, and certainly is working in our group in Fairbanks. Optometrist and Ophthalmologists should complement and support each other. A disregard for excellence that would result from enactment of the proposals in this bill will adversely affect the superior level of eye care offered to patients in Alaska. The regulation of the practice of various professional and paraprofessional groups is not for the benefit of the licensee but for the benefit of the state and its people. Nowhere does case law state that public protection will be qualified, i.e. that the risk may be increased a little bit but not a lot. The language is explicit. The intent is protection. A little bit of this bill is like a little bit of pregnancy.

"NEW ENGLANDERS, THEIR EYES, AND THOSE WHO
PROFESS TO CARE FOR THEM"

(1)

SAMUEL E. WALLACE, Ph.D.
UNIVERSITY OF TENNESSEE *socialist*

Assisted by Robin Ostow
Brandeis University

NOVEMBER, 1974

(2)

Study sponsored by "New England Council of Optometrists," and funded by The National Institute of Health.

I. BACKGROUND

"Oculists evolved in the 19th century but did not do refractions of the eyes or prescriptions of glasses until late 19th to 20th century.* This group is now known as "Ophthalmologists."

(3)

"Opticians" evolved during the 19th century to "sell" glasses, primarily by trial and error from a retail supply. A splinter group began to refract and prescribe glasses in addition to selling them, and began to charge a dispensing fee. This group evolved to the present "Optometrists" and this group became recognized by licensing boards of most states by the 1920's.

II. EDUCATION OF AN OPTOMETRIST

This report deals with a single school, the "MCO" (Massachusetts College of Optometry), which evolved from a private school begun in 1896. The degree O.D. was first conferred in 1951. Today (1969-70) there are 209 students in four classes. Entrance requirements are a minimum of two years undergraduate college work with at least a "C" average. Then four years are required to earn the O.D. degree.

Wallace evaluated the quality of the students and noted the following (quotes are direct quotations from the text):

1. All students had two years of undergraduate training, with most earning a B.A. or B.S. degree.
2. The majority of students did their work at state universities or at junior or community colleges.
3. Only nine ⁴⁷ of the 209 students had an entrance grade average of B or better. Therefore, 200 students were "C" students.
4. Most of the students took pre-medical or pre-dental undergraduate courses but "had to give up their original aspirations because of their poor grades."

*Dr. Allen notes that this is erroneous information provided to the professors. There are records of ophthalmologists prescribing glasses during the 1700's.

X 5. "Frustrated M.D.s make lousy optometrists."

✓ (6) The professors "complained that the students refuse to do any assigned homework, and are immature in their study habits, that they have to be spoon-fed." The students "refuse to take any initiative in the learning process" and "will learn only what is specifically presented to them in class."

Wallace, too, reviewed the faculty and noted the following:

- ✓ 1. Thirty full-time and fourteen part-time faculty members hold degrees varying from O.D. to Ph.D. and M.D., most (19) holding an optometric degree alone as their highest academic degree.
- ✓ 2. Many faculty members are related to M.D.s and "doctors and medicine always serve as positive points of reference."
- ✓ 3. Several teachers proudly said that some of their courses are "almost as good as the courses given in medical schools."
- ✓ (4) "Faculty members both share and unconsciously reinforce the anti-intellectualism and the inferiority feelings" of the students.

Regarding the quality of the courses, Wallace noted:

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

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

✓ III. THE CLINICAL TRAINING OF AN OPTOMETRIST

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

The following points of interest were made by Dr. Wallace:

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

* Even if we ignore the supposed exposure and training the optometry students obtain in detecting pathology, Wallace notes that in the area of visual examinations the "clinic staff did prescribe spectacles more often than was absolutely necessary." (I think this is correct)

In all fairness, Wallace believes "the patient gets an extraordinary complete and thorough refraction." (Note that he was not referring to the complete examination.)

IV. THE PRACTICING OPTOMETRIST

Because of the lower educational requirements, optometrists begin practice generally at a lower age than most other professionals. The average optometrist has been in practice 18 years and therefore has the educational standards of 1951. Wallace notes that 80 percent of practicing optometrists do not have a bachelors degree, and 33 percent do not even have an O.D. degree. Within that 33 percent group, some have had no formal training.

*It is as age 40
Near practice
1.5yr
: on grad
1962*

Wallace has obtained the following data regarding the practice of optometry in New England and contrasts it with ophthalmology as shown:

1. There is one optometrist per 8,253 population vs. one ophthalmologist per 23,545 population. There are roughly three optometrists for every ophthalmologist.
2. Optometrists are adequately distributed between rural and metropolitan regions; whereas, ophthalmologists are primarily based in metropolitan areas.
3. A patient could see an optometrist within one week 62 percent of the time; and, in one-fourth of these optometrists, the patient could be seen the same day.

In contrast, a non-emergency eye patient could not be seen for at least two weeks and on the average must wait three months or more for an appointment with an ophthalmologist.

4. Over one-half of the optometrists work outside of their office practice; whereas, the great majority of ophthalmologists work full-time at their office and related hospital practice.
5. The majority of optometrists take 2 - 3 weeks off per year while the majority of ophthalmologists take off one month per year.

Wallace studied the factors relating to office efficiency of eye practitioners and noted the following:

1. Optometrists schedule 30 - 60 minutes for an examination with an average of 40 minutes. Ophthalmologists allow an average of 20 minutes for a complete eye examination.
2. One-fourth of the optometrists have no office help while another one-half have one office person.

Every ophthalmologist has at least one office person while 37 percent have two or more.

3. Seventy-one percent of optometrists could increase their patient load with no increase in space or office help needed. The average possible increase was ten patients per week, with 12 percent optometrists indicating they could see 16 or more additional patients per week.

In contrast, 87 percent of the ophthalmologists could not increase their patient load. Wallace summarizes that "Ophthalmologists work nearly twice as quickly as optometrists, are in their office 10 - 15 more hours per week, are fully booked 11 weeks further in advance and see almost twice as many patients every week."

Effect in AK

38 $\sqrt{450,000}$
38
100
34

*2k opt
1/11,000*

Ad 62 opt

5 AK

*not seen
AK*

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

* Wallace reported the opinion of a practicing optometrist, "although optometry is a clean job, it doesn't have much dirty work or tension, I would say that seventy percent of the work is mere technician work. Anyone could do it with some training."

Aug
V. OPTOMETRY LOOKS AT OPTOMETRY

The use of drugs (cycloplegics) by optometrists is an "explosive" question for optometrists. Wallace reported "a cycloplegic refraction is in 95-99 percent of the cases not valuable." He noted that under some state laws "optometrists are not forbidden the use of drugs, and thus some of them have decided to go ahead and use drugs when necessary."

Wallace speculated that "the use of drugs in optometric practice is something of a status issue among optometrists."

* Optometrists considered the quality of current optometric graduates and concluded that the students "were not given sufficient clinical experience."

VI. SUMMARIZING NOW AND THE FUTURE *-waited*

* Wallace concluded that based on time and effort spent by optometrists it appeared that "optometrists perform higher quality refractions than do ophthalmologists." However, in terms of pathology detection, he judged from one-fifth to one-half of optometrists to be incompetent.

* In terms of quality care alone, ophthalmologists "without exception delivered high quality care."

→ Wallace states that "for the person with healthy eyes, you're better off seeing an optometrist."

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

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

- ✓ "Quality is optometry's most pressing need, not quantity." Recognizing the quality of optometry students, Wallace reports that half of the current students "probably should be dismissed before they have a chance to go into practice."
- ✓ Wallace suggests that increased communication between ophthalmologists and optometrists would indicate to many optometrists "just how inadequate their examinations now are."
- ✓ Alluding to the optometric-ophthalmologic conflict, Wallace notes that "optometrists have numbers on their side while ophthalmologists have everything else." "Ophthalmologists should begin now to assert the changes which they too know should be made in optometry."
- ✓ In summary, Wallace states that with the present under-utilization of optometrists "at least 10,000 vacancies now exist every week in optometrists' appointment schedules," and that no new optometrists are needed in New England for at least three years.
- ✓ In contrast, there is a serious shortage of ophthalmologists and projected growth of ophthalmological manpower falls far below that required to just maintain the present level of "over-utilization."

How the General Practitioner Can Determine The Need for Ophthalmologic Referral

Henry S. Campell, MD, *Martinsville, Virginia*

WHEN should a patient be referred to an ophthalmologist? Are eye drops and sophisticated instruments needed to make the referral decision? These questions are crucial to the proper care of eye problems, whether the patient presents initially to a physician or to a non-medical practitioner.

This study delineates the ways in which the possibility of visual system disease can be recognized in non-ophthalmologic office practice.

Method

The author, an ophthalmologist practicing in a semi-rural area of Virginia, documented 1,000 consecutive office patient visits from October 9, 1978, through December 14, 1978. Each of these visits was classified into one of three groups: no disease, new disease, and old disease. No disease meant that the patient had no significant complaints, may or may not have required glasses for normal visual acuity and had no findings of a significant medical problem. New disease meant that the patient gave a history suggesting significant visual system disease and/or was found to have significant visual system disease; new disease patients had not been seen or treated previously for this problem by the examiner or by his partner ophthalmologist. Old disease patients had a significant visual system disease which had been seen and/or treated previously by the examiner and/or by his partner ophthalmologist. Patients with concomitant old and new disease problems were classified according to the new problem. Patients with more than one old disease problem were classified according to the more serious problem.

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Submitted 1-12-79.

All patient examinations included history, visual acuity, external examination, slit lamp biomicroscope examination and a view of the fundus oculi through undilated pupils. Tonometry was done in all adult patients without infection. A dilated fundus examination was done in all patients scheduled for a routine examination plus those patients where history and/or other examination indicated the need. Visual field examinations were done where indicated.

Results

In a mature ophthalmologic practice, one expects to see relatively few patients without disease. Indeed, the examiner in this study saw only 284 patients (28.4%) without disease and 716 (71.6%) with disease. In the diseased group, 491 (65.6%) were already under observation or treatment.

Table 1 lists the means by which disease was suspected. Notice the heavy preponderance of history, visual acuity, and external examination by hand-held flashlight as the initial clues to disease. These three are, of course, different facets of the same story and could well be combined, i.e., if a patient states that he does not see well, and if his visual acuity is indeed decreased, then the patient's history is confirmed. In 619 (85.2%) of the 716 patients with disease, this triad

Table 1. Examining Elements That Indicated Ophthalmologic Disease in 716 Patients.

History	255	(35.6%)
Visual Acuity	198	(27.7%)
External Examination by Hand-Held Flashlight	157	(21.9%)
Refraction	4	(.6%)
Tonometry	69	(9.6%)
Slit Lamp	23	(3.2%)
Undilated Fundus	9	(1.3%)
Dilated Fundus	1	(.1%)
	716	100%

indicated visual system disease. Refracting four high myopes or noticing thick spectacle lenses would have indicated the need for careful indirect ophthalmoscopy for peripheral retinal abnormalities.

The majority of patients with new disease presented with acute processes, such as infection, iridocyclitis, foreign bodies and the like; here history, visual acuity and external examination by hand-held flashlight again gave the clue. Those patients with old disease had chronic disorders such as cataracts and glaucoma; for these, tonometry and slit lamp examination added meaningful information. The 69 patients found to have glaucoma could have been suspected of the disease by using Schoitz tonometry or non-contact "air puff" tonometry. The nine patients found to have optic atrophy, glaucomatous cupping, diabetic retinopathy, and macular degeneration were suspected by viewing the fundus oculi through the undilated pupil.

Slit lamp biomicroscopic examination gave the clue in 23 of the 716 patients with disease, mainly for diseases of the cornea, silent iridocyclitis, and potential narrow-angle glaucoma. Two new and seven old patients with potential narrow-angle glaucoma were seen. Dilating the pupils of these nine patients could have precipitated disastrous attacks of acute narrow-angle glaucoma, and mydriatic eye drops were distinctly contraindicated.

An asymptomatic superior retinal hole was found in one patient because the history of retinal detachment in the other eye made an extraordinarily diligent search of the retina mandatory. Without this history and with only a routine examination of the retina, the hole would have been missed by the examiner.

Only one patient had a significant abnormality which was not suspected prior to dilating the pupil. Although her benign choroidal nevus was known to her from an examination about one year prior, she did not reveal this to the examiner initially.

Table 2 sums up how disease was suspected in the 716 patients found to have visual system problems.

Conclusions

How, then, can the non-ophthalmologic practitioner know when a patient should be referred to an ophthalmologist? Most often, the study shows, through the basic medical triad of history, visual acuity, and looking at the external eye with a flashlight. Family physicians can take heart at this. And they may be cheered as well to know that the success of this triad obviates the need for sophisticated instruments. In only 23 of the 716 patients suspected of having dis-

Table 2. How the Non-Ophthalmologic Practitioner Could Have Determined the Need for Ophthalmologic Referral in 716 Patients.

History, visual acuity, external examination (the basic medical triad)	610/716	(85.2%)
History, visual acuity, external examination, undilated fundus	619/716	(86.5%)
History, visual acuity, external examination, undilated fundus, tonometry	688/716	(96.1%)
History, visual acuity, external examination, undilated fundus, tonometry, noticing thick spectacle lenses	694/716	(96.6%)
History, visual acuity, external examination, undilated fundus, tonometry, noticing thick spectacle lenses, slit lamp	715/716	(99.9%)

NOTE: In nine of the above 716 patients, dilation of the pupil with eye drops could have induced an attack of acute narrow-angle glaucoma.

case was an instrument required that is not in the office of most physicians, namely, a slit lamp.

As for eye drops, the recommendation is BEWARE. Eye drops can, in certain cases, change a chronic visual problem into a dangerous emergency. Nine patients seen in this study, as noted, had the potential for acute narrow-angle glaucoma, and dilating the pupils of any of these nine patients could have produced an extreme emergency in the office of the general practitioner or non-medical optometrist. Moreover, eye drops may precipitate alarming side effects; in the course of this study two patients with corneal foreign bodies became faint, with decrease in blood pressure and nausea, after application of topical anesthetic drops (although neither patient had a seizure or total loss of consciousness).

In sum, to both the conscientious physician and the conscientious optometrist the need for referral of a patient to an ophthalmologist is usually obvious through the application of history, visual acuity, and external examination by hand-held flashlight, and does not require sophisticated instruments.

Most importantly, do not dilate the pupil. Routine tonometry according to established standards and viewing the fundus oculi through the undilated pupil are the additional needed methods. The use of mydriatic drugs to dilate the pupil risks precipitating acute narrow-angle glaucoma by a 9:1 ratio over uncovering any hidden disease process.

Acknowledgment

The author thanks Donald W. Richman, MD, and Douglas M. Rampona, MD, for their assistance and advice.

of the
EXPERIENCES IN THE USE OF
OPHTHALMIC PHARMACEUTICAL AGENTS

A survey was conducted in March, 1979 among the Ophthalmologists in the state of Alaska concerning their experiences utilizing dilating drops.

The format of that survey was patterned after a similar survey undertaken by the Texas Ophthalmological Association in 1976. In addition to the three questions posed by the Texas Ophthalmological Association, four more were composed for the survey undertaken in Alaska. A form was devised and mailed with an enclosed addressed envelope to all twenty three Alaskan Ophthalmologists as provided from the listings on record with the Alaska State Medical Association.

As of May 8, 1979 16 (71.8%) of the 23 survey forms had been returned and those responses compiled & calculated. Below is a summary of these seven questions and the results received.

Question 1. Do you see cases in your office that must be dilated cautiously & require close medical observation?

16 (100%) of all received survey forms had responded yes to this question.

In regards to this, several respondents reported that they were more concerned with cautious dilation in the native, elderly and infant individuals and group of peoples. One Ophthalmologist reported these individuals he sees are examined carefully with the slit lamp employing the gonioscope lens prior to use of dilating agents.

Question 2. Have you had cases of acute angle closure glaucoma from dilating drops that required medical &/or surgical care?

13 (81.3%) of the 16 respondents answered yes they had cases of acute angle closure glaucoma from dilating drops that required medical &/or surgical

care. 3 respondents of the 13 that replied affirmatively reported that they had seen "several" and "a number" of such cases. Yet, no specific number was supplied. 1 respondent commented that he had not seen this occurrence since his training. A total number of cases reported among these 13 respondents was three. Two of these cases required emergency surgery to remedy the situation.

2 of the 3 (18.8%) respondents whom replied no they had not seen cases of acute angle closure from dilating drops stated they employed the method of gonioscopy frequently if "suspicious of the safety of dilation". And if dilation be needed after this it would be performed with weak agents that could be counteracted readily.

Question 3. If you are aware that a patient has extremely narrow angles anatomically, and must be dilated for further studies and evaluation of the retina...

- a) Do you dilate them in your office?
- b) Admit them to a hospital for dilation and observation?
- c) Request for a consult &/or refer them to another Ophthalmologist?

15 (93.8%) responded a) they dilate their patients within their office. Of these affirmative responses various comments were reported such as: "dilate with a weak agent that is reversible", "cautiously", "with phenylephrine", "dilate the patient in my office but do not let them leave my office until the pupil has returned to normal", "usually", "also prepare my patient for admission to a hospital if necessary". One respondent answering question 3 stated that he dilates his patients in his office and then stated "there is no way to predict what the patient will choose".

3 of the 15 replying affirmatively, revealed that they have offices in a hospital complex (2) or adjacent to a hospital complex (1).

1 respondent whom did not indicate whether or not he dilates patients in his office did state "if I have a patient with extremely narrow angles that appear occludable I admit the patient to the hospital and do peripheral iridectomies. Then I dilate and examine the peripheral fundus".

Question 4. Estimate or if able, specify the number of patients you see in a year with narrow angles potential &/or precipitated.

(93.8%) reported a specific number of cases. 1 respondent failed to give a specific number when reporting; "a couple a year". Therefore this response

was disregarded in the statistical analysis. These 15 Ophthalmologists supplied a total number of 1,130 cases they would see in a year of potential and/or precipitated narrow angles. The average figure 75.3, is the number of patients PER Ophthalmologist responding, that would be seen a year with potential and/or precipitated narrow angles.

Question 5. From your use of topically applied pharmaceutical agents have you seen other side effects? (excluding narrow angle closure glaucoma)

(100%) of the respondents replied yes to this question.

Question 6. In conjunction with question #5, can you supply what pharmaceutical agents (mydriatics, cycloplegics, miotics and anesthetics either generic or brand name) have induced these side effects in some of your patients?
Please estimate by number or if able specify how many reactions have been induced by the said pharmaceutical agents in your practice for the year 1978.

Compilation of the data revealed 13 (81.3%) respondents citing reactions in the parasympathomimetic family. Of the cycloplegics used atropine and cyclogyl appeared to be the worst offenders for inducing reactions. 8 (50%) of the Ophthalmologists reported from their use of atropine such reactions as: "hypersensitivity", "poisoning", "confusion", "cardiac arrest", "rash & fever", "convulsions", and "hypertension". 9 (56.3%) of the Ophthalmologists cited reactions from the use of cyclogyl as: "sedation", "aloofness", "convulsions", "hallucinations", "seizures", "syncope" and "central nervous system reactions".

9 (56.3%) of the respondents reported reactions with the use of the agents in the sympathomimetic family. Neo-Synephrine (phenylephrine HCL) produced problems for 7 (43.8%) Ophthalmologists' patients. These were indicated as: "hypersensitivity reactions", "conjunctivitis", "toxic keratitis", "cysts", and "heart dis-rythmia". Euphoria had been induced in the adult patients of one Ophthalmologist from the use of 4% cocaine.

5 (31.3%) of the Ophthalmologists cited reactions induced from the miotics. These were reported as: "conjunctivitis", "retinal detachments" and "hypersensitivity reactions".

From the use of anesthetics 11 (68.8%) cited allergic reactions from the use of cphthaine (proparacaine).

3 (18.8%) of the responding Ophthalmologists stipulated they had seen many side effects from the use of pharmaceutical agents but did not report on these reactions nor state from what agents these side effects were induced from.

Question 7. In your practice up to date, being as accurate as possible how many patients are legally blind?

325 legally blind cases were supplied from 11 (68.8%) of the respondents. One Ophthalmologist reported "several cases" in his practice. This response was not calculated in the statistical figures. Three respondents (18.8%) stated such information was not available. One Ophthalmologist declared that 10% of his practice involved legally blind individuals.

SUMMARY and CRITIQUE

This survey had been initiated due to the current legislative situation in Alaska. The introduction of the so-called "drug bill", (use of pharmaceutical agents: anesthetics, cycloplegics, miotics, and mydriatics by the Optometric profession) has been in deliberation within the state house HESS committee. The subject in deliberation became of interest so much so that conducting this survey was of utmost importance to determine any established relevancy, primarily through the use and experience of dilating drops. These deliberations provided the impetus to undertake this survey.

It is a known fact among the Ophthalmologists and few others that the Native Alaskan is predisposed to narrow angle closure glaucoma. With this in mind and the awareness that dilating drops have the potential to induce and precipitate such an attack of glaucoma; questions two & four were directed at seeking a

determinacy of this precarious situation. It would be fair to say predicated from the responses to these two questions that narrow angle closure glaucoma is quite a significant matter in Alaska and cannot be denied.

Examination of all responses lends additional support that medical supervision or personnel medically trained perform dilation in order to deal with the aforementioned and unmentioned side effects that may arise. Most all respondents in this survey had indicated that they could report and list more side effects from the use of ophthalmic pharmaceutical agents. However, they declined from the arduous task of listing the vast array of side effects.

The results of this survey were forwarded to these twenty three Alaskan respondents.

Preliminary Agreement between the Alaskan Association of Optometry represented by Roy Box, O.D. and James N. Matson, O.D. with the Alaska Association of Ophthalmology represented by Peter Canavan, M.D., Samuel A. McConkey, M.D., Robert Page, M.D., Ron Tokar, M.D.

Others attending the meeting were: Rick Urion, lobbyist for the State Optometric Association; Jeff Landry, lobbyist for the Alaska State Medical Association.

RE: House Bill 79 and Senate Bill 75 - concerning the use of medications in the eye by Optometry

It is agreed by both parties that if a solution in this endeavor is to be reached that a compromise position has to be made. That compromise is as follows:

1. Optometry would be allowed to use proparacaine 0.5% as a topical anesthetic for diagnostic purposes, 1% tropicamide or phenylephrine hydrochloride 2.5% - 5% for dilatation of the pupil for diagnostic purposes.
2. Any changes in this list of medications will be by the combined concurrence of the State Board of Optometry and the State Board of Medical Examiners.
3. A training course will be completed by each optometrist desiring to use drugs prior to any ~~Y-123~~ examination. The course shall consist of the following minimum subject matter:
 - A. Clinical pharmacology and drug organ interactions.
 - B. Cardiopulmonary resuscitation and emergency training.
 - C. Techniques of clinical examination.
 - D. Thorough review of clinical signs of fundus, anterior segment, and external disease as well as referral guidelines.
4. Optometrists will take a written exam on the above given by a special test committee comprised of two Optometrists and two Ophthalmologists chosen by each respective professional organization to prove competence in the above subjects. The point of a clinical proficiency demonstration is unsettled by both parties at this time. Any course taken by an Optometrist desiring to use medications in the eye for diagnostic purposes will have to be approved by a committee of two Optometrists and two Ophthalmologists chosen by each respective professional organization.
5. In the current State Statutes regarding Optometry, the word "diagnosis" wherever it appears will be changed to "detection".
6. Mandatory referral guidelines will be followed by all Optometrists. Referral guidelines will be clearly delineated in the Bill and adhered to by all Optometrists whether or not they wish to use drugs in the exam. Those referral guidelines are as follows:

When an Optometrist examines any person, he shall inform that person, parent, guardian, or other responsible party, prior to prescribing

or providing eyeglasses or other services that examination by a licensed physician specializing in diseases of the eye (or if no such licensed physician is available then by a duly licensed physician) is indicated whenever one or more of the following conditions is present. These conditions fall generally into four categories where there is:

1. An abnormality of vision.
2. An abnormality of tissue.
3. An abnormality of motor function.
4. Other.

1. Abnormality of Vision:

- A. Failure on the part of an individual to obtain 20/30 vision in each eye, 20/30 in children under 8 years of age by refractive correction by lenses, unless the cause has been medically determined by a physician and is stable or unless there is improvement within two weeks with visual therapy.
- B. A complaint by the individual of a sudden appearance of spots or flashing lights, scintillating images, transient dimming or loss of vision, or distortion in the shape of objects.
- C. A complaint by the individual of temporary or permanent loss of any part of the visual field.
- D. A history of rainbow halos around lights in the absence of contact lens causes.
- E. Diplopia (double vision) of sudden onset.

2. Tissue Abnormalities:

- A. Presence of redness, swelling, mass or ulceration of the eye or its surrounding tissues in the absence of contact lens causes.
- B. Opacities of the cornea, lens or vitreous.
- C. Changes in the appearance of the optic discs.
 1. Cupping greater than 0.5 cup-disc ratio (C-D).
 2. Difference greater than 0.2 C-D ratio between the two eyes, that is .2 C-D one eye and .5 C-D the other eye.
 3. Difference in appearance between the optic discs of each eye.
 4. Change in appearance of the optic discs from a previous exam.
 5. Suspicion of elevation of the optic nerve head.
- D. Observation of a deviation from the normal appearance of the retina or its vessels.

3. Abnormalities of Motor Function:

- A. Strabismus. A deviation of the eyes from their normal parallel position in straight ahead gaze or gaze in any direction. *This needs to be further defined and refined for Optometry to accept.
- B. A difference in the size of the pupils or failure to constrict with illumination or with near vision.
- C. Ptosis or lag ophthalmus (drooping of the eyelids) with onset within one week of examination.
- D. Nystagmus (rapidly oscillating eye movements).

4. Other:

- A. Continuous tearing of longer than 24 hours duration or complaints of watering eyes not associated with visual tasks.
- B. Intraocular tension of 22 or more on any occasion or a family history of glaucoma.
- C. Any other observation or deviation from the usual appearance of the eye and related tissues or any complaint which is not attributable to the refractive state or muscle balance, or which is not amenable to lenses, prisms, or visual training.

Exception to any of the preceding conditions would be previous evaluation by a physician and discharge from medical treatment and followup for that condition.

Failure to comply with the provisions of the Act shall subject the offender to revocation or suspension of his licenses to practice Optometry and this Act shall take effect immediately.

It is completely understood at the outset that there is to be no Grandfather Clause attached to any of the above.

In recent years, the public as well as legislators have been hesitant to take the word of the medical profession as gospel. While this skeptical attitude is often a healthy one, it must be remembered that **PHYSICIANS ARE STILL THE LEGAL EXPERTS ON MEDICAL ISSUES.** On the issue of optometry drug laws, the medical profession has the great preponderance of evidence in its favor and legislators would be wise to follow its advice.

Kay S. Kelly

Loyola Law Review

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THE PEN...—

Oregon Optometric College Professor Says Student Apathy Prompted Resignation

Dr. J. Gordon Betts, a practicing ophthalmologist in Portland, Oregon, and a recent former part-time faculty member at Pacific University College of Optometry, resigned his faculty post as Assistant Professor of Pathology because of a "lack of student interest."

This is the same College of Optometry that produced John Shank, O.D., who initially examined and failed to promptly refer Timothy Steele, the eight-year-old military dependent whose eye was removed because appropriate treatment was not instituted in time.

In this highly publicized case, United States District Judge James M. Fitzgerald called the optometrist's failure to inform or refer a "violation of the governing principles of professional standards," and concluded that Timothy Steele was entitled to recover from the United States for the loss of his right eye.

The College of Optometry is presided over by Willard Bleything, O.D., who was an "expert" witness for the defense. He showed an identical ignorance of signs of disease in the eye as defendant optometrist Shank. All the medical doctors who testified in the trial, including a defense witness, faulted his medical knowledge.

Dean Bleything testified, "A significant part of optometric training is given over to recognition of disease of the eye." During the time of Shank's schooling, Dr. Betts was the only qualified instructor who was teaching disease recognition.

Dr. Betts' reason for resigning from Pacific University College of Optometry was brought out in testimony he gave to the Committee on State and Federal Affairs of the Oregon House of Representatives on March 24, 1975. On that occasion he was testifying in what turned out to be a futile effort to defeat an optometric drug law in that state.

In the light of the Timothy Steele case and Dr. Bleything's testimony, Dr. Betts' testimony takes on new significance. He told the Oregon House Committee that, "My salary was satisfactory and the equipment was up to date. The only problem was student interest and participation. Eighty to ninety percent of the time the student was not in attendance with his patient and consequently never benefited from the experience or followup."

"This leads me to believe," Dr. Betts reported, "that the desire and/or ability of the recent graduates from this College to detect eye diseases is very superficial. It would seem they are not interested in this aspect of ocular problems and have little or no background in ocular diseases and how they relate to general body health. Their best training is in what they are presently licensed to do (measure for and fit eyeglasses)."

He continued, "The post-graduate education

of the use of dangerous drugs does not open the doors to accurate ocular diagnosis. One must be aware of the abnormal before one can recognize its presence."

Many optometrists do not believe their profession should attempt to perform medical functions.

Loren L. Pace, O.D., of Findlay, Ohio, in a letter to the editor of the Journal of the American Optometric Association, Vol. 49 - No. 5 - 1978, wrote, "For the past several years the major theme and emphasis of official optometry in every available medium of communication has been 'primary health care provider.' In particular the younger O.D.s are evincing a marked interest in moving the profession toward a rudimentary form of quasi-medical practice, leading to a potentially harmful and dangerous schism."

Despite the warning of ophthalmologist J. Gordon Betts, the expressed reservations of optometrist Loren L. Pace, and the loss of a youngster's eye whose root cause can be traced to the optometric concept of "primary care" (seeing an eye patient before an M.D. does), organized optometry continues its efforts to "sell" the "primary care" concept and lobby for drug laws across the nation. Although their efforts were thwarted in 15 of 17 states last year, bills have already been introduced in 10 states this year. ●

West Virginia Optometric Drug Law Causes Governor Concern

Governor John D. Rockefeller IV of West Virginia, in a letter to Richard C. Bashid, M.D., chairman of the West Virginia Committee to seek repeal of that state's optometric drug law, has expressed concern about the law and assured the Charleston ophthalmologist that he will "keep an open mind" regarding the issue.

A bill has been filed that would repeal the odious 1976 drug law now permitting optometrists, without medical training, to use dangerous drugs for therapeutic purposes. The bill is sponsored by Troy Wayne Hendrix of Madison and Charlotte Lane of Charleston, West Virginia.

In his letter to Dr. Bashid, Governor Rockefeller states, "Thanks for your letter and information about proposed changes to the Optometric Drug Bill of 1976."

"I will be following this legislation closely, and am keeping an open mind to arrive at the facts. I am concerned about the scope of drugs which optometrists can dispense and the amount of training which they are given in the field of pharmacology." ●

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 mani-

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. 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

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. ●

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.



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 responsi-



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.

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

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.

*Memory
copies made*

Dr. Jeffrey A. Gonnason

Doctor of Optometry
Medical - Dental Bldg.
140 East 5th
Anchorage, Alaska 99501

Telephone (907) 276-2080

February 20, 1981

Senator Charles H. Parr
Senate HESS Committee
Pouch V
Juneau, Alaska 99811

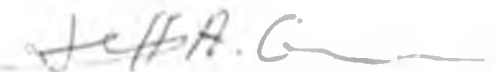
Dear Sen. Parr:

Please convey to your committee my strong support for Senate Bill #136, allowing optometrists to use those drugs and drug related procedures for which they are trained.

It is more than a little disconcerting to be recently trained in Oregon to use drugs, but not be able to use them in Alaska. It is hard to see how the patient does not come out the loser from this restriction in the range and quality of services I am qualified to perform. Furthermore, Alaska will not be able to attract a high calibre of practitioner in the future if this policy continues for long.

Please allow the Board of Examiners in Optometry to function like other health care boards in determining the appropriate activities of the professionals it oversees.

Respectfully yours,



Jeffrey A. Gonnason, O.D.

JAG:rms



Member
American Optometric Association



February 19, 1981

Senator Tim Kelly and
Senate HESS Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

gentlemen:

I know that you've been bombarded by both sides concerning drug use by doctors of optometry. I have talked to many of my Eagle River-Chug'ak patients in regard to this legislation. They cannot understand that if these ophthalmic drugs are a potential help to them, why the law wasn't passed many years ago.

Since I am the only vision care doctor in this area, I am the primary entry point into the health care system for many people. I don't want to practice general medicine --- I do want to help my patients within the scope of my education, with minor eye infections, and I do want to recognize an eye health problem or a general health problem that is visible with the help of ophthalmic drugs, so I can refer the patient to the proper health care practitioner.

Ophthalmic drug use by doctors of optometry has an overwhelming benefit-to-risk ratio, as evidenced that all three military services, the Veterans Administration hospital system, and thirty two states allow their use. I have administered ophthalmic drugs extensively while serving in the Navy, using them for minor eye infections and contact lens overwear reactions, and for detecting eye tumors, diabetes, hypertension, retinal tears, vascular disruptions, brain tumors and other health problems. Also I might add that in my travels to Bush communities in Alaska, I have been asked to evaluate various eye infections and disorders and help in planning the best therapy. Since our training in this area is about one hundred times more in depth than any community health aide, this only makes sense.

I have taken several pharmacology and physiology courses that deal with ophthalmic drugs and I am licensed to use them in Oregon. Optometrists aren't going to lose if this legislation doesn't pass; it will be my patients and your constituents who will be the losers.

Sincerely,

Jeffrey G. Keene, O.D.

JGK/ml

cc: Other members of HESS Committee
Sen. Brad Bradley

Ophthalmologists

Anchorage: Donald Dippe
Marvin Grendahl
Thomas Harrison
Jan Nyboer
James Patterson
Kenneth Richardson
Robert Rigg
Joseph Shelton
Jon Shiesl
Mahlon Shoff
Boyd Skille

Anchor Point: Milo Fritz

Fairbanks: John Esters
William Kinn
Sam McConkey
Bruce Wolf

Ketchikan: Ron Tokar

Soldotna: Peter Cannava

Optometrists

Anchorage: Aharon Sternberg,
Phillip Bach
Robert Miller
Maynard Falconer
James Falconer
Dennis Albert
George Hall
Boyd Walker
Thomas Roselius
Thomas Harbour
Jeffery Allen Gonnason
William Faulkner

Fairbanks: Nancy Lefevre
Curtis Johnson
Robert Hammond

Ketchikan: E.E. Smith
E.L. Craig
Ricky Dean Swearingen

Kenai: Robert O'Connell
Dennis Swarner

Kodiak: John Shank

North Pole: John Charles Cobbett

Palmer: James Taylor

Sitka: Timothy McLaughlin

DISTRIBUTION OF OPTOMETRISTS AND OPHTHALMOLOGISTS IN ALASKA

source: Alaska Division of Occupational Licensing and
the Alaska State Medical Association

<u>Location</u>	<u>Optometrists</u>	<u>Ophthalmologists</u>
Anchorage ✓	12	11
Fairbanks ✓	3	4
Juneau	2	1
Kenai-Soldotna ✓	2	1
Ketchikan ✓	3	1
Kodiak ✓	1	0
North Pole	1	0
Palmer	1	0
Sitka ✓	1	0
Anchor Point (Hammer)	<u>0</u>	<u>1</u>
TOTAL	26	19

note: Licensure is not required for those practicing with the armed services or with the United States Public Health Service (AS 8.64.370), so those persons are not reflected on this list.

Final



Official Business

Alaska State Legislature

Senate

Committee on

Health, Education & Social Services

Charlie Parr, Chairman
Terry Stimson, Vice-Chairman
Vic Fischer
Tim Kelly
Mike Colletta

Pouch V
State Capitol
Juneau, Alaska 99811

465-4907
465-4908

Committee Substitute for Senate Bill 136 - Optometry (HESS)

* Section ? AS 08.72. is amended by adding a new section to read:

The Department of Health and Social Services shall establish specific diagnostic drugs and the strengths thereof within the limits of AS 08.72.300(7) by regulation.

(see pages)

* Section ? AS 08.72 is amended by adding a new section to read:

Sec. 08.72.272. Use of "Dr." or "Doctor". When an optometrist uses the title "Dr." or "Doctor" as a prefix to his name, without using the word "optometrist" as a suffix to his name or in connection with it, it constitutes a cause to revoke or suspend his certificate of registration.

(The intent of this section is for writing or advertising, not orally.)
(If appropriate, please include language to specify the intent.)

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

Sec. 08.72.280. REFERRAL TO OTHER MEDICAL SPECIALISTS. If, during the course of examining a person, an optometrist determines the possibility of the existence of a pathological condition, the optometrist shall so advise the person and shall refer the person to an appropriate ~~medical-specialist~~ health care practitioner for further evaluation.

* Section AS 08.72.300(2) is amended to read:

(2) "optometry" is the examination, other than by the use of drugs, except diagnostic drugs as defined in this section, of the human eyes and the visual system for the purpose of ascertaining a departure from the normal, ascertaining the status of the human visual system, including refractive and functional abilities, or ascertaining the presence of ocular disease and any other departure from the normal which requires referral to other health care practitioners; or the diagnosis of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription of application of lenses, prisms or ocular exercises for the correction or relief of the human eye;

* Section AS 08.72.300(3) is amended to read:

(3) "practicing optometry" is an examination, other than by the use of drugs, except diagnostic drugs as defined in this section, of the human eyes and visual system for the purpose of ascertaining a departure from the normal, ascertaining the status of the human visual system, including refractive and functional abilities, or ascertaining the presence of ocular disease and any other departure from the normal which requires referral to other health care practitioners; or the diagnosis 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;

* Section As 08.72.300 is amended by adding a new subsection to read:

(7) "diagnostic drug" means a cycloplegic, mydriatic, or topical anesthetic which is listed in the official United States Pharmacopoeia, or official National Formulary, or a supplement to either of them.

* Section 08.72. is amended by adding a new section to read:

Sec. 08.72.305. Use of drugs for diagnosis. No optometrist shall be registered or certified to practice optometry in the state of Alaska in any area that is beyond the scope of his educational training as determined by the board of optometry. Any optometrist presently registered in the state of Alaska and who desires to employ the use of diagnostic drugs must submit to the board of optometry evidence of satisfactory completion of all necessary educational requirements as made mandatory by the board. The board of optometry shall provide for continuing educational requirements by all optometrists desiring to employ diagnostic drugs.

Please include the following intent in the above section:

The board of optometry must approve those optometrists who qualify to use diagnostic drugs and shall issue an endorsement in addition to regular certification.

(3)

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* Sec. AS 17.15.010 is amended by adding a new subsection to read:

(b) ^{necessary?} (Notwithstanding ~~(a)~~ of this section,) an ophthalmic drug identified by regulation of the ^{Department of Health and Social Services} ~~Board of Examiners in Optometry~~ may be sold, given away, bartered, exchanged, or distributed upon the written order or prescription of an optometrist who is authorized to use the drug as provided in AS ~~08.72.297~~ ^{08.72.305 (see page 3)}

* Sec. AS 17.15.030 is amended by adding a new subsection to read:

(b) AS 17.15.010 and 17.15.020 do not apply to the sale at wholesale by drug jobbers, drug wholesalers and drug manufacturers, or at

retail in a pharmacy by a pharmacist, of an ophthalmic drug identified by regulation of the ^{Department of Health and Social Services} ~~Board of Examiners in Optometry~~ to an optometrist who is authorized to use the drug as provided in AS ~~08.72.297~~. AS 17.15.010 and 17.15.020 do not apply to the sale of an ophthalmic drug ^{Department of Health and Social Services} ~~Board of Examiners in Optometry~~ identified by regulation of the ~~Board of Examiners in Optometry~~ by one optometrist authorized to use the ophthalmic drug to another optometrist authorized to use the drug.

(i)



ALASKA STATE MEDICAL ASSOCIATION

4107 Laurel Street, Suite 1 • Anchorage, Alaska 99504 • (907) 277-6891



SB 136 fl

March 7, 1981

The Honorable Charles Parr
Chairman
Senate HESS Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

I am writing to follow up on my previous testimony to your committee, both in person and by teleconference, regarding SB 136. I would also like to make reference to the preliminary compromise between the optometrists and the medical doctors that was worked out last year, and to address the suggested language to amend SB 136 authored by the DHSS.

Diagnostic pharmaceutical agents that could, with proper safeguards, be considered reasonably safe for use by optometrists include a pure mydriatic, such as phenylephrine hydrochloride 2.5% or 5%; combination cycloplegics and mydriatics, to include tropicamide 1% and cyclopentolate hydrochloride 1%; and a topical anesthetic such as proparacaine 0.5%. This list of drugs would satisfy the economic wishes of those optometrists who wish to expand their practices without unduly endangering the Alaskan public.

The Alaska State Medical Association is strongly opposed to optometrists using therapeutic agents. Medications are expensive when prescribed needlessly, dangerous when prescribed inappropriately, and well outside the scope of training for most optometrists currently practicing in the state. The DHSS amendments included this limitation.

We believe it is very important that the public be given the opportunity to make an informed decision regarding their vision care when an abnormality is detected. We believe it is essential that the patient understand that they are seeing a non-physician in cases where a pathologic condition is suspected. The DHSS amendments assured this.

Since it is the optometrists who are seeking expansion of their definition of their profession, not a limitation on existing practice by the medical profession, we believe it very important that the Legislature protect the public interest. The consistent testimony by members of the public at the recent teleconference was solidly in support of the Legislature moving very slowly, if at all, regarding expansion of the definition of optometry.

We are prepared to provide further information and recommendations regarding this legislation, should you wish to have further information from us.

Thank you for the opportunity to offer testimony on this most important matter.

Yours truly,


David E. Johnson, M.D.
President

cc Rep. Don Clocksin, House HESS

TELECONFERENCE HEARINGS



DATE: 3-9-81
 LOCATION: Ketchikan Life Office
 SUBJECT: SB 136, S. H.E.S.S.
 Practice of Optometry

NAME	REPRESENTING	ADDRESS	PHONE	HERE TO OBSERVE	HERE TO TESTIFY
Rick SWEARINGEN, OD	KETCHIKAN VISION CLINIC	P.O. Box 7131	225-2050	X	
DAVID E JOHNSON MD	ALASKA STATE MEDICAL ASSOC.	3612 TOMKASS AVE. KETCHIKAN	225-5149		X
Ron Torker MD	ophth-ology	108 8636 Ketchikan	221 3320	X	
Oliver W. Hauger	self	3470 BANAHOFF KETCHIKAN	225-3293		X
John J. Chesarek R.Ph.	Self	Box 5745 Ketchikan	225-5542	X	

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
 Bill/Resolution No. CS for Senate Bill No. 136 (HESS)
 Title "An Act relating to the practice of optometry and authorizing the use of ophthalmic
 Requested by Commissioner's Office Date 4/7/81

drugs by optometrists."

II. FISCAL DETAIL
 Agency Affected Department of Health and Social Services
 Program Category Affected Public Health/Division of Public Health
 BRU, Program, or Subprogram(s) Affected Family Health Administration
 (Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	1.5	0	0	0	0
300 CONTRACTUAL	0	19.2	0	0	0	0
400 COMMODITIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
TOTAL		20.7				

FUNDING (Thousands of Dollars)

GENERAL FUND	0	20.7	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Fund Source)	0	0	0	0	0	0

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

line 300 - The Department of Law advised us to use a sum of \$80/hr. for a contract attorney.

$$\$80/\text{hr.} \times 40 \text{ hr./wk.} \times 6 \text{ wk.} = \$19,200.$$

The funding is to provide for contracting with a private attorney to draft the proposed regulation. As part of the process, the contract attorney will work in conjunction with designated representatives from the fields of optometry and ophthalmology. We will fund the travel and per diem at state rates for the individuals to come to Juneau. After the proposed regulations are drafted, they will be handled as per the "Drafting Manual for Administrative Regulations" with public hearings to be held at key locations around the state.

IV. DATE 4/7/81 PREPARED BY David Bruce
 AGENCY Department of Health and Social Services
 PHONE 465-3090
 Original: Legislative Finance
 cc: Budget and Management
 Prime Sponsor (First Legislator Name) M&B Approval [Signature] Date 4/8/81

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CS for Senate Bill No. 136 (HESS)
 Title "An Act relating to the practice of optometry and authorizing the use of ophthalmic
 Requested by Commissioner's Office Date 4/7/81

drugs by optometrists."

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 Program Category Affected Public Health/Division of Public Health
 BRU, Program, or Subprogram(s) Affected Family Health Administration
 (Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section)

EXPENDITURES (Thousands of)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	1.5	0	0	0	0
300 CONTRACTUAL	0	19.2	0	0	0	0
400 COMMODITIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
TOTAL		20.7				

FUNDING (Thousands of Dollars)

GENERAL FUND	0	20.7	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Fund Source)	0	0	0	0	0	0

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

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IV. DATE 4/7/81

PREPARED BY David Bruce

AGENCY Department of Health and Social Services

PHONE 465-3090

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

USE OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS
BY STATE, TYPE, AND CLASSIFICATION

State	Optometric Drugs		Classifications of Drugs Used					
	Diagnostic Only	Diagnostic & Therapeutic	Cycloplegics	Mydiatics	Topical Anesthetics	Dyes such as Fluorescein	Miotics	None Specifically Listed In Statute or Regulations
Arizona	X		X	X	X			
Arkansas	X		X	X	X	X		
California	X		X	X	X			
Delaware	X		X	X	X		X	
Florida	X	X						X
Georgia	X							X
Idaho	X							X
Indiana	X							X
Iowa	X		X	X	X			
Kansas	X		X	X	X			
Kentucky	X		X	X	X		X ^E	
Louisiana	X							X
Maine	X			X	X			
Minnesota	X							X
Montana	X		X	X	X	X	X ^E	
Nebraska	X		X	X	X			
Nevada	X		X	X	X		X	
New Jersey	X							X
New Mexico	X							X
North Carolina	X	X						X
North Dakota	X							X
Oregon	X		X	X	X	X	X ^E	
Pennsylvania	X		X	X	X		X	
Rhode Island	X			X	X		X	
South Dakota	X							X
Tennessee	X		X	X	X		X	
Utah	X		X	X	X			
West Virginia	X ^X	X ^X						X
Wisconsin	X		X	X	X	X	X ^E	
Wyoming	X		X	X	X	X	X ^E	
TOTAL	30	3	16	18	18	5	10	12

Key

E = In Emergency Use Only

x = Excludes Oral or Injectable Drugs

Source: American Optometric Association (1980)

August 6, 1981

The Honorable Richard Eliason
Alaska State Senate
P. O. Box 143
Sitka, Alaska 99835

Dear Senator Eliason:

Recently you requested that the Department review two versions of Senate Bill 136, regarding the use of certain ophthalmic drugs by optometrists. We have conducted that review and our summary notes are attached for your reference. We also included in our review a third version, the draft of SB 136 which we provided to you and was the basis of the Senate Finance Committee Substitute prepared by Legislative Affairs Agency, Legal Division.

First, although the legal attorney made substantial revisions to the draft we provided to your office, we can support the final product produced. The draft finance version is a superior bill to CSSB 136(H.E.S.S.) in the following ways:

- A. It involves the State Medical Board in the establishment of educational and examination requirements, with a six month time limit from which to hold public hearings from the time of the effective date.
- B. It mandates that both classroom and clinical educational experience is required to use ophthalmic drugs in practices.
- C. It mandates that the educational and examination requirements address reactions to pharmaceutical agents and treatment of adverse reactions.
- D. It mandates that the optometrists must take an examination in use of ophthalmic drugs, while CSSB 136(H.E.S.S.) does not.
- E. It puts the authority for selecting and regulating drug use with the Board of Examiners in Optometry and the State Medical Board, rather than in the Department of Health and Social Services as CSSB 136(H.E.S.S.) does. We have neither the staff expertise to evaluate the use nor the regulatory power to control possible optometrist misuse. We believe CSSB 136(Finance) to be a superior bill in this respect.

F. It requires statutorily that the optometrist must publicly display his or her certificate in a conspicuous place. We believe this is important to protect the consumer since there will be two classes of optometrists practicing in the state - one authorized to use drugs and one not. We believe this provision is a good one and in the public's best interest.

In conclusion, the Department of Health and Social Services has no objection to the passage of CSSB 136(Finance) as drafted by Legislative Affairs Agency, Legal Division for it protects the public health by limiting use of ophthalmic drugs to only diagnostic ones, mandating clinical as well as classroom training in use of drugs, requiring continuing education to keep skills current, and provide certain consumer protection provisions to make the public more aware in the purchase of eye care services.

We anticipate no fiscal impact to our Department if CSSB 136(Finance) were passed into law.

We appreciated the opportunity to work with you on this matter.

Sincerely,

Helen D. Beirne
Commissioner

Enclosures

COMPARISON OF THREE ALTERNATIVES
TO AUTHORIZE OPTOMETRISTS TO USE CERTAIN OPHTHALMIC
DRUGS IN THEIR PRACTICES
(SB 136)

General Topic Regarding Use
of Ophthalmic Drugs

Senate HESS Version (CSSB 136) (HESS)

Senate Finance Drafted Version
CSSB 136 (Finance)
(Prepared by Department of Health
and Social Services)

Senate Finance Drafted Version
CSSB 136 (Finance)
(Prepared by Legislative Affairs
Legal Division)

Educational Requirements

- a) Who prescribes?
- b) Requirement for clinical and classroom training?
- c) Continuing Education?
- d) Specific topics to be covered in course work noted in Statute?
- e) Are educational institutions required to be accredited?

- a) Board of Examiners in Optometry only.
- b) No Statutory mandate for clinical training. Board of Examiners in Optometry determines.
- c) Yes; Board of Examiners in Optometry only prescribes.
- d) None; Board of Examiners in Optometry determines.
- e) No reference; Optometry Board prescribes. (Refer: Pg. 1, line 9-12, AS 08.72.050(6))

- a) Board of Examiners in Optometry with advice and consent of the State Medical Board, with such consent to be provided within six months from effective date.
- b) Yes; both general and clinical educational requirements statutory mandated.
- c) Yes; Board of Examiners in Optometry with advice and consent of the State Medical Board with such consent to be provided within six months of effective date.
- d) Yes; emphasis required on systematic effects of and reactions to pharmaceutical agents, including the treatment of any adverse reactions that may occur.
- e) Yes; and both Board of Examiners in Optometry and State Medical Board must approve. (Refer: Pg. 1, AS 08.72.050(6))

- a) Board of Examiners in Optometry and State Medical Board shall jointly adopt. Public hearings shall be held on regulations within six months of the effective date.
- b) Yes; both general and clinical educational requirements statutorily mandated.
- c) Yes; Board of Examiners in Optometry and State Medical Board shall jointly adopt. Public hearings shall be held on regulations within six months of the effective date.
- d) Yes; emphasis is on systemic effects of and reactions to pharmaceutical agents and the treatment of adverse reactions to pharmaceutical agents.
- e) Yes; and both Board of Examiners in Optometry and State Medical Board must approve. (Refer: Pg. 1, Line 9-22, AS 08.72.061; Pg. 3, Line 4-7,

General Topic Regarding Use
of Ophthalmic Drugs

Senate HESS Version (CSSB 136) (HESS)

Senate Finance Drafted Version
CSSB 136 (Finance)
(Prepared by Department of Health
and Social Services)

Senate Finance Drafted Version
CSSB 136 (Finance)
(Prepared by Legislative Affairs
Legal Division)

Specific Examination Re-
quirements for Drugs

- a) In Statute?
 - b) Who prescribes?
 - c) Specific topics to be covered?
- a) None
 - b) None
 - c) None

- a) Yes
- b) Board of Examiners in Optometry with advice and consent of the State Medical Board with such consent to be provided within six months from the effective date of this Section.
- c) Systematic effects of and reactions to pharmaceutical agents, including the treatment or adverse reactions that may occur.
(Refer: Pg 1, AS 08.72.050(6))

- a) Yes
- b) Board of Examiners in Optometry and State Medical Board shall jointly adopt. Public hearings to be held within six months.
- c) Systematic effects of and reactions to pharmaceutical agents and treatment of adverse reactions to pharmaceutical agents.
(Refer: Pg. 1, line 9-22 and pg. 4, line 4-7)

Types of Ophthalmic Drugs
Permitted

- a) Diagnostic and/or therapeutic
 - b) Who specifies generic types?
- a) Diagnostic
 - b) Department of Health & Social Services.
(Refer: Pg. 1, AS 08.72.051)

- a) Topical ocular diagnostic drugs.
- b) Board of Examiners in Optometry with advice and consent of the State Medical Board, with such consent to be provided within six months of the effective date of this section.
(Refer: Pg. 2, AS 08.72.050(7))

- a) Diagnostic drugs.
- b) Board of Examiners in Optometry and the State Medical Board shall jointly adopt regulations. Public hearings shall be held within six months after effective date.
(Refer: Pg. 1, line 23-26))

General Topic Regarding Use
of Ophthalmic Drugs

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Legal Division)

Consumer Protection

- a) Endorsement on certificate to distinguish these Optometrists qualified to use drugs in practice?
- b) Limiting use of professional title?
- c) Statutory mandate for display of certificate?

- a) Yes
 -) Yes
 - c) No
- (Refer: Pg. 1, line 14-29 and Pg. 2, lines 1-2, AS 03.72.061 & AS 03.72.254)

- a) Yes
 - b) Yes
 - c) Yes
- (Refer: Pg. 2 & 3, AS 03.72.061, AS 03.72.254, AS 03.72.255)

- a) Yes
 - b) Yes
 - c) Yes
- (Refer: Pg. 2, line 5-22, AS 03.72.204-256)

Referral to Other Medical Specialists

- a) Mandatory when possible existence or pathological conditions.

- a) Yes
- (Refer: Pg. 2, line 3-9, AS 03.72.286)

- a) Yes
- (Refer: Pg. 3, AS 03.72.286)

- a) Yes

Effective Date

None

Immediate

Immediate



1200 West Godfrey Avenue
Philadelphia, Pa. 19141
215 424 5900

Center for Continuing and
Post Graduate Education

Pennsylvania College of Optometry

The Eye Institute
1201 West Spencer Street
Philadelphia, Pa. 19141

INTRODUCTION

OCULAR THERAPY FOR THE OPTOMETRIC PRACTITIONER #750

The following material will define and describe the 150 hour offering of Ocular Therapy for the Optometric Practitioner #750. The introductory remarks present some basic elements regarding the structure of the program.

1. The program is given at a singular site or multiple sites based on suggestion and considerations of the State organization. Each site is limited to a maximum of approximately 60 doctors.
2. A total of approximately 20 lecturers participate in presenting 96 hours of lecture. The faculty all hold professional degrees including O.D., M.D., Ph.D., etc. All are experienced clinicians and academicians from various departments of medical and health care institutions and are well indoctrinated in the goals and needs of optometrists.
3. Given sufficient notice (about 2 months), the course(s) could begin whenever specified.
4. A suggested schedule is 2 days of lecture followed by a 2 to 4 week break. The normally preferred days are a Saturday and Sunday combination with adjustments made for holidays, professional meetings, etc. However, there is flexibility in the program to create virtually any type schedule necessary to meet the requirements of the doctors in specific states.
5. Two examinations are normally administered:
 - a. Three hour examination covering material in first half of course (Examination, Part I).
 - b. A three-hour final examination covering material in second half of course (Examination, Part II)
6. Examinations are presented in a sufficient number of rooms to assure adequate spacing between the doctors taking the examination.
7. Examination, Part I consists of approximately 200 questions of the multiple choice variety and Examination, Part II consists of approximately 200 questions of the same type.

8. Forty-eight hours of clinic are held at a suitable location within the state. Facilities of the Pennsylvania College of Optometry are available, and clinic sessions could be held in The Eye Institute which would represent a savings to the State Association of travel and lodging of the clinical staff.
9. Doctors must demonstrate confidence in each of 6 specified areas for completion of the clinic session (see description).
10. Student numbers are of particular importance in the clinic. Every attempt is made to maintain a ratio of 6 doctors per 1 staff member.
11. Special tutorials and course reviews (delivered on Friday evenings prior to lecture week-ends) are available as part of the pre-requisites for eligibility. Tuition for these tutorials and reviews are not included in the total program tuition. Rate for 3 hour session shall be \$25.00 per person with minimum group size of 5 and maximum size of 10.
12. The program is costed on the basis of direct and indirect expenses plus a 15% institutional fee. Any additional services beyond the program structure and content, (i.e. testimony, consultation, etc.) are charged separately to the State Association.
13. The recommended printed materials for the courses include the following:
 - a. The Pharmacological Basis of Therapeutics, by L. S. Goodman and A. Gilman (a recognized pharmacology reference text) priced at approximately \$50.00 per book.
 - b. Manual of Ocular Therapy, by Deborah Pavan Langston, priced at approximately \$15.00 per book
 - c. Complete preprinted, bound and indexed lecture outline notes priced at approximately \$40.00 per book.
 - d. Each student is supplied with a comprehensive bibliography from which he/she may select additional reading material.
14. Additional considerations include the following:
 - a. A minimum passing grade of 70 is recommended with each Examination (Part I and Part II) counting equally in the final grade.
 - b. The doctor may be permitted 4 days of absence from lectures but no absence from the clinic. Notwithstanding such absences, the doctor remains responsible for all material covered in all sessions.
 - c. Forms are supplied by the Pennsylvania College of Optometry for strict monitoring of attendance records.



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Center for Continuing and
Post Graduate Education

**Pennsylvania College
of Optometry**

The Eye Institute
1201 West Spencer Street
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215 276 6000

COURSE TITLE: OCULAR THERAPY FOR THE OPTOMETRIC PRACTITIONER

COURSE NUMBER: 750

DESCRIPTION: An in depth post-graduate curriculum including 150 hours of didactic (102 hours) and clinical (48 hours) education in the diagnosis, treatment and management of ocular diseases. Emphasis is placed upon pharmacology and ocular therapeutics; diagnosis and management of anterior segment disease and glaucoma; and recognition of ocular manifestations of systemic disease.

COURSE OBJECTIVES:

1. To improve the practicing optometrist's knowledge base and clinical skills in the following areas:
 - a. Knowledge of the presentation, examination, differential diagnosis, treatment and management of ocular disease.
 - b. Clinical experience in the procedures, techniques and professional judgements required in the application of each parameter delineated in objective (a) above.
 - c. Knowledge of actions, toxicities (adverse reactions), indications and contra-indications of pharmaceutical agents used in the clinical care of eye diseases.
 - d. Knowledge of actions, toxicities (adverse reactions), indications and contra-indications of pharmaceutical agents used systemically which potentiate secondary affects upon the eye and vision.
2. To evaluate, examine and certify practitioner skills and competencies in the comprehensive care of eye disease.

PRE-REQUISITES:

1. Graduate of accredited school or college of optometry.
2. Minimum 60 hours of pharmacology education.
3. Pre-assessment evaluation in the following areas:
 - a. Basic concepts in pharmacology.
 - b. General knowledge of ocular anatomy and physiology.
 - c. Applied skills in ophthalmic examination techniques and instrumentation.
4. Pre-course tutorials where indicated from number 3 above.

COURSE SCHEDULE: (See Attachment #1)

ANALYSIS OF CURRICULA ELEMENTS

I.	Total Course Curricula	150 Hours
	A. Didactic (Lecture)	96 Hours
	B. Clinical ("Hands-on")	48 Hours
	C. Examinations	6 Hours
	1. Part I (Midterm)	3 Hours
	2. Part II (Final)	3 Hours
	3. Clinical Evaluation by Instructors	
II.	Didactic Curricula	102 Hours
	A. Pharmacology	24 Hours
	1. Ocular	12 Hours
	2. Systemic	12 Hours
	B. Anterior Segment Disease	30 Hours
	C. Glaucoma	12 Hours
	D. Systemic Disease	6 Hours
	E. Trauma & Emergency Care	3 Hours
	1. Emphasis in clinical portion	
	2. Also included in Anterior Segment, Pharmacology and Posterior Segment discussions.	
	F. Ocular Neurology	6 Hours
	G. Cataract	3 Hours
	H. Posterior Segment	12 Hours
	I. Examinations.	6 Hours
III.	Clinical Curricula	48 Hours
	A. Anterior Segment Disease	21 Hours
	B. Glaucoma	10 Hours
	C. Systemic Procedures	3 Hours
	1. Includes laboratory workup	
	2. Neurological examination	
	3. Cardiovascular tests and procedures	
	D. Trauma & Emergency Care	6 Hours
	1. CPR Course included	
	E. Posterior Segment Disease	8 Hours
	1. Includes Binocular Indirect Ophthalmoscopy	

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

June 1, 1981

The Honorable Donald C. Clocksin
Chairman, Health, Education and
Social Services Committee
Alaska State House of Representatives
Room 110 Capitol Building
Juneau, Alaska 99811

Dear Representative Clocksin:

On May 30, I was authorized by the Alaska Optometric Association to enter into negotiations with the Pennsylvania College of Optometry to determine how they might best provide the attached course in primary care ocular therapeutics to Alaskan optometrists.

Under HB 111, ODs would be able to put this training to use. Under CSSB 136, this training could not be used because the bill restricts optometrists to diagnostic usage of ophthalmic drugs.

Since this training represents substantial time and expense to our practicing ODs, including the probability of taking a portion of the training at the Eye Institute in Philadelphia, I would like your opinion as to the probability of HB 111 in its present enabling form receiving approval by the House, or indeed by both houses, during the tenure of the Twelfth Legislature.

I realize you have many matters to consider, but this bill affects potentially every citizen in the state, and is in no sense a parochial issue.

Please call me collect at 276-8120 if a telephone conversation would be more convenient for you than a letter.

Thank you.

Respectfully yours,



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

PWB/lr

Attachment

cc: Senator Parr ✓

PROPOSED DRAFT COMMITTEE SUBSTITUTE FOR SENATE BILL 136 - OPTOMETRY
by the Senate HESS Committee - March 28, 1981

* Section 1. AS 08.72.020 is amended to read:

Sec. 08.72.020. Membership of board and terms of office. The board consists of six (FIVE) persons, appointed by the governor. Members serve staggered terms of four years.

* Section 2. AS 08.72.040 is amended to read:

Sec. 08.72.040. Qualifications. Four board members shall be licensed, practicing optometrists who have been residents for at least three years. One board member shall be a public member with no interest, direct or indirect, in the practices of optometry, opticianry or medicine. One board member shall be a licensed physician pursuant to AS 08.64.170. - AS 08.64.350. A person who has served two successive complete terms may not be reappointed until four years from the expiration of the second term that he served.

* Section 3. AS 08.72.050(c) is amended to read:

(c) The board shall

(1) elect a president and secretary from among its members;

(2) order a licensee to submit to a reasonable physical examination if his physical capacity to practice safely is at issue.

(3) establish specific diagnostic drugs and the strengths thereof within the limits of AS 08.72.300(7), with the advice and guidance of the state medical board.

* Section 4. AS 08.72 is amended by adding a new section to read:

Sec. 08.72.272. Use of "Dr." or "Doctor". When an optometrist uses the title "Dr." or "Doctor" as a prefix to his name, without using the word "optometrist" as a suffix to his name or in connection with it, it constitutes a cause to revoke or suspend his certificate of registration.

* Sec. 5. AS 08.72 is amended by adding a new section to read:

Sec. 08.72.280. REFERRAL TO OTHER MEDICAL SPECIALISTS. If, during the course of examining a person, an optometrist determines the possibility of the existence of a pathological condition, the optometrist shall so advise the person and shall refer the person to an appropriate medical specialist for further evaluation.

* Section 6. AS 08.72.300(2) is amended to read:

(2) "optometry" is the examination, other than by the use of drugs, except diagnostic drugs as defined in this section, of the human eyes and the visual system for the purpose of ascertaining a departure from the normal, ascertaining the status of the human visual system, including refractive and functional abilities, or ascertaining the presence of ocular disease and any other departure from the normal which requires referral to other health care practitioners; or the diagnosis of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription of application of lenses, prisms or ocular exercises for the correction or relief of the human eye;

* Section 7. AS 08.72.300(3) is amended to read:

(3) "practicing optometry" is an examination, other than by the use of drugs, except diagnostic drugs as defined in this section, of the human eyes and visual system for the purpose of ascertaining a departure from the normal, ascertaining the status of the human visual system, including refractive and functional abilities, or ascertaining the presence of ocular disease and any other departure from the normal which requires referral to other health care practitioners; or the diagnosis 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;

* Section 8. As 08.72.300 is amended by adding a new subsection to read:

(7) "diagnostic drug" means a cycloplegic, mydriatic, or topical anesthetic which is listed in the official United States Pharmacopoeia, or official National Formulary, or any other supplement to either of them.

* Section 9. As 08.72. is amended by adding a new section to read:

Sec. 08.72.305. Use of drugs for diagnosis. No optometrist shall be registered or certified to practice optometry in the state of Alaska in any area that is beyond the scope of his educational training as determined by the board of optometry. Any optometrist presently registered in the state of Alaska and who desires to employ the use of diagnostic drugs must submit to the board of optometry evidence of satisfactory completion of all necessary educational requirements as made mandatory by the board. The board of optometry shall provide for continuing educational requirements by all optometrists desiring to employ diagnostic drugs. Diagnostic drugs may be sold, given away, bartered, exchanged, or distributed upon the written order or prescription of an optometrist who is authorized to use diagnostic drugs as provided in this chapter.

POSITION PAPER

SENATE BILL NO. 136

"An Act relating to the practice of optometry, and authorizing the use of ophthalmic drugs by optometrists."

This bill would permit the use of selected drugs by certain optometrists and as such would delete from the definition of optometry the restriction against the use of drugs. All of these are drugs which are instilled directly into the eye.

In addition to topical anaesthetics, drugs used in examining the human eye include:

Mydriatics - cause pupil to open;

Myotics - cause pupil to close down;

Cycloplegics - cause temporary paralysis of the muscles controlling the shape of the lens.

A majority of states now allow optometrists to use diagnostic topical drugs, either through specific enabling legislation or through the lack of specific prohibitions. The issue of the use of such drugs by optometrists has been controversial. In recent years certain states have given permission while it has been denied in other states. Those in favor of the use of drugs by optometrists argue that optometric services are more widely distributed than ophthalmologic services and that the optometrist serves as an entry point for primary eye care. The use of diagnostic drugs is said to expand the ability of the optometrist to recognize eye abnormalities and to increase medical referral for diagnosis and treatment. The optometric group also states that the drugs which are proposed rarely have adverse effects.

Those opposing permissive legislation argue that the use of drugs would not materially improve the capacity of optometrists to recognize abnormalities. Optometrists are not expected to diagnose diseases of the eye, and if a departure from normal is noted, the patient is expected to be referred to a physician for diagnosis. The concern on the part of the medical community is that the optometrists would be making diagnostic judgments which the physicians do not believe them qualified to make. Moreover, the medical community notes that adverse reactions, while admittedly rare for certain of the drugs, can have extremely serious consequences when they do occur. A higher rate of predisposition to a certain type of glaucoma in Alaska Natives is cited. Use of mydriatics could possibly precipitate an attack.

Limitations are placed on the use of certain drugs by the permissive legislation of some states. None are described in the proposed Alaska bill. In Oregon, for example, the Board of Optometry is empowered to designate the diagnostic pharmaceutical agents for topical use, but provides that the designation shall be with the advice and guidance of

the Board of Medical Examiners for the State of Oregon. Rhode Island permits the use of mydriatics, miotics and topical anaesthetics while Maine permits only the use of topical anaesthetics and mydriatics. A bill which has been considered in the Ohio legislature specifically prohibits use of pilocarpine (a drug which constricts the pupil), atropine and homatropine (drugs which dilate the pupil and temporarily paralyze accommodation of the lens) and 10% phenylephrine (a strong mydriatic).

Some states define the type of training in pharmacology which would be required before an optometrist would be permitted to use diagnostic drugs. SB 136 contains such provisions.

If the Legislature chooses to authorize use of certain drugs by optometrists, the Department of Health and Social Services suggests that definitions and restrictions similar to those in use in other states may be advisable, and that the professional opinion of the medical and optometric communities should be sought to insure the health and safety of the general public.

Recommended by:

David Bruce
David Bruce, Deputy Director

Date:

February 29, 1981

Approved by:

Helen D. Beirne
Helen D. Beirne, Commissioner

Date:

2-26-81

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
 Bill/Resolution No. Senate Bill No. 136
 Title "An Act relating to the practice of optometry, and authorizing the use of drugs..."
 Requested by Commissioner's Office Date February 26, 1981

II. FISCAL DETAIL.
 Agency Affected Department of Health and Social Services
 Program Category Affected Health/Public Health
 BRU, Program, or Subprogram(s) Affected _____
 (Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)
EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	0	0	0	0	0
300 CONTRACTUAL	0	0	0	0	0	0
400 COMMODITIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Fund Source)	0	0	0	0	0	0

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

IV. DATE February 26, 1981 PREPARED BY David Bruce
 AGENCY Division of Public Health
 PHONE: 465-3090
 Original: Legislative Finance
 cc: Budget and Management
 Prime Sponsor (First Legislator Named)



ALASKA STATE MEDICAL ASSOCIATION

4107 Laurel Street, Suite 1 • Anchorage, Alaska 99504 • (907) 277-6891



March 17, 1981

The Honorable Charles Parr
Chairman
Senate HSS Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

I am writing to follow up on my previous testimony to your committee, both in person and by teleconference, regarding SB 136. I would also like to make reference to the preliminary compromise between the optometrists and the medical doctors that was worked out last year, and to address the suggested language to amend SB 136 authored by the DHSS.

Diagnostic pharmaceutical agents that could, with proper safeguards, be considered reasonably safe for use by optometrists include a pure mydriatic, such as phenylephrine hydrochloride 2.5% or 5%; combination cycloplegics and mydriatics, to include tropicamide 1% and cyclopentolate hydrochloride 1%; and a topical anesthetic such as proparacaine 0.5%. This list of drugs would satisfy the economic wishes of those optometrists who wish to expand their practices without unduly endangering the Alaskan public.

The Alaska State Medical Association is strongly opposed to optometrists using therapeutic agents. Medications are expensive when prescribed needlessly, dangerous when prescribed inappropriately, and well outside the scope of training for most optometrists currently practicing in the state. The DHSS amendments included this limitation.

We believe it is very important that the public be given the opportunity to make an informed decision regarding their vision care when an abnormality is detected. We believe it is essential that the patient understand that they are seeing a non-physician in cases where a pathologic condition is suspected. The DHSS amendments assured this.

Since it is the optometrists who are seeking expansion of their definition of their profession, not a limitation on existing practice by the medical profession, we believe it very important that the Legislature protect the public interest. The consistent testimony by members of the public at the recent teleconference was solidly in support of the Legislature moving very slowly, if at all, regarding expansion of the definition of optometry.

We are prepared to provide further information and recommendations regarding this legislation, should you wish to have further information from us.

Thank you for the opportunity to offer testimony on this most important matter.

Yours truly,


David E. Johnson, M.D.
President

3-20-81

make-up SB 136 - optometry

use both boards for reg.
(medical/optometric)

language limits to "letterhead" & "shingle"

drug fields ~~are~~ are very broad

class? strength?

who decides? - Law or Board?

(Spence-Hess)

drug generic name & by strength by reg-
ulatory process

(Bach) draft does not allow use of
therapeutic drugs (which optometric
all being trained to use)

(Medbury) don't want to include therapeutic drugs

no section on the "management"

no examination

clinical experience should be necessary
(section 7)

~~Wally~~
draft at
reg. drugs by dept. H&SS
give exam by H&SS
H&SS should determine
exam

like exam concept more than clinical
control on distribution of drugs (by PH&SS)

referrals:

08.01.125 -

state med. board agreeable to
joint reg. -
promulgation of

majority, by each board
voted on separately

look at Oregon working

→ "w/ advice & guidance of Medical Board"

USE OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS
BY STATE, TYPE, AND CLASSIFICATION

State	Optometric Drugs		Classifications of Drugs Used					
	Diagnostic Only	Diagnostic & Therapeutic	Cycloplegics	Mydiatics	Topical Anesthetics	Dyes such as Fluorescein	Miotics	None Specifically Listed In Statute or Regulations
Arizona	X		X	X	X			
Arkansas	X		X	X	X	X		
California	X		X	X	X			
Delaware	X		X	X	X		X	
Florida	X	X						X
Georgia	X							X
Idaho	X							X
Indiana	X							X
Iowa	X		X	X	X			
Kansas	X		X	X	X			
Kentucky	X		X	X	X		X ^E	
Louisiana	X							X
Maine	X			X	X			
Minnesota	X							X
Montana	X		X	X	X	X	X ^E	
Nebraska	X		X	X	X			
Nevada	X		X	X	X		X	
New Jersey	X							X
New Mexico	X							X
North Carolina	X	X						X
North Dakota	X							X
Oregon	X		X	X	X	X	X ^E	
Pennsylvania	X		X	X	X		X	
Rhode Island	X			X	X		X	
South Dakota	X							X
Tennessee	X		X	X	X		X	
Utah	X		X	X	X			
West Virginia	X ^x	X ^x						X
Wisconsin	X		X	X	X	X	X ^E	
Wyoming	X		X	X	X	X	X ^E	
TOTAL	30	3	16	18	18	5	10	

Key

E = In Emergency Use Only

x = Excludes Oral or Injectable Drugs

Source: American Optometric Association (1980)

Memorandum 58136

I am writing in regard to 58136.
on opportunity.

I definitely oppose what is being proposed
by the opportunity program.

I personally would not feel eye having an
opportunity - but we for a similar. But
should only be handled by an opportunity -
eye Dr.

Thank,

Emilio P. P.

1800 Howard Way

Lawrence, DE

97801

Charlie — 3-28-81

Phil Bach says that (he called) ^{this a.m.}
rather than an additional
doc on the board of optometry
just use "advice & guidance"
for establishing drugs & strengths
other than the above, he
seemed pleased w/ the new draft

Rachy

P.S.

I mailed a copy to
Bach & received today.

Drugs:

30 states use diagnostic
drugs

16 include cycloplegics

18 include mydriatics

18 include topical anesthetics

10 include miotics (5 states
authorize only in emergencies)

certification by the "board"
provide training to a commercial
medical doctor on the "board" *
pharmacist on the "board" *
* - the "board" which certifies
diagnostic drugs: 1) cycloplegics
2) mydriatics
3) topical anesthetics

Repd. HESS to approve

"drug"

(Official United States Pharmacopoeia
Official National Formulary

West
Virginia

as any other supplement to either

"Bible" of pharmacy