HB

225

UPDATING THE ALASKA OPTOMETRY LAW

Alaska Board of Examiners
in Optometry

Alaska Optometric Association

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Explanatory Notes to the Bill

Section 1

Addition of the phrase, "or other procedures taught by schools and colleges of optometry", in the definitions is designed for maximum flexibility, so the statute will not have to be revised in the future as optometric education changes.

Deletion of the phrase, "other than by the use of drugs", is the core element of this proposal. The private sector of optometry is the only sector that cannot use drugs, due to this provision.

Section 2

In approving undergraduate and post graduate programs in theoretical and applied pharmacology, the board has access to uniform guidelines (Exhibit A).

Optometry and medical school training programs in the eye and eye medicine are compared in Exhibit B. This is to show that relatively little emphasis is placed upon the eye in medical schools despite the fact that generalists in medicine can and do use eye medications.

Section 3

This revises the pharmaceutical section of the Alaska Statutes to allow pharmacists to sell drugs to optometrists.

EXHIBIT A

Guidelines for Pharmacology Training

in Optometry

Major Points

1. Uniform standards exist for training programs in the schools and colleges of optometry

(4)

ASSOCIATION of SCHOOLS and COLLEGES of OPTOMETRY

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Pharmacology Curriculum Guidelines for Continuing Education Courses

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

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

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

Adopted
March 13 1975

Guidelines for Pharmacology Continuing Education

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

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

III. Guidelines for the course content.

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

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

4. Drug abuse
5. Drug contraindications during pregnancy

B. Ocular Pharmacology

1. Principles of Drug Actions
   a. Dosage forms
   b. Routes of administration
   c. Pharmacodynamics
      (1) absorbtion
      (2) distribution
      (3) fate (metabolism)
2. Drug Categories, to include adverse ocular and systemic effects, and
   a. Neuropharmacoligic agents (autonomics)
      (1) review of nervous systems
      (2) autonomic drugs
         ((a)) sympathomimetics
         ((b)) parasympathomimetics
         ((c)) sympatholytics
         ((d)) parasympatholytics
      (3) ocular anesthetics
   b. Agents affecting trans-membrane fluid transport
   c. Antibacterial agents
   d. Antinflammatory agents
      (1) antihistamines
      (2) steroids
      (3) sympathomimetics
      (4) parasympatholytics
   e. Antiviral agents
   f. Antifungal agents
3. Differential Diagnosis of Ocular Neuromuscular Disorders
4. Review of Ocular Side Effects of Systemic Drugs
5. Review of Systemic Side Effects of Ocular Drugs
6. Review of Ocular Side Effects of Ocular Drugs
7. Ocular Urgencies and Emergencies, including glaucoma management
8. Drug Contraindications During Pregnancy
9. Medical Urgencies and Emergencies
10. Malpractice and Jurisprudence

IV. Teaching/Learning Activities

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

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

B. the effect of systemic medication on ocular structure

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

EXHIBIT B

Comparison of optometry and medical school training in ocular anatomy, physiology, pathology, general and ocular pharmacology

Major Points

1. Optometric training far exceeds medical school training in the eye and eye medicine.

2. Medical school graduates can prescribe over 2000 drugs, including all eye drugs, under the principle of unlimited licensure.

3. Doctors of optometry use some of the eye drugs, approximately 15-20 in number.

Southern College of Optometry

Course	Quarter Credits
Required Courses	
BIOMED 110-130 Human Anatomy & Physiology (special emphasis on eye, related structures)	18
BIOMED 133 Vegetative Physiology: Ocular Biochemistry	3
BIOMED 213 Principles of Pharmacology & Therapeutics	2
BIOMED 220 Principles of Medicine II: Clinical Pathology and Pharmacology	4
BIOMED 221 Physiological Optics II: Monocular Sensory and Motility	4
BIOMED 224 Ophthalmic Pathology I	6
BIOMED 230 Principles of Medicine III: Clinical Pathology and Pharmacology	4
BIOMED 231 Physiological Optics III: Monocular Sensory & Binocular Vision	
BIOMED 234 Ophthalmic Pathology II	6
BIOMED 310 Principles of Medicine IV: Pediatrics and Pediatric Optometry	3
BIOMED 313 Advanced Principles of Pharmacology and Therapeutics	2
BIOMED 320 Principles of Medicine V: Gerontology & Geriatrics	3
BIOMED 323 Pharmacology: Ocular and Systemic Pharmacology	4
BIOMED 330 Principles of Medicine VII: Dermatology	2
BIOMED 333 Pharmacology: Clinical Pharmacology	4
CLINIC 310-431 General and Special Clinics	43

University of Minnesota Medical School

Course	Quarter Credits
Required Courses	
Phcl 5110-5111 Pharmacology	8
InMd 5229 Eye	2
Elective Courses	
8101 Clinical Ophthalmology	not specifie
8102 External Diseases	"
8103 Medical Ophthalmology	"
8104 Radiology of the Eye, Orbit and Head	"
8105 Motility	"
8107 Ocular Anatomy	"
8122 Physiologic Optics	"
8141 Ocular Pathology Conference	"
8142 Ophthalmic Pathology Laboratory	"
8143 Pathology of the Eye	"
8151 Basic and Applied Ophthalmology	"
8152 Ophthalmology Laboratory	"
8154 Seminar in Ophthalmology	"
8155 Special Topics in Ophthalmology	"

EXHIBIT C

States Authorizing Drug Utilization

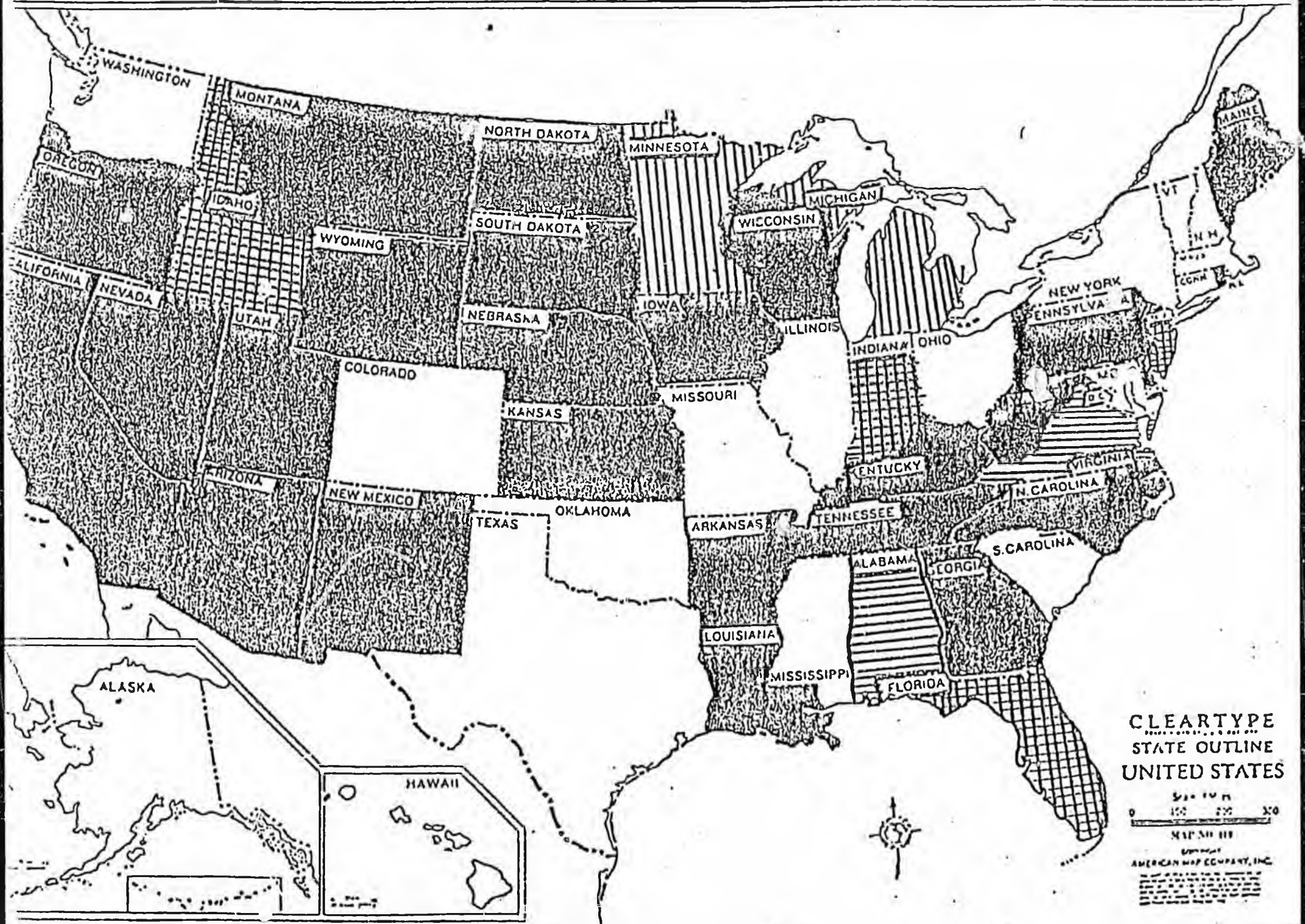
in the Practice of Optometry

Major Points

A majority of states have passed drug legislation, despite political opposition by ophthalmologists.

UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

JUNE 8, 1979



UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

NAME	DATE OF ENACTMENT
Rhode Island	July 16, 1971
Pennsylvania	March 1, 1974
Tennessee	May 8, 1975
Oregon	May 20, 1975
Maine	June 24, 1975
Louisiana	July 6, 1975
Delaware	July 10, 1975
*West Virginia	March 4, 1976
California	July 9, 1976
Wyoming	February 17, 1977
New Mexico	March 4, 1977
Montana	April 12, 1977 (at 10:10 a.m.)
Kansas	April 12, 1977 (at 2:00 p.m.)
*North Carolina	June 3, 1977
Kentucky	March 29, 1978
Wisconsin	April 29, 1978
Nebraska	February 13, 1979
South Dakota	March 15, 1979
Utah	March 21, 1979
North Dakota	March 22, 1979
Arkansas	April 2, 1979
Nevada	May 25, 1979
Iowa	June 8, 1979
Georgia	February 14, 1980
Arizona	April 1980

*both diagnostic and therapeutic

[In addition, there are eight (8) other states that do not statutorily prohibit the use of DPAs by optometrists; several of these states have attorney general opinions (+favorable) (-unfavorable) on this point: Alabama (AG-), Florida (AG+), Idaho (State Board Statement +), Indiana (AG+), Michigan (AG-), Minnesota, New Jersey (AG+), Virginia (AG-).]

For your information we are including an updated map showing geographically the utilization of pharmaceutical agents by optometrists.

Public Benefits of the Legislation

1. Availability of Services

Ophthalmologists are located in only 5 Alaskan cities: Anchorage, Fairbanks, Juneau, Ketchikan and Soldotna. Optometrists are located at the following cities not served by ophthalmologists: Sitka, Kodiak, Bethel, North Pole, Wasilla, Palmer, Kenai. In most of these cities, a patient with minor eye disease has no practical recourse but to see a general physician, who does not have the optometrist's degree of training in differential diagnosis or the instruments with which to accomplish the diagnosis. Since optometrists make trips to many rural and bush areas, they can provide basic eye health services to villages now principally served by health aides, with 6 to 24 weeks of training and having only radio contact for doctor consultation.

2. Quality of Services

Besides their obvious value to the health aide system, optometrists can serve as a valuable resource to physicians in cities not served by an ophthalmologist. This occurs with the optometrist employed by the native health corporation in Bethel (not bound by the drug restrictions of the Alaska optometry law). General physicians, to their credit, tend to refer patients to the most qualified practitioner in their area. It is not surprising therefore, that MDs in Kodiak have endorsed previous drug usage bills in optometry.

3. Cost of Services

Just as a general practitioner charges a lower fee (typically half) than does a specialist for doing similar work (obstetrics, pediatrics, etc.), so an optometrist (a generalist and primary care provider with respect to the eye) can be expected to charge less for treating minor eye diseases than does the ophthalmologist (the specialist).

Criticism of the Legislation by Ophthalmologists,

and Answers to the Criticism

1. The legislation is not necessary. The present system of ophthalmologists, general practitioners and health aides handles the eye care needs of Alaskans quite well.

Doctors of optometry are an underutilized resource. They can deliver services of higher quality, at greater availability and lower cost than can the existing system alone. This is detailed in the section entitled, Public Benefits of the Legislation.

2. Optometrists claim competancy, but their training programs are inadequate, particularly as to qualifications of faculty, and clinical experiences available to their students.

Optometry schools receive state and federal funds, and are accredited by both regional and professional accrediting organizations. It is not in the interest of schools or the profession at large to allow inadequate programs to exist in this sensitive area, for the sake of saving money. All optometric faculties include MDs, and PhDs in such specialized fields as physiology, pharmacology, biochemistry and microbiology. Many are present or past members of medical school faculties. With drugs, as in other areas of the professional curriculum, optometrists are trained well beyond the level at which they must function in day to day practice. While it is impossible to have too much clinical experience, optometry students enjoy more than adequate exposure to the common eye diseases they must deal with. In their two years of clinic experience, they see much more eye pathology than general medical students, but less than residents (trainees) in ophthalmology. Many rare eye diseases will not be seen in a three year residency in ophthalmology.

3. Optometrists can detect abnormalities but cannot diagnose. Treatment requires, first of all, an accurate diagnosis.

Optometrists can diagnose some eye diseases; definitive diagnosis of others requires specialized examination by the ophthalmologist. At still other times, consultation with the specialist will allow a diagnosis to be made. The same is true for a general physician or for a specialist whose case lies partly in the province of another specialist. No practitioner is going to be foolish enough to treat a case if he isn't sure what it is, if more competant authority is reasonably available.

4. Optometrists study the eye but they are not trained in broad medical principles. The general physician knows the entire body and can generalize certain principles to the eye even though he may not have as many hours of study specifically in the eye as the optometrist.

Optometrists study general anatomy, physiology, pathology and pharmacology precisely because certain general principles need to be understood before considering a particular organ system like the eye. The educational model is similar to dentistry. In both professions, the body as a whole is studied in less detail than is done by medical students, because neither are treating kidney disease or setting broken legs. Yet the necessary general principles are learned. Both dentists and optometrists are medically trained, in ways that are appropriate to their respective fields of work.

5. Given drugs for diagnosis and some treatment, ODs would go in over their heads, attempt to be ophthalmologists.

This is not the case in other fields and there is no evidence that it has happened or will happen in optometry. Malpractice insurance rates are no higher in drug states than in non-drug states. Besides a basic conservatism common to all professionals, optometrists are constrained by the knowledge that their malpractice insurance coverage does not extend to activities that are outside their recognized scope of practice.

6. Defining procedures "as taught by schools and colleges of optometry" is too general, could allow the optometry board to do almost anything.

"As taught" is purposely general, to allow the board to react to continuing changes in the education of the profession. It is the responsibility of the board, as an agency of the State of Alaska, to know the areas in which optometrists are trained and educated, to examine them for competance and license or fail to license them accordingly. Most board members are also practitioners. It is not in their interest to license fellow practitioners to do procedures that could bring discredit to the profession or raise malpractice insurance rates. This is also true of other health care regulatory boards.

7. Drug usage by optometrists constitutes competition in the historical province of ophthalmology.

Ophthalmologists, nationally and in Alaska, tend to concentrate in urban areas, where they spend a majority of their time practicing optometry. In the last 15 years they have entered the field of contact lenses, an area pioneered by optometry. Much earlier, their predecessors (oculists), entered the optometrists' field of refraction after abandoning the belief, common among Victorian era physicians, that glasses weakened the eyes. Competition both ways is appropriate. It is not in the public interest to exclude a qualified bidder from the marketplace.

APPENDIX

Full curricula of optometry and medical schools compared in Exhibit B

Southern College of Optometry

Catalog 1979-80

FOURTH PROFESSIONAL YEAR (CONTINUED) SPRING QUARTER			HOURS CREDIT
Optometry	430	Optometry Seminar: Curent Problems (3 HRS. LEC.)	3
Optometry	431	Clinical Case Analysis III (2 HRS. LEC.)	2
Biomedical	432	Vision Science Seminar: Current Problems (2 HRS. LEC.)	2
Clinic	430	General Clinic Practice VII (1 HR. LEC., 16 HRS. LAB)	5*
Clinic	431	**Specialty Clinics (Two required, each for 1 Qtr. Hr. of credit) (8 HRS. LAB)	2
		TOTAL	14

*Credit will be reduced by 1 quarter hour after 1979-80.

**A minimum of two quarter hours of credit each must be completed in Contact Lenses and in Orthoptics & Vision Training, during the fourth year, as well as a minimum of one quarter hour of credit in Pathology. Additional clinic rotations may be selected from Geriatrics, Low Vision, Dermatology, Neurology, Pediatrics, Neurophysiology, or any other approved clinical area.

COURSE DESCRIPTIONS

Courses numbered in the 100 series are for first professional year students, 200 for second professional year students, 300 for third professional year students, and 400 for fourth professional year students. The letter E following a course number indicates that the course is offered for college credit through the Continuing Education Program. The four-year program provides more than 4000 clock hours of instruction in optometric science and clinical optometry and carries a minimum of 232 quarter hours of credit.

The curriculum is organized for administrative purposes into three departments: Biomedical Sciences, Optometry and Clinic. The Biomedical Sciences Department is inter-disciplinary, offering sequences in anatomy and physiology, chemistry, physics, physiological optics and psychology. The Optometry Department offers diversified instruction in all phases of optometric theory and practice. The Clinic Department offers extensive experience in out-patient vision care.

BIOMEDICAL SCIENCES DEPARTMENT

110 HUMAN ANATOMY & PHYSIOLOGY I: STRUCTURE & FUNCTION (6 quarter hours)
Five hours of lecture and one two-hour laboratory per week. A course covering basic cell biology, general human embryology, ocular embryology and histology, with detailed emphasis on the tissue structure of the eye and ocular adnexa. The gross anatomy of the human body is studied, particularly the skull, circulatory system of the orbit, orbital contents, and ocular adnexa. The course also includes general physiology of the organ systems.

111 VISUAL OPTICS I: PHYSICAL AND GEOMETRICAL OPTICS (5 quarter hours)
Three hours of lecture and one two-hour laboratory. A detailed study of the variations in light rays between different optical media. Includes the theory of rectilinear propagation, reflection and refraction at plane, spherical, and cylindrical surfaces, and thin lenses.

120 HUMAN ANATOMY AND PHYSIOLOGY II: STRUCTURE AND FUNCTION (6 quarter hours)
Five hours of lecture and one two-hour laboratory per week. Continuation of 110.

121 VISUAL OPTICS II: PHYSICAL AND GEOMETRICAL OPTICS (4 quarter hours)
Three hours of lecture and one two-hour laboratory. A continuation of Bio 111. Includes the Gaussian system, the schematic eye and its applications, selected optical instruments, common aberrations, and the effect of apertures. Prerequisite: Bio. 111.

122 VISUAL PERCEPTION: PSYCHOPHYSIOLOGICAL OPTICS (5 quarter hours)
Four hours of lecture and one two-hour laboratory per week. An introduction to Vision Science, which involves the behavior-scientific approach to understanding vision and visual perception. Special emphasis is placed on monocular visual function and on the theories and data relevant to visual perceptions.

130 HUMAN ANATOMY AND PHYSIOLOGY III: STRUCTURE AND FUNCTION (6 quarter hours)
Five hours of lecture and one two-hour laboratory per week. Continuation of 120.

131 VISUAL OPTICS III: PHYSICAL AND GEOMETRICAL OPTICS (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. Physical Optics comprises those phenomena bearing on the nature of light, including processes which involve the interaction of light with matter. Some topics considered are nature and propagation of light, photometry, dispersion, interference, diffraction, polarization, and spectra.

133 VEGETATIVE PHYSIOLOGY: OCULAR BIOCHEMISTRY (3 quarter hours)
Three hours of lecture per week.
Analysis of the intraocular fluids, aqueous chemistry and flow; secretory mechanism, intraocular pressure; vitreous structure and protein; lens and its function related to its composition. Lens proteins, metabolism cataract. The cornea and sclera; metabolism, nutrition and growth processes; retinal metabolism, glycolysis.

210 PRINCIPLES OF MEDICINE I: GENERAL PATHOLOGY (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. An introduction to reaction of the body as a whole to disease. Injuries including genetic, metabolic, infectious, immunologic degenerative, hemorrheologic and neoplastic processes are reviewed.

211 PHYSIOLOGICAL OPTICS I (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. A study of the eye as an optical system including the dioptric and physiological components, and the functioning of the visual system.

212 NEUROANATOMY AND NEUROPHYSIOLOGY I (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. Embryological development, structure, and function of the nervous system are studied. Functional components of the nervous system with special reference to modifications are studied.

* 213 PRINCIPLES OF PHARMACOLOGY AND THERAPEUTICS (2 quarter hours)
Two hours of lecture per week. The course covers basic principles of pharmacology, including drug absorption, distribution, metabolism, and excretion. The autonomic nervous system will be covered and an introduction to drug dosage forms and drug dosage regimens.

* 220 PRINCIPLES OF MEDICINE II: CLINICAL PATHOLOGY AND PHARMACOLOGY (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. The study of the etiology, pathophysiology, treatment and ocular complications of systemic diseases. An organ system modular approach will be adop

221 PHYSIOLOGICAL OPTICS II (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. A stud monocular sensory aspects of vision and the physiology of ocular mot

224 OPHTHALMIC PATHOLOGY I (6 quarter hours)
Five hours of lecture and one two-hour laboratory per week. A thoro consideration of diseases of the eye, its adnexa, and the visual pathv and of pathologically induced changes in the visual fields. Techniques instrumentation for detection, measurement, and diagnosis of eye orders are studied intensively.

* 230 PRINCIPLES OF MEDICINE III: CLINICAL PATHOLOGY AND PH/ MACOLOGY (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. A contin tion of Bio. 220.

231 PHYSIOLOGICAL OPTICS III: MONOCULAR SENSORY AND BINOCUL VISION (3 quarter hours)
Two hours of lecture and one two-hour laboratory per week. A continuat of monocular sensory aspects of vision, color vision and binocular visi

234 OPHTHALMIC PATHOLOGY II (6 quarter hours)
Five hours of lecture and one two-hour laboratory per week. Continuati of Bio. 224.

235 APPLIED PSYCHOLOGY: PATIENT BEHAVIOR (1 quarter hour)
One hour of lecture per week. The psychology of patient handling, wi respect to refractive error and numerous ocular and visual anomalie Patient management with respect to age (infancy to the elderly) a counseling, generally. Special attention is given to how the doctor explai and informs the patient of clinical entities, particularly "referral typ cases. Emphasis will be given to the commonest conditions met with practice, including cataract, glaucoma, retinal separation, multip sclerosis, strabismus, and refractive error.

* 310 PRINCIPLES OF MEDICINE IV: PEDIATRICS AND PEDIATRIC OPTOMETR (3 quarter hours)
Three hours of lecture per week. The course will be concerned with growt and development of the young; childhood diseases; hereditary and geneti disorders of the eye and adnexa in pediatric ophthalmic medicin emotional components in pediatrics; disease processes and therapeutic of the eye and adenxa. The ophthalmic examination of infants an children; ophthalmic optics and dispensing for refractive errors and th correction of refractive errors, the correction of low vision problems i children.

312 NEUROANATOMY & NEUROPHYSIOLOGY II (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. A laboratory course dealing with the electrical properties of the body and the means of measuring and interpreting electrical activity of the ner[illegible]stem and the muscular system: EEG, EMG, ERG, EOG.

* 313 ADVANCED PRINCIPLES OF PHARMACOLOGY & THERAPEUTICS (2 quarter hours)
Two hours of lecture per week. The course covers principles of phar-

macology, including drug absorption, distribution, metabolism, and excretion. The autonomic nervous system will be covered and an introduction to drug dosage forms and drug dosage regimens.

320 PRINCIPLES OF MEDICINE V: GERONTOLOGY & GERIATRICS (3 quarter hours)
Three hours of lecture per week. The processes of aging; diseases of the elderly. Disease processes and therapeutics of the aging eye and adnexa. Ophthalmic optics and correction of refractive errors in the geriatric patients, aphakia, correction of low vision problems in the elderly.

321 PRINCIPLES OF MEDICINE VI: NEUROLOGY (2 quarter hours)
Two hours of lecture per week. Introduction to neurology, including the peripheral nervous system, diseases of the spinal cord and brain; clinical examination of the nervous system; special senses; neurological symptoms; diseases of the cranial nerves; common psychiatric disorders, neurosis, psychosis, alcoholism, anxiety, etc.

323 PHARMACOLOGY: OCULAR & SYSTEMIC PHARMACOLOGY (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. A course covering basic concepts of current ocular pathological problems. Included are consideration of local and systemic treatment of ocular pathologies, use of diagnostic agents, and ocular side effects of non-ocular drugs.

330 PRINCIPLES OF MEDICINE VII: DERMATOLOGY (2 quarter hours)
Two hours of lecture per week. Appreciation of skin disorders with emphasis on ocular or adnexa implications. Topics will include collagen diseases, pre-cataract skin changes, psoriasis, facial tumors, tumors of eyelid, eyelashes, eyebrows, eczemas; Seborrheic, atropic and allergic dermatitis; Steven-Johnson and dry eye syndrome; Xeroderma, Lipoid Storage Diseases, Xanthalasma; Seborrheic exfoliation. Viral diseases of skin with ocular manifestation, including Vaccinia, Herpes Simplex, Herpes Zoster, Chickenpox, measles, Verrucae; Bullous Dermatoses, disturbances of pigmentation, nutritional disturbances and drug reactions.

333 PHARMACOLOGY: CLINICAL PHARMACOLOGY (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. An advanced course designed to integrate the student's knowledge of pathology and pharmacology. Special emphasis will be placed on further developing differential diagnostic skills, the skills necessary to manage and/or monitor patients who manifest diagnosed ocular conditions and/or systemic conditions with ocular and visual complications, and in addition, to develop further screening techniques for detecting high incidence general health problems.

432 VISION SCIENCE SEMINAR: CURRENT PROBLEMS (2 quarter hours)
Two hours of lecture per week. Various topics concerning aspects of vision science are discussed in terms of current problems.

OPTOMETRY DEPARTMENT

110 BASIC OPTOMETRY (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. Introduction to the use of the trial frame, trial case, retinoscope, ophthalmoscope, ophthalmometer and other instruments used in the visual analysis. Normal refractive states and deviations are studied along with common visual anomalies. Techniques of taking the principal optometric data and the case history are introduced, followed by the evaluation of single findings and the inference of deviant processes from patterns of findings.

111 PREVENTATIVE AND COMMUNITY OPTOMETRY: EPIDEMIOLOGY AND RESEARCH METHODOLOGY (4 quarter hours)
Four hours of lecture per week. Statistical methods as applied to data obtained in optometric examinations and visual science. Measures of central tendency, variability, correlation, standard errors, and tests of significance of commonly used statistics including introduction to the analysis of variance. Experimental design and logic of controlled experimentation, reliability of observations, statistical versus experimental means of controlled experimentation, analysis, interpretation and communication of experimental results.

120 INTERMEDIATE OPTOMETRY I (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. A continuation of 110.

121 PREVENTATIVE AND COMMUNITY OPTOMETRY: JURISPRUDENCE (2 quarter hours)
Two hours of lecture per week. Prevailing statutory and common laws relevant to rights and responsibilities of the optometrist are presented and the legal principles with which an optometrist should be familiar are discussed.

130 INTERMEDIATE OPTOMETRY II (5 quarter hours)
Four hours of lecture and one two-hour laboratory per week. A continuation of 120.

131 HISTORY OF OPTOMETRY (1 quarter hour)
One hour of lecture per week. The development of the profession of optometry from antiquity to the present is surveyed. The role of certain optometric organizations, as well as noted figures in the history of vision science and optometry are studied for perspective.

210 ADVANCED OPTOMETRY I (4 quarter hours)
Three hours of lecture and one two-hour laboratory. The procedures and rationales of graphical, normative and functional visual analysis are studied and compared. Selected optometrics are compared in relation to the diagnosis and treatment of various visual problems.

220 ADVANCED OPTOMETRY II (4 quarter hours)
Three hours of lecture and one two-hour laboratory. A continuation of 210.

222 OPHTHALMIC OPTICS I (2 quarter hours)
Two hours of lecture per week. Fundamentals of ophthalmic mechanics, pertinent mathematics, practical training in the fabrication of common types of ophthalmic lenses and spectacles. Dispensing procedures of fit-

ting and adjusting of spectacles to various facial contours are included. Tool kits are required.

230 ADVANCED OPTOMETRY III (5 quarter hours)
Four hours of lecture and one two-hour laboratory. A continuation of 220.

232 OPHTHALMIC OPTICS II (2 quarter hours)
One hour of lecture and one two-hour laboratory per week. A continuation of Opt. 222. Tool kits are required.

310 CONTACT LENS PRACTICE I (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. The history and development of contact lenses, lectures on the anatomy and physiology of the cornea and eyelids, optics, instrumentation, and lens design. Symptomatology with emphasis on differential diagnosis is presented. Flurorescein analysis of diagnostic lens/cornea relationships is emphasized. Material concerning lens modification procedures, verification of lenses, and fitting techniques is presented in the laboratory.

311 ORTHOPTICS & VISION TRAINING I (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. A study of the influence of vision on human potential, performance, and behavior at various levels of development.

320 CONTACT LENS PRACTICE II (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. Advanced optics, bifocal lenses, scleral lenses, and contact lens telescopic systems are presented. Prerequisite: Optometry 310.

321 ORTHOPTICS & VISION TRAINING II (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. Fundamental principles and modern concepts of vision training and orthoptic procedures are presented as they apply to improvement of vision function, reestablishment of efficient binocular vision, and modification of behavior through performance and achievement gains in the individual.

331 PREVENTATIVE & COMMUNITY OPTOMETRY: ENVIRONMENTAL VISION (3 quarter hours)
Three hours of lecture per week. An analysis of the role of the optometrist and the practice of optometry in industry and other public, military, and educational settings where large groups of individuals are sharing a common environment.

332 VISION SCIENCE LABORATORY (2 quarter hours)
A group of courses from which the student elects one. Each course includes two hours of lecture or one hour of lecture and one two-hour laboratory per week and is research oriented, with classroom activity devoted to clarifying and discussing laboratory techniques. Offered to appeal to student interests in pursuing special research topics in greater depth in areas such as Physical Optics, Geometrical Optics, Physiological Optics, Psychological Optics, and Experimental Optometry.

333 LIMITED VISION (PARTIAL SIGHT) (4 quarter hours)
Three hours of lecture and one two-hour laboratory per week. Differential procedures of evaluation of patients with severe and intractable visual deficits. Anatomical, physiological, and psychological aspects are integrated in considering the most suitable optic compensation.

401 PREVENTATIVE & COMMUNITY OPTOMETRY: ECONOMICS & PRACTICE MANAGEMENT (4 quarter hours)
Four hours of lecture per week. Professional and economic aspects of the ethical practice of optometry are studied in detail. Special attention is given to selection of a practice location, planning and equipping the office, fee structures, office and personnel management, records systems, and effective communications at the professional level. The basic concepts of ethical professional conduct and their application to standards of practice are considered from the points of view of the individual optometrist, the patient, the profession, and the public.

402 PREVENTATIVE & COMMUNITY OPTOMETRY: PUBLIC HEALTH (2 quarter hours)
Two hours of lecture per week. A general introduction to the principles of public health, the concepts of epidemiology, and the structure and functioning of local, state, and federal health departments and agencies.

410 OPTOMETRY SEMINAR: CURRENT PROBLEMS (3 quarter hours)
Three hours of lecture per week. Modern techniques used in various aspects of optometry, including contact lenses, general refraction, pathology, etc.

411 CLINICAL CASE ANALYSIS I (2 quarter hours)
Two hours of lecture per week. Analysis of patient cases, including general, and various specialty areas.

420 OPTOMETRY SEMINAR (2 quarter hours)
Two hours of lecture per week. A continuation of 410.

421 CLINICAL CASE ANALYSIS II (2 quarter hours)
Two hours of lecture per week. A continuation of 411.

430 OPTOMETRY SEMINAR: CURRENT PROBLEMS (3 quarter hours)
Three hours of lecture per week. A continuation of 420.

431 CLINICAL CASE ANALYSIS III (2 quarter hours)
Two hours of lecture per week. A continuation of 421.

CLINIC DEPARTMENT.

Satisfactory completion of all course work in the Optometry Department (excluding History of Optometry) and Clinic Department in the First and Second Professional Years is prerequisite to the Third Professional Year Clinic Department work. Additionally, the three-quarter, Second Professional Year general and ocular pathology series; the Second Professional Year course in Pharmacology and Therapeutics; and the Second Professional Year course in Applied Psychology, all in the Biomedical Department, are prerequisites for Third Professional Year clinic assignments.

110 CLINIC ORIENTATION (1 quarter hour)
One two-hour laboratory per week. An orientation to the clinic by means of participation in school screenings and external clinics, to the extent of recording and assisting upper classmen in performance of clinical routines. This one-hour course is extended over the first three quarters of the optometry program and is designed to afford the beginner an appreciation of the social aspects of vision care.

210 CLINICAL PROCEDURES (1 quarter hour)
One two hour clinic laboratory per week. This course is an introduction to clinical procedures, emphasizing patient handling, case histories, record keeping, preliminary testing, and instrumentation. This one-hour course is extended over the Fall, Winter and Spring quarters of the Second Professional Year.

* 310 CLINICAL PRACTICE I (3 quarter hours)
↓ One hour of lecture and two four-hour laboratories per week. Extensive familiarization with clinical facilities and procedures and individually supervised experience in the coordination and application of various theories and techniques of optometry in the out-patient clinic. The taking of case histories, measurement of visual skills, refractive status, status of accommodation and convergence and their coordination, pathology and visual fields examination, subnormal vision, eikonometry, prescribing and dispensing.

320 CLINICAL PRACTICE II (4 quarter hours)
One hour of lecture and three four-hour laboratories per week. A continuation of 310.

330 CLINICAL PRACTICE III (4 quarter hours)
One hour of lecture and three four-hour laboratories per week. A continuation of 320.

331 SPECIALTY CLINICS (2 quarter hours)
Two four-hour laboratories per week. Introduction to clinical procedures in Contact Lenses and in Orthoptics and Vision Training.

400 CLINICAL PRACTICE IV (5 quarter hours)
One hour of lecture and four four-hour laboratories per week. A continuation of 330.

401 SPECIALTY CLINIC (2 quarter hours)
A topic selected from a wide variety of subjects. A minimum of two quarter hours of credit each must be completed in Contact Lenses and in Orthoptics and Vision Training, during the fourth year, as well as a minimum of one quarter hour of credit in Pathology. Additional clinic rotations may be selected from Geriatrics, Low Vision, Dermatology, Neurology, Pediatrics, Neurophysiology, or any other approved clinical area.

410 GENERAL CLINIC PRACTICE V (5 quarter hours)
One hour of lecture and four four-hour laboratories per week. A continuation of 400.

411 SPECIALTY CLINICS (2 quarter hours)
Two four-hour laboratories per week. A continuation of 401.

420 GENERAL CLINIC PRACTICE VI (6 quarter hours)
One hour of lecture and five four-hour laboratories per week. A continuation of 410.

421 SPECIALTY CLINICS (3 quarter hours)
Three four-hour laboratories per week. A continuation of 411.

430 GENERAL CLINIC PRACTICE VII (5 quarter hours)
† One hour of lecture and four four-hour laboratories per week. A continuation of 420.

* 431 SPECIALTY CLINICS (2 quarter hours)
Two four-hour laboratories per week. A continuation of 421.

FOURTH-YEAR EXTERNSHIPS. The externship program is designed for fourth-year clinicians in optometry to broaden and supplement their experience in evaluating, diagnosing, and treating conditions of the eye and visual system. Externships are five weeks in duration, and they may be scheduled during any of the four quarters of the fourth professional year. Fourth-year students are required to take at least one externship prior to graduation. A student who is unable to participate in an assigned externship for exceptional reasons must consult with the Dean of Faculty.

It is permissible for a fourth-year student to participate in more than one externship, or in an externship of longer than five weeks in duration. No more than one quarter may be spent in any one location.

The externship program provides a wide range of geographical locations in hospital, private clinic, and private practice settings. In all cases the extern serves under the direct supervision of optometric, osteopathic, or medical physicians who hold at least temporary appointments to the adjunct faculty of the College.

Eligibility requirements for externship participation are as follows:

1. The student must be in good standing (i.e., not subject to termination for disciplinary reasons); and
2. Not on probation (either academic or disciplinary); and
3. Be a regular student (i.e., pursuing a course of study leading to certification or to a degree offered by the College); and
4. Must have satisfactorily completed all courses in the O.D. degree curriculum through the spring quarter of the third year; and
5. Must have passed clinical competency evaluation.

EXTERNAL STUDIES PROGRAM COURSES

133E VEGETATIVE PHYSIOLOGY: OCULAR BIOCHEMISTRY (3 quarter hours)
Three hours of lecture per week. Analysis of the intraocular fluids, aqueous chemistry and flow; secretory mechanism, intraocular pressure; vitreous structure and protein; lens and its function related to its composition. Lens proteins, metabolism cataract. The cornea and sclera; neurological aspects of sensation; metabolism, nutrition and growth processes; retinal metabolism, glycolysis.

316E GENERAL PHARMACOLOGY (3 quarter hours)
Three hours of lecture per week. A comprehensive course covering contemporary therapeutic principles and agents. Included are origins, chemical nature, mechanism of actions and interactions, major effects, and absorption and fate of the most commonly used drugs.

326E OCULAR PHARMACOLOGY (3 quarter hours)
Three hours of lecture per week. A course covering basic concepts of current ocular pathological problems. Included are consideration of local and systemic treatment of ocular pathologies, use of diagnostic agents, and ocular side effects of non-ocular drugs.

336E CLINICAL PHARMACOLOGY (3 quarter hours)
Two hours lecture and one two-hour laboratory per week. An advanced course designed to integrate the student's knowledge of pathology and

UNIVERSITY OF MINNESOTA

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Medical School

UNIVERSITY OF MINNESOTA

Medical Student Government and Student Societies

The Medical Student Council, the student governing body, is composed of representatives from each class and from several minority groups that are elected each year. Council members meet regularly and frequently to discuss problems common to the student body and to plan a variety of projects and service activities. The council represents the interests of the medical students to the administration and the faculty. The medical students, through the council, have adopted an honor code covering examination procedures. Upon admission to the Medical School, each student, after suitable briefing, signs a statement indicating that he or she is well acquainted with the provisions of this code and agrees to abide by it. The Ethics Committee of the Medical Student Council is responsible for investigating reports of any suspected violations of this code.

There are several medical fraternities available for men and one medical sorority available for women. These organizations play a major role in the social life of many medical students.

The national medical scholastic society, Alpha Omega Alpha, selects academically high-ranking students from the junior and senior classes for election to membership. The James Moore Society is composed of 25 students elected by the membership on the basis of research interest and achievement. The group meets monthly at the home of one of several faculty members for discussions of medical subjects and other topics of current interest. The Cyrus P. Barnum, Jr., Society, an organization of students working toward the combined M.D.-Ph.D. degree, meets regularly for scientific and informative evening discussions to which speakers are invited.

The American Medical Student Association (AMSA), an integral part of the Medical Student Council, is incorporated as one of the major activities of the council. The association chairperson acts as local AMSA chapter president. This group sponsors certain school-wide functions through the student council. The membership fee is nominal, and members receive monthly copies of the national periodical.

The wives of many medical students are active in the Women's Auxiliary of the Student American Medical Association (WA-SAMA). This group holds monthly meetings featuring speakers who discuss topics of interest.

IV. M.D. PROGRAM

The Medical School provides the faculty and facilities for instruction of students in the course in medicine. The primary goal of medical education is to produce good physicians possessing sound training in quantitative human biology. Beyond the Medical School and the award of the M.D. degree, all graduates are obliged, by requirements for specialization and/or licensure, to undertake additional formal education or training. And beyond these formal programs are the continuing education activities that individuals in practice must demand of themselves. Much of the success of the sequence of undergraduate-graduate-continuing education, called the continuum of medical education, is dependent on individual responsibility and initiative. Therefore, to encourage such development in medical students, the concept of the student as learner is emphasized in the curriculum.

The course of study for the M.D. degree consists of a core program of 8 academic quarters and a track (option, elective) program of 5 academic quarters. Within the core program, the first 4 quarters, termed Phase A, include course work in basic medical sciences, behavioral science, and introductory experiences with patients. The next 4 academic quarters of the core program, termed Phase B, consist of integrated interdepartmental courses organized and taught along organ, system, and topical lines. In the Phase D portion of the curriculum students, with the help of an adviser, plan a program of elective courses. All students must include in this program experience in both medicine and surgery that will be suitable preparation for advanced clinical responsibilities in subsequent training after completion of work for the M.D. degree. Students making satisfactory progress may, after adviser, track, and special committee review, be approved to complete Phase D in less than 5 academic quarters (minimum 3 quarters of study) providing they make arrangement for a first year of graduate study in a teaching hospital. Alternatively, students may complete Medical School in 5 quarters in Phase D with no restriction or requirement as to type of graduate program activity. Students are required to take and pass parts I and II of the National Board Examinations as a requirement for graduation and the M.D. degree.

Phase A

In the first 4 quarters of the Medical School program, studies cover the structure and function of the human organism and the emotional, social and psychological development of the individual. In Phase A, the student begins clinical activities through tutorial assignments and clinical correlation sessions in Introduction to Clinical Medicine. The Phase A program is intended to involve the student physician in individual synthesis and correlation of the basic sciences with clinical applications and in direct, personal confrontation with human illness and patient care. The required program in Phase A consists of the following courses:

Fall Quarter and Winter Quarter (A-1 and A-2)

- Gross Anatomy (Anat 5100-5101)
- Human Histology (Anat 5103-5104)
- Embryology (Anat 5106-5107)
- Medical Biochemistry (MdBc 5100-5101)
- Introduction to Clinical Medicine (InMd 5100-5101)
- Behavioral Science (AdPy 5107-5108)

Spring Quarter and Summer Quarter (A-3 and A-4)

- Medical Physiology (Phsl 5110-5111)
- Pathology (Path 5101)
- Neuroanatomy (Anat 5111)

Introduction to Clinical Medicine (InMd 5002-5003)
Microbiology (MicB 5205-5206)
Pharmacology (Phcl 5110-5111) 8 cr. See p 56

In both fall and winter quarters, students may elect to attend one of several weekly small group meetings at which topics of personal concern, current interest, or medical importance are brought up for discussion.

Phase B

The 4-quarter sequence of Phase B begins in the fall and consists of integrated, interdepartmental courses designed to highlight fundamental principles in clinical medicine and to emphasize pathophysiologic concepts. The courses are organized in relation to organs, systems, or topics. Two courses in the Phase B sequence, Student as Physician and Human Behavior, are designed, respectively, to increase the student's clinical skills and knowledge and to enhance the student's awareness of psychopathology and psychological factors related to illness.

Core activities in some courses consist of small group discussions, with lectures and other formal presentations optional. Extensive syllabi and reference lists are provided for each student. The student is encouraged to exercise independent and mature judgment in the learning process by arranging her or his own activities. The student may utilize this time for study in the Learning Center, participation in additional clinical experiences, or completion of elective courses available to students in Phase B. The formal Medical School activities in Phase B are divided into three categories:

1. Core Time—Lectures or small group discussions related to a specific organ, system, or topic, and weekly clinical tutorials. Attendance is expected.
2. Optional Activities—Supplementary scheduled activities, such as lectures that expand material offered in the core or, in some cases where lectures are optional, films, additional clinical experiences, laboratories, demonstrations, clinical rounds, teaching rounds, or clinical-pathological conferences. Attendance is voluntary.
3. Electives—Courses offered throughout the year covering various topics of interest to medical students but not necessarily related to the core program.

The required program in Phase B consists of the following courses:

REQUIRED PHASE B COURSES

InMd 5110—Medical Genetics	2 cr
InMd 5220—Cardiovascular	3 cr
InMd 5221—Respiratory	3 cr
InMd 5228—Ear, Nose, and Throat	2 cr
InMd 5212—Human Behavior	5 cr
InMd 5231—Gut	4 cr
InMd 5234—Biometry and Epidemiology	1 cr
InMd 5226—Blood	3 cr
InMd 5222—Fluid and Electrolytes	3 cr
InMd 5223—Kidney and Urinary Tract	3 cr
InMd 5230—Nervous System and Muscle Disorders	5 cr
InMd 5232—Bones, Joints, and Connective Tissue	4 cr
InMd 5224—Endocrine and Metabolism	4 cr
InMd 5225—Reproduction	4 cr
InMd 5227—Skin	2 cr

InMd 5229 Eye 2 cr
InMd 5233 Human Sexuality 3 cr

Student as Physician Tutorials

Medicine Tutorial	Cr ar
Pediatrics Tutorial	Cr ar
Obstetrics-Gynecology Tutorial	Cr ar
Psychiatry Tutorial	Cr ar
Surgery Tutorial	Cr ar
Family Practice and Community Health	Cr ar
Physical Medicine and Rehabilitation	Cr ar
Laboratory Medicine	Cr ar

Phase D

Phase D is designed to extend the curriculum goals of relevance, flexibility, and the student as learner. Prior to completion of Phase B, students select a track and an adviser within that track for the balance of the Medical School program. Students are reminded not to confuse the selection of a track at this point with their eventual need to choose a practice specialty. The six broadly defined career pathways or tracks, encompassing all disciplines and providing varied options for all students, are the following:

Track 1—Medicine, Pediatrics, Medical Specialties including Obstetrics
Track 2—Surgical Specialties
Track 3—Psychiatry and Behavioral Sciences
Track 4—Neurological Sciences
Track 5—Family Practice
Track 6—Medical Investigation and Special Programs

The student, with the help of an adviser, develops an individualized elective program of study related to personal interests and career goals. Each student's program is approved and progress monitored by the appropriate track committee.

There are electives strongly recommended for the several tracks. In general, and as a logical extension of the core material and tutorial format in Phase B, each student is advised to spend 12 to 18 weeks in externship-type electives such as those offered in medicine, neurology, obstetrics, pediatrics, psychiatry, and surgery. The balance of the individual program is drawn from the extensive elective courses offered by each Medical School department. Students may consider elective work in other medical schools, in the United States or elsewhere. Up to 1 quarter of credit for such activities may be approved by the adviser and track committee. The flexibility of the elective program and the general nature of the pathways provide an opportunity for creative and interested students to avail themselves of the widest possible spectrum of educational activities to further their professional growth.

Students are eligible to begin Phase D on completion of Phases A and B and after taking part I of the national boards. Students with deficiencies in Phase A or B or who have taken but not passed part I are reviewed by the Scholastic Standing Committee for a decision as to arrangement of their continuing academic program. The content of Phase D, approved by the adviser and Phase D track committee, is determined by a review of each student's educational needs in light of his or her projected career goals. There are no restrictions on the type of internship or first-year training program for students graduating in 4 years. In the standard 13-quarter curriculum, in the case of 3-quarter programs, students must provide evidence that they will spend their first postdoctoral year (internship or first year of graduate training) in a university or other major affiliated teaching hospital.

Lydia Nerbergs, M.D.
Thomas O'Hare, M.D.
Richard T. Olson, M.D.
Charles Ostrow, M.D.
Rene Pelletier, M.D.
Charles Roach, M.D.
Robert Sigelman, M.D.
James Standafer, M.D.
Alfred Steidl, M.D.
Richard Student, M.D.
Byron Teska, M.D.
James Thompson, M.D.
Jon Tierney, M.D.
Elliot Troup, M.D.
Paul Wicklund, M.D.

Clinical Instructor

Peter Arny, M.D.
Judith Bennington, M.D.
John E. Bergstedt, M.D.
Herbert Billman, M.D.
Dwayne Bron
Christopher Brown, M.D.
Emmett Carpel, M.D.
Richard Carroll, M.D.
David Chirek, M.D.
Raymond Croissant, M.D.
Mickie Haddad, M.D.
David Hendrickson, M.D.
Donald Herrick, M.D.
George O. Hilgerman, M.D.
Herbert T. Hobday, M.D.
Douglas Holmen, M.D.
James Householder, M.D.
Martin Kaplan, M.D.
Aaron Nathanson, M.D.
Mark Norman, M.D.
Robert Ostrow, M.D.
Jerome Poland, M.D.
Thomas Purcell, M.D.
Wesley Sondreal, M.D.
Robert Warshawsky, M.D.

ELECTIVE COURSES

5180. EXTERNSHIP IN OPHTHALMOLOGY. (Cr ar; prereq regis med)

5190. OPHTHALMOLOGY RESEARCH PROBLEMS. (Cr ar; prereq regis med)

ADVANCED CREDIT COURSES

8101. CLINICAL OPHTHALMOLOGY
8102. EXTERNAL DISEASES
8103. MEDICAL OPHTHALMOLOGY
8104. RADIOLOGY OF THE EYE, ORBIT, AND HEAD
8105. MOTILITY
8106. STRABISMUS MANAGEMENT
8107. OCULAR ANATOMY
8121. REFRACTION
8122. PHYSIOLOGIC OPTICS
8131. PRACTICAL OCULAR SURGERY
8132. DIDACTIC OCULAR SURGERY
8141. OCULAR PATHOLOGY CONFERENCE
8142. OPHTHALMIC PATHOLOGY LABORATORY
8143. PATHOLOGY OF THE EYE
8151. BASIC AND APPLIED OPHTHALMOLOGY
8152. OPHTHALMOLOGY LABORATORY
8153. RESEARCH IN OPHTHALMOLOGY
8154. SEMINAR IN OPHTHALMOLOGY
8155. SPECIAL TOPICS IN OPHTHALMOLOGY
8701. NEUROOPHTHALMOLOGY

Medical student may take any or none of these courses

Orthopaedic Surgery (OrSu)

Roby C. Thompson, Jr., M.D., professor and head

Professor

David S. Bradford, M.D.
Robert B. Winter, M.D.

Clinical Professor

Ramon B. Gustilo, M.D.
Harry B. Hall, M.D.
Sheldon M. Lagaard, M.D.

Associate Professor

Thomas H. Comfort, M.D.
James H. House, M.D., M.S.
Robert F. Premer, M.D.

Clinical Associate Professor

Robert M. Barnett, M.D.
Lester W. Carlander, M.D.
Frederick D. Drill, M.D.
Arnold L. Hamel, M.D.
Walter Indock, M.D.
Richard H. Jones, M.D.
Lowell Kleven, M.D.
Lowell Lutter, M.D.
Harvey E. O'Phelan, M.D.
Wayne W. Thompson, M.D.

Assistant Professor

Alfred F. Behrens, M.D.
John E. Lonstein, M.D.
Jack K. Mayfield, M.D.
Theodore R. Oegema, Jr., Ph.D.

Clinical Assistant Professor

Richard J. Aadalen, M.D.
Gordon Aamoth, M.D.
Paul Arneson, M.D.
Frank S. Bibb, M.D., M.S.
Vincent E. Eilers, M.D.
David W. Florence, M.D.
Daniel Gailhore, M.D.
John A. Hartwig, M.D.
Edward H. Kelly, M.D.
Charles C. Lai, M.D.
Donald R. Lennin, M.D., M.S.
Lloyd Leider, M.D.
Edward McEllistrem, M.D.
John E. McMahon, M.D.
Joseph M. Tamborrino, M.D.

Instructor

Khalid B. Ahmed, M.D.
John H. Scarpino, M.D.

Clinical Instructor

John J. Beer, M.D.
Roland Birsebak, M.D.
Joseph Bocklage, M.D.
Charles J. Cooley, M.D.
Michael W. Davis, M.D.
Leo DeSouza, M.D.
Richard B. Edwards, M.D.
Philip Haley, M.D.
James E. Johanson, M.D.
Richard J. Johnson, M.D.
Stephen Kusiach, M.D.
John Larkin, M.D.
Dick R. Lavender, M.D.
Thomas Lyman, M.D.
Donald Madsen, M.D.
James D. Pugh, M.D.
Jerry Reese, M.D.
George E. Ressler, M.D.
Richard Stimmel, M.D.
Ivan Scholl, M.D.
Peter Strand, M.D.
Warren S. Strehlow, M.D.
Francis J. Trost, M.D.
John Wilson, M.D.

The major goals of the orthopedic surgery courses are to provide the medical student with the foundation necessary for performing a basic neuromusculoskeletal examination of the patient, for correlating the clinical expressions of disease with basic science knowledge, and for recognizing those patient problems that require immediate appraisal and resolution. In a number of clinical electives the student experience has the option of participating in the diagnostic and therapeutic management of patients with orthopedic and traumatic disabilities; this advanced experience provides an understanding of fundamental orthopedic principles, the scope of orthopedic surgery, and the opportunities for both clinical and basic investigation in orthopedic surgery.

ELECTIVE COURSES

5180. ORTHOPEDICS I. (Cr ar; prereq regis med)

5185. ORTHOPEDICS II—EXTERNSHIP IN ORTHOPEDIC SURGERY. (Cr ar; prereq regis med)

5186. RESEARCH PROBLEMS IN ORTHOPEDIC SURGERY. (Cr ar; prereq regis med)

5187. EXTERNSHIP IN ORTHOPEDIC SURGERY AND FRACTURES—St. Paul-Ramsey Hospital. (Cr ar; prereq regis med)

5188. EXTERNSHIP IN ORTHOPEDIC SURGERY AND FRACTURES—Gillette State Hospital, St. Paul. (Cr ar; prereq regis med)

5189. EXTERNSHIP IN ORTHOPEDIC SURGERY AND FRACTURES—Fairview-St. Mary's Hospitals. (Cr ar; prereq regis med)

5190. EXTERNSHIP IN ORTHOPEDIC SURGERY AND FRACTURES—Veterans Hospital. (Cr ar; prereq regis med)

5191. ORTHOPEDIC EXTERNSHIP AT HENNEPIN COUNTY GENERAL HOSPITAL. (Cr ar; prereq regis med)

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

HESS

January 29, 1984

The Honorable Mae Tischer
Chairman, Health, Education and
Social Services Committee
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Tischer:

The attached draft committee substitute for HB 225 incorporates the following changes requested by your committee:

1. Specific exclusion of controlled substances and surgery (Sections 4 and 5)

2. Listing of categories of drugs that will be permitted (Sec. 1)

3. Specific requirements for certification, with mandated continuing education after certification (Section 1)

Previous versions of the bill had changes in AS 08.64 (medical practice act) that appear no longer necessary, since the 1983 revision of the medical practice act adds language (AS 08.64.170(a)(4)) stating that "A person who is licensed or authorized under another chapter of this title may engage in a practice that is authorized under that chapter."

In Section 1, we have added the further limitation that drugs be topically applied only. (In North Carolina and Florida, optometrists can use systemic drugs. The topical limitation will effectively restrict Alaskan optometrists to mild cases of anterior eye pathology.)

In Section 2, we have revised AS 08.72.240(9) (Grounds for imposition of disciplinary sanctions) to make it consistent with the intent of the bill.

Section 3 adds non-compliance with certification provisions as grounds for disciplinary sanctions.

The attached article from the Journal of Medical Education shows the contrast between the median 15 hours of eye medicine received by general physicians (who can and do use these drugs) and the 200 hours required of optometrists under this draft substitute. This understates the comparison, for the 200 hours does not include the detailed courses in ocular anatomy, physiology and pathology which form a portion of the basic medical science training received by the optometrist.

Please let me know if we can provide further information.

Very truly yours,

Phillip W. Bach

Phillip W. Bach, O.D., Ph.D.
FOR THE LEGISLATIVE COMMITTEE
ALASKA OPTOMETRIC ASSOCIATION

PWB/lr

2 Attach

Original sponsors: Hurlbert and Martin

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR HOUSE BILL NO. 225 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTEENTH LEGISLATURE - SECOND SESSION

A BILL

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

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

* Section 1. AS 08.72 is amended by adding a new section to read:

Sec. 08.72.277. USE OR PRESCRIPTION OF LEGEND DRUGS. (a) A licensee may not use, dispense or prescribe legend drugs under this chapter without a license endorsement issued by the board, certifying his competance to use such drugs.

(b) A licensee may not use, dispense or prescribe any drug identified by the United States Drug Enforcement Administration as a controlled substance.

(c) A licensee may not use, dispense or prescribe a legend drug that is not prepared and marketed for topical application to the human eye or eyelid. Topical drugs which may be used under this section shall be limited to the following categories:

(1) Anesthetics;

(2) Antihistamines;

(3) Anti-infectives

(4) Anti-glaucoma agents;

(5) Antivirals;

(6) Corticosteroids;

(7) Cycloplegics;

(8) Decongestants;

(9) Hyperosmotics;

(10) Mydriatics.

(d) An applicant for certification under (a) of this section shall furnish transcript credits or other evidence, acceptable to the board, showing that he has completed not less than 200 hours of didactic instruction, practical training and supervised experience devoted exclusively to the subjects specified in (1) - (3) of this subsection, given by an accredited school or college of optometry or medicine, and indicating that he has passed written and practical examinations in these subjects. The subjects are

(1) general and ocular pharmacology;

(2) review of ocular pathology and differential diagnosis;

(3) treatment of pathology of the eye and its adnexa, including the use of legend drugs.

(e) An endorsement issued under (a) of this section shall expire with the license to which it attaches and may be renewed upon evidence of satisfactory completion of continuing education specified by regulation of the board for holders of such an endorsement.

* Sec. 2. AS 08.72.240(9) is amended to read:

(9) failed to refer a patient to the appropriate health care practitioner [AFTER ASCERTAINING THE POSSIBLE PRESENCE OF OCULAR DISEASE.] <u>for conditions beyond the scope of his training;</u>

* Sec. 3. AS 08.72.240 is amended by adding a new paragraph to read:

(10) used, dispensed or prescribed a legend drug except as provided under AS 08.72.277.

* Sec. 4. AS 08.72.300(2) is amended to read:

(2) "optometry" is the examination [, OTHER THAN BY THE USE OF DRUGS,] 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 diagnosis and treatment, including the use of drugs but excluding the use of surgery, of inflammations, infections and injuries of the eyes and eyelids; [,] or the prescription or application of lenses, prisms or ocular exercises for the correction or relief of the human eye;

* Sec. 5. AS 08.72.300(3) is amended to read:

(3) "practicing optometry" is an examination [, OTHER THAN BY THE USE OF DRUGS,] 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 diagnosis and treatment, including the use of

drugs but excluding the use of surgery, of inflammations, infections and injuries of the eyes and eyelids; [,] or the prescription or application of lenses, prisms or ocular exercises for the correction or relief of the human eye; [,] or the holding of oneself out as being able to do so;

* Sec. 6. AS 08.72.300 is amended by adding a new paragraph to read:

(7) "legend drugs" means drugs whose containers must bear a label prohibiting dispensing without a prescription.

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 arenas (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

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Dr. Kalina is professor and chairman, Department of Ophthalmology, University of Washington School of Medicine, Seattle. Dr. Van Dyk is professor, Department of Ophthalmology, Louisiana State University School of Medicine, New Orleans. Dr. Weinstein is professor and chairman, Department of Ophthalmology, West Virginia University School of Medicine, Morgantown.

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 20 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 and as a supplement to lectures. The microfiche illustrations, newly added in the third edition (1978), had been found useful by students in 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

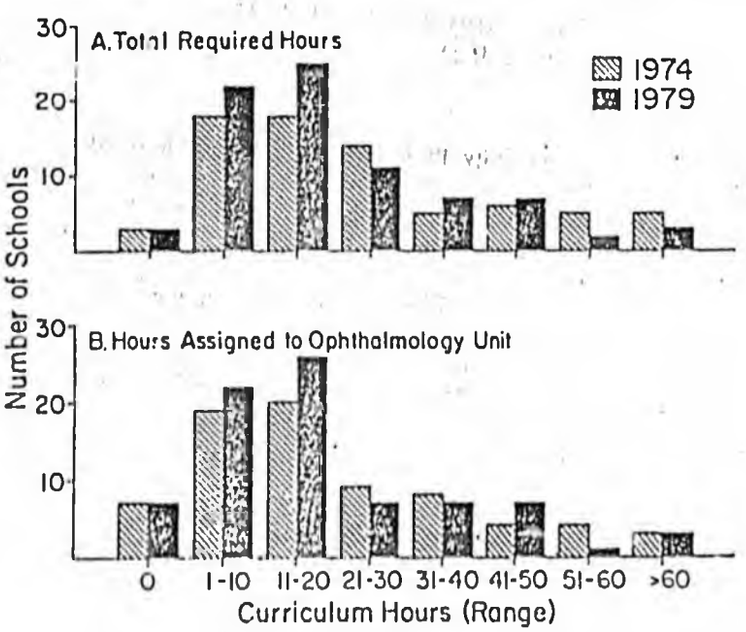

FIGURE 1
Minimum requirements for ophthalmology in U.S. medical schools.

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 duced 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.

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By: Fred S. Berlin, M.D., Ph.D.
Assistant Professor
The Johns Hopkins University
School of Medicine
4-181 Meyer Building
The Johns Hopkins Hospital
Baltimore, Maryland 21205

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People do not decide voluntarily what will arouse them sexually. Rather, in maturing, they discover the nature of their own sexual orientation and interests. Persons differ from one another in terms of a) the types of partners whom they find to be erotically appealing and b) the types of behaviors that they find to be erotically appealing. They also differ in intensity of sexual drive, the degree of difficulty that they experience in trying to resist sexual temptations, and in their attitudes about whether or not such temptations should be resisted.

When persons experience strong erotic desires to engage in types of sexual behaviors that could cause themselves or others harm (eg; sadistic, coercive or masochistic sexual involvements), or when they experience strong erotic attractions toward unacceptable sexual partners (eg; children), psychiatric help may become a consideration. This is particularly so when a person reports an inability to successfully resist sexual temptations through "will power" alone, even though in terms of conscience and intellect he may want to resist, and in addition may have been trying very hard to do so.

Some psychiatric diagnoses can be made then, simply by asking cooperative persons about the range of behaviors that they find to be erotically appealing, and about the difficulty they experience in trying to resist succumbing to such sexual temptations. This line of questioning can identify persons who meet the DSM-III diagnostic criteria for sexual exhibitionism, sexual sadism, sexual masochism, transvestism, and compulsive voyeurism.[1] Each of these represents an unconventional form of sexual appetite. Such questioning can also identify the compulsive paraphilic rapist. These men, unlike the average man, often experience great difficulty resisting erotic temptations to repeatedly expose themselves, to repeatedly have themselves beaten, to repeatedly peep in windows, or to repeatedly rape, depending upon the nature of their particular sexual compulsion. Masturbation cannot fully satisfy these cravings because what they crave is not just sexual release, but a specific type of sexual activity.

Another way in which sexual problems, possibly requiring psychiatric assistance, can be identified is by inquiring about the types of sexual partners that a person finds to be erotically appealing, and about how difficult it is to resist the temptation to become involved sexually with such partners. Some men, for example, report that they are attracted sexually to both children and adults, but that when they have a satisfying adult relationship they are able to resist the temptation of becoming sexually intimate with a child. Some such men, however, during periods of time in their lives when they do not have a satisfying adult relationship, do become involved sexually with children. Nicholas Groth has referred to men who find both adults and children to be erotically appealing as regressed pedophiles.[2] There are other men who experience absolutely no erotic attraction whatsoever towards adults, but who have a great deal of difficulty resisting the sexual temptations that they experience towards children. Nicholas Groth has referred to these men as fixed pedophiles. Some men who experience pedophilic desires report feeling sexually driven to repeatedly seek out intimate relationships with children whereas others

seem most vulnerable primarily in situations where a child is already easily and readily available.

Pedophilia, then, is simply a term used to indicate that an adult finds children to be sexually appealing. This condition, for unknown reasons, seems to occur almost exclusively in men. If it is only children and not adults that a man finds to be sexually appealing then the term fixed pedophilia can be used. If a man is attracted sexually only to boys, a diagnosis of homosexual pedophilia can be made, whereas, if he is attracted only to girls a diagnosis of heterosexual pedophilia may be in order. If gender is not a factor, the appropriate diagnosis is bi-sexual pedophilia.

Some men who are attracted sexually to children desire not to be, and would like to change. Under such circumstances, their sexual attraction to children is said to be ego-dystonic. If a man's sexual attraction towards children does not conflict with his conscience and personal moral convictions, then his pedophilic desires are said to be ego-systonic. In very rare instances, some men experience erotically sadistic desires towards children. Under such circumstances a diagnosis of sexual sadism should also be made.

Following is a brief verbatim quote from a man whose sexual orientation can be characterized as fixated, ego-dystonic, homosexual pedophilic. This man was also found, on chromosomal analysis, to have Klinefelter's Syndrome. Normally persons are erotically attracted to members of the opposite sex. In Klinefelter's Syndrome, in several ways, it is unclear which sex is the opposite sex.[3] Klinefelter's patients manifest a 47 XXY chromosomal karyotype pattern. Thus, genetically, Klinefelter's patients can be thought of either as males (XY) with an extra X chromosome, or as females (XX) with an extra Y chromosome. That some patients with Klinefelter's syndrome experience ambiguity regarding sexual or gender preference at a psychological level is not incongruous with the gender ambiguity manifested at the genetic level. The comments of this homosexual pedophilic Klinefelter's patient give some sense of how tortured and conflicted he feels by the sexual lusts and cravings that he experiences towards young boys.

> "What starts a person like myself doing what I do? Why me? Why can't I be normal like everybody else? You know, did God put this as a punishment or something towards me. I am ashamed. Why can't I just go out and have a good time with girls. I feel empty when a female is present. An older "gay" person would turn me off. I have thought about suicide. I think after this long period of time I have actually seen where I have an illness. It is getting uncontrollable to the point where I can't put up with it anymore. Its a sickness, I know its a sickness, but as far as society is concerned you are a criminal and should be punished. Even if I go to jail for 12 or 15 years, or whatever, I am still going to be the same when I get out."

This last statement was not meant to be defiant.

Etiology of Pedophilic Sexual Desires

How is it that sexual orientation and interests are acquired? It appears that both life experience and constitution play a role. Many years ago, Dr. John Money reported a tragic case in which one of two genetically identical male twins was so severely damaged at the time of circumcision several months after birth that a total penectomy was required. That child was then reared as a girl. The child's chromosomal pattern, of course, remained unchanged and she has now reached her teenaged years. She has developed breasts by virtue of having been administered estrogens and surgically an artificial vagina has been created. According to Diamond, however, she nevertheless experiences considerable difficulty adjusting as a female, and she is in some ways ambivalent about her status.[4] This has led him to conclude that although social forces can indeed play some role in the development of gender identity and sexual orientation, this is so only within the very circumscribed limits set by biological heritage. Still, at age 19 this twin raised as a female apparently feels herself to be a women in terms of gender identity and also experiences at least some level of sexual attraction towards age appropriate males. Thus, although she is a woman with an XY rather than an XX chromosomal karyotype, as a consequence presumably of how she had been raised, she feels herself to be a woman and she finds men to be sexually appealing.

There are many additional examples showing that environment and life experience can play at least some role in the development of gender identity and in the development of sexual orientation and interest. Nicholas Groth and others have shown that many men who experience pedophilic erotic urges as adults were themselves sexually involved with adults when they were children.[2] Why sexual involvements with an adult during childhood seems to put one at risk of experiencing pedophilic sexual urges later on in life is unknown.

Biology, too, can play a role in the development of sexual orientation and interest. In most species of birds, for example, only the male sings. Such songs are ones of courtship, apparently designed to attract females. However, if a female zebra finch is given testosterone at crucial times during early development she too will sing.[5] There are numerous other similiar examples.

In humans, sexual behavior is often a response to subjectively experienced erotic desires and fantasies. Although it appears that specific sexual tastes or preferences may sometimes be modified by virtue of early life experiences, the phenomenon of sexual desire itself is apparently unlearned and rooted deeply in biology. Males do not have to be taught, for example, how to attain an erection. Furthermore, just as is true of language and dialect, once acquired sexual desires are not readily modified. There is no reason to believe that it is any easier for the fixated homosexual pedophile to lose his interest in children and to become sexually aroused by females, than it would be for the average male to lose his interest in women and to instead begin lusting for young boys.

It is just as reasonable to ask whether one might be put at risk of developing unconventional sexual interests such as pedophilia by virtue of

the presence of certain biological abnormalities, as it is reasonable to ask whether one can be put at such risk by being exposed early on in life to certain environmental events. One way of addressing this issue would be to determine whether or not there is an increased prevalence of biological abnormalities of the sort thought to be related to human sexuality, amongst a group of men who experience unconventional sexual interests.

Table 1 shows the frequency of various sorts of biological abnormalities in a group of 41 men, all of whom met the DSM-III diagnostic criteria for some form of paraphilia, ("sexual deviation disorder").[3] The majority of these men were either pedophiles or exhibitionists. As documented in Table 1, and confirmed by statistical analysis, there does appear to be an association between certain kinds of biological abnormalities and the presence of unconventional kinds of sexual interests such as pedophilia.

Recently, as shown in Figure I, Dr. Gary Gaffney of the Johns Hopkins Hospital in a soon to be published study, documented an abnormal pattern of leutinizing hormone (LH) release over time in response to the intravenous administration of a bolus of leutinizing-hormone-releasing-factor (LHRF) in a group of pedophilic patients. The development of new technologies such as positron emission tomography may help document which areas of the brain become metabolically active during sexual arousal.[4] Such techniques may also be able to determine whether the brains of men who experience pedophilic sexual urges differ in regional metabolism from the brains of men who experience more conventional sexual attractions.

Assessing the "Sex Offender": The distinction between (1) diminished mental capacities, (2) personality traits, and (3) sexual orientation

Sexual involvements with children are against the law. Thus, a person may be defined as a "sex offender" by virtue of having behaved in a particular way. Many such men are referred for psychiatric evaluation following legal transgressions. However, a diagnosis such as pedophilia cannot be made simply by considering behavior alone. Rather, for purposes of diagnosis and for proper treatment, the physician must try to appreciate the state of mind which contributed to the individuals behavior.

Like any behavior, sexual behavior with a child can occur for a variety of reasons. For example, a person with schizophrenia may behave in a particular way in response to hallucinations "telling him to do so," whereas the alcoholic's behavior may be a reflection of diminished judgement secondary to intoxication. A mentally retarded individual may become involved sexually with a child (who incidently, may be of the same approximate mental age as he) because of the lack of availability of adult partners and the lack of capacity to fully appreciate and understand the wrongful nature of his actions. In none of these instances would a primary diagnosis of pedophilia necessarily apply.

In DSM-II, conditions such a pedophilia used to be considered sub-categories of a specific personality type (ie; the so-called antisocial personality disorder). DSM-III acknowledges that this is by no means necessarily so. Diagnosing a person as a pedophile says something about

the nature of his sexual desires. It says nothing whatsoever, however, about temperment, or about traits of character such as kindness versus cruelty, caring versus uncaring, sensitive versus insensitive, conscientious versus lacking in conscience, and so on. Thus, a diagnosis of pedophilia does not necessarily mean that a person is lacking in conscience, diminished in cognitive capabilities, or somehow "characterologically flawed." Rather, he may be a concerned person dealing less than successfully with sexual temptations of a sort which are very foreign to most men.

It is easy for a non-smoker to argue that any smoker could stop if he or she really wanted to; in the case of the pregnant smoker, if not for her own sake than surely for the sake of not damaging her unborn child. It is easy for a non-obese person to argue that successful dieting can be accomplished through will power alone. Patients on kidney dialysis made thirsty by the procedure often have great difficulty maintaining necessary fluid restrictions even though not doing so can be life threatening to them.[7] The more thirsty they are made by the procedure, the more difficulty they experience in limiting fluid intake. The researchers who documented this finding concluded that limits to fluid intake set by physicians may not suffice because they differ from those set by the patients own physiology. It is easy however, for a person who is not thirsty to argue that such patients could resist the temptation to consume excessive amounts of fluid if they really wanted to do so. Similarly, it is easy for a person who is not tempted sexually by children to argue that any pedophile could stop having sex with children if he really wanted to, and would simply make up his mind to do so. When it comes to appetites, or drives, such as hunger, thirst, pain, the need for sleep, or sex, however, biological regulatory systems may exist that can cause an individual to experience desires to satisfy those hungers in ways that cannot invariably be successfully resisted by "will-power" alone. Persons can become so discomforted by cravings related to such appetites that they feel compelled to act in ways that diminish their discomfort. Thus, in each of the above instances, professional assistance is often required.

Professional assistance may be extremely crucial in the case of the pedophile because it is imperative that he stop his prior behavioral patterns immediately, one hundred percent of the time, and forever. Though necessary, this can nevertheless be a very formidable goal to have to achieve. It is a goal made possibly even more difficult if the individual in question does not believe that sexual involvements with children are morally wrong (ie; if he finds his pedophilic desires to be ego-syntonic). It may also be more difficult to achieve, if in addition to desiring sex with children, the individual in question is one for whom the children in his life form the sole basis for love, affection, companionship, intimacy and other deeply rooted human needs.

When a person falls deeply in love with another person, be it a child or an adult, it becomes easy for that person to convince himself that the relationship is good and healthy and not harmful or wrong. One of the major issues in trying to understand human behavior relates to where the line should be drawn between considering a person to be the passive product of life experience and constitution versus considering him by virtue of his

having subjective consciousness to be an active agent capable of transcending prior determinants. Most of us feel a strong emotional bond with children. Why some men experience intense erotic feelings in the context of their otherwise healthy relationships with children, in a way that is not so for most men, and why in the absence of professional assistance it is so difficult for some such men to change is not fully understood.

Treatment of Pedophilia

Four major modalities have been proposed for the treatment of pedophilia. They are psychotherapy, behavior therapy, surgery and medication. Classical psychodynamic theory assumes that all men would ordinarily develop conventional erotic attractions towards age appropriate partners of the opposite sex, but that this does not occur in some instances because unhealthy early life experiences interfere with the normal process of psychological maturation. Therapy utilizes the process of introspection to try to figure out what went wrong, with the expectation that newly acquired insights will then facilitate the problem being rectified.

It is doubtful that persons can come to fully understand the basis of their own sexual interests through the process of introspection alone. The average man probably cannot figure out simply by thinking about it, why he prefers women rather than men. Similarly, it is not certain that the pedophile can figure out the basis of his own sexuality. Furthermore, even if he could, knowing why one is hungry, be it for food or for children, doesn't make one any less hungry. Nor does it make it any easier for one to resist the temptations experienced by virtue of one's own appetites. Finally, there is little convincing evidence showing that the traditional psychotherapies alone are an invariably effective means for treating pedophilia.

Behavior therapies tend to be less concerned with the historical anticedents of pedophilia than with the question of what can be done about it. The feature common to most behavioral approaches is an attempt to extinguish erotic feelings associated with children, while simultaneously teaching an individual to become sexually aroused by formerly non-arousing age appropriate partners. Although in laboratory situations behaviorists have shown that some pedophilic men no longer demonstrate physiological evidence of sexual arousal when looking at pictures of naked children, and that they can begin to show arousal to age appropriate stimuli, it has not been well established that such changes invariably carry over into the non-laboratory situation. Most of us can appreciate how difficult it would be to try to stop feeling the sexual attractions that we have experienced as natural throughout our lives.

Two types of surgery have been proposed as a treatment for pedophilia, (1) stereotactic neurosurgery and (2) removal of the testes. Neurosurgery for this purpose is still investigational and will not be discussed here, but its rationale has been explored in an excellent review article by Dr. Kurt Freund.[8]

Removal of the testes (castration) has been suggested as a treatment for pedophilia because the testes are the major source of testosterone production in the body. There has been much confusion about castration, a procedure which does not remove the male genitals, but which instead is simply intended to lower testosterone. Lowering testosterone is one way of lowering sexual libido. The idea of lowering testosterone in the case of the pedophile is to try to decrease the intensity of his sexual cravings for children. Some critics have argued that castrating the "sex offender" is like cutting off the hand of the thief. This is in no way so. Cutting off the penis would be analogous to cutting off the hand of the thief. Removal of the testes lowers testosterone, which in turn can lower the intensity of consciously experienced erotic desires. In human beings such desires constitute a motivating basis for sexual behavior.

Testosterone is an extremely powerful hormone. If the testes of a male fail to produce adequate amounts in early embryonic life he will be born with the external anatomical appearance of a female. Thus, testosterone causes external anatomical masculinization of the fetus and also produces certain changes in the endocrinological functioning of the male brain. The marked increase in testosterone level which occurs at the time of puberty in males is associated with the development of increased pubic and facial hair, deepening of the voice, an increase of muscle mass, and a marked increase in sexual libido.

In animals, lowering testosterone by means of removing the testes usually eventually leads to total cessation of virtually all sexual behavior, although sometimes this may take as long as two years to occur.[8] In humans, the relationship between very low testosterone levels and low sexual libido is fairly well established. This evidence comes from a variety of sources including studies on hypogonadal men, data from persons with adreno-genital disorders, studies on drugs which lower testosterone as a side effect, and from several well controlled studies looking at the effects of administering testosterone in an attempt to increase sexual libido.[9-11]

In an article entitled, "Therapeutic Sex Drive Reduction" Dr. Kurt Freund reviewed data regarding removal of the testes in humans as a method of lowering testosterone.[8] Several studies with long followup periods from a variety of European and Scandinavian countries documented that lowering testosterone in this way did indeed frequently lower both sexual libido, and subsequent frequencies of improper sexual activities. In one study in Denmark, for example, Sturup reported upon a 30 year investigation on 900 castrated "sex offenders" involving over 4,000 followup examinations documenting less than a 3% recidivism rate.[12] Ficher Van Rossum, in Holland, Kinmark and Oster in Sweden and Cornu in Switzerland reported comparable findings, as did several other investigators.[13-15] The study in Holland involved 237 men with a 1.3% recidivism rate. The Swedish studies with similarly low recidivism rates, evaluated 307 men. In the Swiss study there was a 5.8% recidivism rate among 121 men following castration contrasted with 52% recidivism in the non-castrated control group. Followups ranged from 5 to 30 years. Bremer reported a 58% recidivism rate in the 5 years prior to treatment in a group of men who showed only a 7.3% recidivism rate during the 5 years post-surgery.[16] Thus the surgical

method of lowering testosterone did seem to enable many men to better control their sexual behaviors. Furthermore, many of these men did not lose the capacity to perform sexually following castration. Perhaps this finding seems somewhat less surprising if one considers the analogy of suppressing hunger. In being less hungry a person may feel less driven to seek out food, thereby making dieting easier, but under such circumstances he would not lose the ability to eat.

Today it is no longer necessary to perform castration in order to reduce testosterone levels. Rather, this can now be done pharmacologically in a graduated way without the physical or psychological trauma of surgery. In Europe and the Scandinavian countries cyproterone acetate has been used for this purpose and there are several "blind" as well as non-blind studies supporting its effectiveness.[17,18] In the United States, since Dr. John Money first began doing so in 1967 the drug most often employed as a pharmacological method for lowering testerone has been medroxyprogesterone acetate (Depo-Provera).[19-23]

Depo-Provera can be injected intramuscularly once per week. There it binds to the muscle from which it is then gradually released over the course of several days into the blood stream. At this time the initial starting dosage used in the Hopkins clinic has been 500 mgs IM once per week of the 100 mg per cc concentration. No more than 250 cc is given into a single injection site. Major side effects have been weight gain and in some cases hypertension. The drug, which is not feminizing, may cause an increased incidence of breast cancer in female beagle dogs, and of uterine cancer in monkeys. It has been used in over 80 countries of the world as a female contraceptive; supported in its use for this purpose by the World Health Organization. No studies showing an increased risk of cancer in males (either humans or animals) have been reported.

There is no doubt that Depo-Provera consistently decreases serum testosterone levels significantly. This can be confirmed by means of a simple blood test. Lowering testosterone can in turn lower sexual libido, which in turn seems to enable some men to more appropriately control their sexual behaviors. The idea of using Depo-Provera in the case of the pedophile is to try to decrease the intensity of his sexual cravings, thereby hopefully making it easier for him to successfully resist unwanted temptations.

Most pedophiles receiving Depo-Provera also attend group counseling sessions similiar to the type often used with alcoholics. That is, men are expected to acknowledge being tempted to something that they realize they must not do. They then discuss amongst themselves strategies intended to help enable them to resist such temptations successfully (ie; whom to call, what situations to avoid, early warning signs, and so on). The medication is intended to make resisting such temptations somewhat easier.

What is not yet fully established regarding the use of Depo-Provera is optimal dosage, which of the paraphilias will respond most adequately, long term side effects, compliance rates, and precise long term recidivism percentages. There is little reason to believe, however, that recidivism rates should be any higher than those low rates documented when surgical

removal of the testes was used as a method for lowering testosterone. It is not clear why in some cases Depo-Provera fails to be of help. Like any effective medication, Depo-Provera seems to help some men, fails to help some for whom it had been considered appropriate, and for others should not even be considered appropriate in the first place.

Of over 130 men treated at Hopkins over the past year for some form of paraphilia (mostly pedophilia and exhibitionism) less than 5% have relapsed. In addition, compliance rates have been better than 90%. There has been some concern about whether Depo-Provera should be given to men who are on legal probation. If it is not an effective drug then it should not be used at all. If it is effective as it often seems to be, then it is difficult to see why a person should be denied the opportunity to take it just because he is on probation, or perhaps even incarcerated. Some incarcerated men report that Depo-Provera frees them from intrusive obsessional sexual preoccupations.

It appears then that Depo-Provera can be used to help some men help themselves. Some pedophiles report being unable to successfully resist sexual temptations through "will-power" alone even with the assistance of professional counseling. Such individuals should be afforded the opportunity to see whether or not Depo-Provera confers upon them an increased capacity for self control, thereby enabling their behavior to be more a reflection of their intellectual desires and conscience than of their lusts and passions.

Some critics have argued that psychotrophic drugs such as Depo-Provera may in some way be "mind controlling". No drugs used in psychiatry are capable of "mind control" in the sense of being able to transform a conservative into a liberal, a Democrat into a Republican, a Jewish person into a Catholic, and so on. The only medical indications for which psychotrophic drugs are used is (a) to decrease suffering (as in the case of antidepressant medications), (b) to restore function (as in the case of "antipsychotic medications"), or (c) to increase, rather than decrease, a persons capacity to successfully exercise self-control (as in the case of Depo-Provera).[24]

Pedophilia refers to a particular type of sexual orientation. By virtue of experiencing such desires, desires that many pedophiles wish they did not have, professional assistance is often needed. When such men seek help, understanding, empathy, and professional competence is required, not stigmatization or unenlightened scorn.

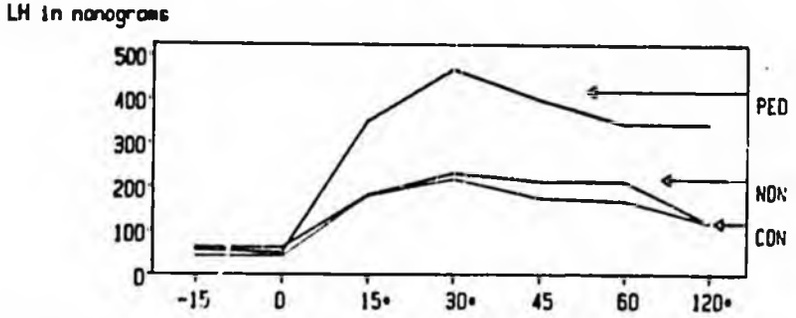
Table 1

Biological abnormalities in a group of 41 Consecutively Assessed Paraphilic Male Patients

	Abnormality	*Number of Patients Showing this type of abnormality
1.	Chromosomal Anomalies	7 (most common = XXY)
2.	Hormone Abnormalities	
	A. Testosterone	18 (4 low) (14 high)
	B. FSH	8 (high)
	C. LH	14 (2 low) (12 high)
3.	Abnormality of Brain Structure (on CT Scan)	7
4.	Abnormal Electrical Activity of Brain (on EEG)	4
5.	Abnormal Neurological Examination	5
		N = 63
6.	"NC" Abnormalities Detected (excludes dyslexia, schizophrenia, and learning disorders)	

*Some patients had more than one type of abnormality.

LH RESPONSE TO LH-RH IN PEDOPHILIA



PED: Pedophilic (7)
NON: Non-pedophilic paraphilic (5)
CON: Control (5)

100 mcg. LH-RH given at Time = 0

*p < 0.05 H-test

Figure 1. Abnormal release of leutenizing hormone (LH) over time in response to the intraveneous injection of a bolus of 100 micrograms of leutenizing hormone releasing factor (LHRF) in a group of 7 male pedophilic patients. The control groups consisted of (a) 5 men with conventional sexual interests, and (b) 5 men with unconventional sexual interests (paraphilias) other than pedophilia. LHRF was injected at time zero.

* = statistically significant at the .05 level

Ped = pedophiliacs

Non = nonpedophilic paraphilics

Con = conventional sexual interests

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Psychiatric Clinics at The Johns Hopkins Hospital

Larry E. Tune, editor

Sexual Deviation Syndromes

FRED S. BERLIN AND GENEVIEVE S. COYLE

Department of Psychiatry and Behavioral Sciences, The Johns Hopkins Hospital, Baltimore, Maryland

CASE PRESENTATION (VOYEURISM)*

The patient, a white man in his early forties, entered hospital in the fall of 1980 to begin treatment for voyeurism. Although he had experienced the urge to spy upon naked or partially clad women as early as age 6, it was not until his late teens that this interest became a consuming preoccupation. Since his late teens, he had spent as many as five or six evenings a week "peeping" through windows at women disrobing, usually masturbating himself while doing so. Never desiring further contact with any of them, he never attempted entry into a home, nor had he wished to be observed while watching.

The patient found voyeurism more erotically arousing than sexual intercourse with a consenting partner. Voyeuristic urges were with him much of the time, and he reported frequently having to make an effort to inhibit erection when in the presence of an attractive female.

Voyeurism, usually performed alone, but occasionally with a group of other men, caused him numerous problems over the years. While in college, the amount of time consumed "peeping" caused decreased academic performance, and similar activities during his second term in the Navy led to a less than honorable discharge.

His first wife committed suicide, possibly in part as a response to discovery of his sexual predilections. His second wife obtained a legal separation after discovering that he had been masturbating while watching his daughter sleeping, a behavior that troubled him a great deal afterwards, once his sexual desires had been relieved by orgasm. Although arrested twice for voyeurism, once in 1967 and again in 1976, he had never broken the law in any other way; he is responsibly employed; and he is otherwise a pleasant and conscientious person. A devout man of above average intelligence, he had often prayed for "divine inspiration to help solve his problem." In spite of compulsory court-ordered psychotherapy following each of his arrests, he continued experiencing voyeuristic urges until hospitalization. Upset about the recent separation from his wife, the patient had referred himself for hospitalization. He had not been apprehended recently and was facing no legal charges at the time of admission.

Family history was unremarkable except that his father was 69 years old when the patient was born, and during childhood the patient had been separated from his mother for five years after she contracted tuberculosis. Physical examination was essentially normal, but his luteinizing hormone (LH) level was 98 ng/ml (normal, 36–64).

While still hospitalized the patient began treatment with weekly intramuscular injections of 500 mg of medroxyprogesterone acetate, which suppressed his serum testosterone to below normal levels. For the last seven months he has continued weekly injections on an outpatient basis. Since the third week of treatment he has been reporting relief from incessant voyeuristic urges and thoughts, along with cessation of related behaviors. He and his wife have reunited, and he has been speaking to church groups and other interested organizations about his apparent success in treatment.

* Case discussed at Psychiatric Grand Rounds, February 2, 1981.

Reprint requests to Dr. Fred S. Berlin, Phipps 235A, The Johns Hopkins Medical Institutions, Baltimore, Maryland 21205

DISCUSSION

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM III), voyeurism involves the repetitive seeking out of situations in which an individual observes unsuspecting women who are either naked, in the act of disrobing, or engaging in sexual activity (1). The act of looking ("peeping") is accompanied by sexual excitement, frequently with orgasm, usually produced concurrently by masturbation, or later in response to the memory of what was witnessed. Further sexual contact does not occur, with the memory or act of looking, rather than intercourse, constituting the final basis for sexual gratification.

Approximately 25% of known voyeurs are married, dramatizing the desire of these men to spy upon women who do not know they are being observed. Although voyeuristic behavior usually begins around puberty, related fantasies may be experienced much earlier. Untreated, the behavior is ordinarily chronic, which is not surprising since it is sexually motivated, and the sex drive does not cease. Factors predisposing to development of voyeurism are unknown, with associated complications usually resulting from discovery or arrest. The prevalence of voyeurism in the general population has not been ascertained, but thus far it has been reported only in men. Visual stimulation can be an integral part of conventional sexual activity, but in those instances optimal sexual arousal does not require that the observed partner be unsuspecting, nor is observing the final desired act.

Rationale for Treatment

Voyeurism is classified as one of the paraphilias (sexual deviation disorders). Other paraphilias include pedophilia (sexual craving for children), exhibitionism, transvestism (cross dressing for erotic pleasure), zoophilia (sexual attraction towards animals), erotic masochism, and raptophilia (paraphilic, or compulsive, rape). Behaviors engaged in by persons manifesting one of these syndromes can bring them into conflict with the law, raising the issue of whether punishment or treatment is more appropriate. In considering the possibility of treatment one must try to determine whether the behavior in question was an expression of a recognizable and treatable psychiatric syndrome (2). Not all sex offenses (a legal term) are committed by persons manifesting a sexual deviation disorder, or paraphilia (a medical term). Sex offenses can be committed for a variety of reasons depending upon the state of mind that led the offender to act.

Some sex offenders may be treatable even when their behavior is not the manifestation of a sexual deviation disorder, but rather the reflection of another psychiatric condition. For example, rape could be perpetrated by a deluded person out of touch with reality, responding to the auditory hallucinations of schizophrenia. In this case, phenothiazine medication might be helpful, whereas lithium carbonate might aid the person responding in a sexually inappropriate manner to the heightened erotic appetite of mania. Treatment with antabuse and counseling might benefit the alcoholic who becomes sexually disinhibited when intoxicated, and education might be useful to the mentally retarded individual who must learn to express his sexual urges appropriately.

In contrast to the examples just cited, some sexual offenses are enacted as a response to intense and persistent unconventional sexual cravings, that is, secondary to a sexual deviation disorder. Most men with conventional heterosexual interests have no desire for erotic intimacy with a seven-year-old boy (as does the homosexual pedophile), or to expose themselves repeatedly on a street corner (as does the exhibitionist). In addition, few men experience an overwhelming desire to peek in windows—a desire sufficiently intense to lead to repeated risk to job, reputation, family, and possibly encarceration. Thus, the belief that exhibitionists, paraphilic rapists, pedophiles, or voyeurs are simply "normal, self-indulgent men" with conventional sexual interests, men who are merely misbehaving (requiring punishment rather than treatment) seems incorrect, as well as rehabilitatively ineffectual.

Diagnosis

Diagnosis of a sexual deviation syndrome can be made by examining a person's thoughts, feelings, and behavior. Persons with sexual deviation syndromes such as pedophilia or voyeurism experience repeated persistent fantasies about unconventional sexual activities. The homosexual pedophile (often impotent with women), repeatedly fantasizes about young boys, whereas the voyeur is preoccupied with thoughts of "peeping." Asking an individual about his masturbatory fantasies can give a clue regarding his sexual interests, because erotic arousal and erection for the purpose of masturbation may be difficult in the absence of sexually stimulating mental imagery.

Accompanying the unconventional sexual fantasies experienced by persons with sexual deviations are intense erotic cravings. These cravings lead to a discomforting feeling when frustrated; a discomfort which can be relieved temporarily if deviant fantasies are enacted. Thus, the temptation to act can become difficult to resist. If a person experiences a strong desire to engage in illegal sexual involvements, there is considerable risk he may get into trouble repeatedly because his unconventional sexual drive keeps reoccurring. The paraphilic rapist who craves coercive sexual activities may repeatedly rape in spite of incarceration because punishment does little to reduce his intense unconventional sexual drive. Although many men can become sexually aroused by descriptions or scenes of coercive sexual acts, most do not have the constant ruminations that characterize a craving, and most do not have to resist repeatedly the temptation to rape in order to stay out of trouble. Groth reported that although about 25% of child molesters re-

ferred to his clinic were "first offenders" according to the law, first conviction rarely constituted the first such incident in the offender's life (3).

Rape, sexual involvement with children, public exposure of genitals, and "peeping" are behaviors, and in and of themselves do not allow one to make the diagnosis of a sexual deviation syndrome. Men with conventional sexual desires, for instance, may occasionally look through a window at a partially clad woman; an occasional incident of this sort does not make one a voyeur. However, when such behaviors are a reflection of ongoing sexual preoccupations and cravings to act repeatedly in those ways, a diagnosis of paraphilia can be made. Karl Jaspers described deviant sexual cravings as intolerable states, similar to addictions, that demand action in order to be alleviated (4).

Individual paraphilic syndromes tend to be relatively stable, just as is conventional heterosexuality. Voyeurs do not become transformed into pedophiles, transvestites or exhibitionists. Sexual behavior seems to be a relatively stereotyped response to one's erotic interests, and these appear to be relatively stable throughout an individual's adulthood.

Types of Treatment

Conventional heterosexuality can be conceptualized as a syndrome, comprising erotic thoughts, feelings, and associated behaviors, just as is exhibitionism or voyeurism. Thus, use of the term "treatment" involves making a value judgment. Some (e.g., NAMBLR—The National Association for Man-Boy Love Relationships) have argued that sexual involvement with children causes no harm, and should not be considered sick or bad. Most persons in our culture disagree. Those who do use the term "treatment" feel that it should become a consideration when one's sexual behaviors compromise the rights of well-being of others. Four general types of treatment have been proposed: psychotherapy, behavior therapy, surgery and medication.

Psychodynamic therapies usually assume that sexually deviant behaviors are the result of unconscious conflicts, and that "uncovering" these conflicts allows a person to better understand himself. However, it seems doubtful whether persons can really come to fully understand the basis of their own sexual interests. Eicher, for example, discovered that feelings of gender identity may be related to the presence or absence of H-Y antigen (5). In addition, understanding the etiology of one's sexual urges doesn't necessarily change them. There is little evidence that traditional psychotherapies are consistently effective in treating paraphilic syndromes.

Behavior therapies are less concerned with the historical antecedents of unconventional sexual behaviors than with the question of what can be done about them. A variety of techniques have been attempted. A common feature involves efforts to diminish the appeal of previously erotic deviant stimuli (such as children), while at the same time teaching an individual to become sexually aroused by a more appropriate partner, or sexually satisfied in a more appropriate way. This is clearly a formidable task, analogous to trying to teach a man with conventional heterosexual interests to become erotically attracted to boys. Most of the literature on behavioral treatment of sexual deviation consists of anecdotal case reports without proper controls. However, Marks was able to document good results at two-year follow-up with behavioral treatment of transvestites (men who dress in women's clothing for erotic pleasure), but he obtained poor results using the very same behavioral technique with transsexuals (men who feel themselves to be women trapped in the body of the wrong sex) (6). A recent review by Blair and Lanyon suggests that exhibitionism may sometimes respond well to a behavioral approach (7).

Two types of surgery, neurosurgery and orchidectomy, have been used to treat paraphiliacs, often when violent physical assault has been a significant component of the sexual syndrome. A recent article by Freund reviewed the literature dealing with the effects of such surgery on animals and humans (8). For humans undergoing neurosurgery to try to decrease deviant sexual desires the population size is too small to allow generalization of results, but in animals specific brain areas seem to be important contributors to sexual behavior. While castration is an unacceptable form of treatment in the United States, its use as an option to incarceration in other countries dramatically decreased the recidivism rate of deviant sexual acts (though not to zero), sometimes without causing total impotence (9).

Two medications used to treat sexual deviations are cyproterone acetate, which is unavailable in this country, and medroxyprogesterone acetate. Both decrease levels of serum testosterone. The intent is to try to decrease the intensity and frequency of sexual fantasies and preoccupations, making self-control easier. Neither drug acts specifically on deviant urges, but rather each appears to be a suppressant of sexual desire in general. Counseling is ordinarily given in conjunction with medication to help the patient cope with difficulties resulting from his deviant sexual needs.

Associated Biological and Characterological Pathologies: Questions of Etiology

Goy and McEwen, at a conference at The Massachusetts Institute of Technology, suggested that biological factors may contribute more than previously recognized to human sexual behavior (11). Recently, an entire issue of *Science* (Vol. 211, No 4488) addressed this topic, as well as related issues. Biological factors in animals significantly influence sexually related activities. In some species of birds, normally only males sing, but if a female zebra finch that has been administered estradiol while just an embryo is given androgen hormones as an adult, she will do so also, and will have an increased number of cells in the nucleus robustus archistraitalis and other brain areas (12). She will also display distinctly male courtship behavior. Adult female rats who were exposed to testosterone at a specific time *in utero* will show sexual mounting behavior that normally predominates in male rats (13). In humans, there is evidence that some women initiate sexual activity most often during the ovulatory period of the menstrual cycle (14). Because sexual behavior is so intimately related to biology and species preservation, as well as to psychological and experiential factors, it is reasonable to look for organic pathologies in men experiencing unconventional sexual cravings.

Table 1 lists associated pathologies found in a group of 22 consecutively assessed paraphilic patients. Most were referred to Hopkins by their attorneys, or by the courts, though a few were self-referred. Eighteen of the twenty-two evidenced a variety of abnormalities that included structural brain damage, elevated testosterone levels, genetic anomalies, seizure disorders, and pituitary hormone dysfunctions. As a safeguard against selection bias, appropriate control group data are needed for comparison purposes, especially regarding the variance of testosterone levels in "normal" men. "Normal" laboratory values of testosterone are based on small sample sizes, and conceivably could be in error. However, it is clear that many sex offenders seen here at Hopkins have evidenced significant organic pathology. This finding makes plausible the hypothesis that biological vulnerabilities in some individuals may predispose them to develop unconventional sexual desires (15). As the data presented are preliminary this is only a hypothesis, and further research is planned.

Factors contributing to the development of normal, as well as unconventional, sexual desires are poorly understood. In addition to the possible role of biogenic elements, there is evidence that particular sorts of early life experiences (e.g., being a victim of child abuse), may also sometimes be relevant (16). Many pedophiles have been sexually molested themselves as children (3).

Expression of sexual desire can be influenced by many aspects of a person's character. Thus, whether a pedophile is physically assaultive toward children may depend not only upon his sexual feelings, but also upon whether he is assaultive in general. There is no evidence that persons with deviant sexual cravings are more assaultive (except for paraphilic sadists and rapists) than persons with more conventional orientations. A study in Detroit of over 1,252 sex offenses against children, for

TABLE 1

Associated Findings in 22 Consecutively Referred Male Patients with Sexual Disorders

Patient	Diagnosis	Associated Findings	
1	Exhibitionism	Elevated testosterone: 912 ng/ml	History of head injury in auto accident, grand mal seizures
2	Homosexual pedophilia	905 ng/ml	
3	Heterosexual pedophilia	1263 ng/ml	Mild ventriculomegaly. Cortical atrophy most pronounced in area of right sylvian fissure. 24 hour urine pregnanetriol = 3.1 ng
4	Raptophilia	916 ng/ml	Grand mal seizures
5	Homosexual pedophilia	1230 ng/ml	
6	Hypersexuality	880 ng/ml	Family history of adrenogenital syndrome
7	Voyeurism	Elevated LH: 98 ng/ml	
8	Homosexual pedophilia	77 ng/ml	Generalized muscular hypotonia
9	Homosexual pedophilia	Cortical atrophy (on CAT scan, secondary to auto accident)	Grand mal seizures, recurrent slow delta wave and sharp activity over frontal anterior region (more pronounced on right)
10	Hypersexuality		Cortical blindness, mild mental retardation
11	Homosexual pedophilia		Cortical blindness
12	Heterosexual pedophilia		Visual spatial defects. Right sided partial hemiparesis of upper extremity with spasm
13	Homosexual pedophilia	Dyslexia	
14	Homosexual pedophilia	Dyslexia	Childhood lisp requiring speech therapy
15	Homosexual pedophilia	Childhood learning disorder	Strabismus
16	Homosexual pedophilia	Kleinfelter's syndrome	90% mosaic (previously undiagnosed). Elevated FSH and LH
17	Sexual sadism	Basal ganglion dysfunction	Oculomotor abnormality. Gait disturbance
18	Homosexual pedophilia	Schizophrenia	
19	Homosexual pedophilia	No abnormalities detected	
20	Voyeurism		
21	Voyeurism		
22	Homosexual pedophilia		

Testosterone was considered elevated if blood levels were more than 2 standard deviations above the mean (mean = 575 ± 15[illegible] SD). Ordinarily 2.5% of men would be expected to have such an elevation. In this sample 27% (6 of 22) had elevations. Normal 24 hour urine pregnanetriol = <2.5 ng

example, found that the great majority did not result in physical injury (3). Although outdated psychiatric classification schemes listed sexual deviation as a form of sociopathy, persons with unconventional sexual desires may show no other evidence of antisocial character traits.

Pharmacological Treatment With Medroxyprogesterone Acetate

Medroxyprogesterone acetate can be injected intramuscularly, usually weekly, frequently at an initial dosage of 500 mg. It is then slowly absorbed into the blood stream and carried to receptor sites, reducing circulating levels of testosterone by decreasing testicular output. It does not appear to affect testosterone production by the adrenal gland, but does prevent the compensatory elevation of follicle-stimulating hormone (FSH) and LH ordinarily expected as a response to decreased testicular output. Dosage can be titrated to obviate total impotence, and the medication is not feminizing. Major side effects are weight gain and mild lethargy, but cold sweats, nightmares, myalgia, dyspnea, hyperglycemia, azospermia, hypertension, and breast cancer (in dogs) have all been reported. Most effects seem fully reversible when medication is discontinued, although long-term follow-up in excess of ten years has not yet been possible. The 100 mg/ml concentration has greater bioavailability and is less painful than the 400 mg/ml solution. No more than 250 mg should be administered into a single injection site.

A number of carefully documented studies conducted by Dr. John Money suggest that administration of this drug decreases the frequency of erotic imagery and the intensity of erotic cravings, as well as the frequency of erection and masturbation (17). Following treatment, a number of paraphilic patients have stopped deviant behavior entirely, reporting relief from pressure to enact troublesome sexual urges, while still maintaining the capacity for intercourse.

Table II summarizes changes in sexual behavior in 20 chronic paraphilic patients treated with medroxyprogesterone acetate. These data suggest that the drug can be helpful in a high proportion of cases, provided the patient is compliant in taking it. Compliance may depend partially upon the nature and intensity of the deviant cravings themselves, and also upon other aspects of a person's character and behavior such as his tendency to abuse alcohol, his capacity to form affectionate relationships, his temperament, and his attitude about treatment. Certain syndromes such as pedophilia may be more or less difficult to treat than others such as exhibitionism.

When patients stop taking the medication, their hunger for deviant sexual activities seems to return, putting them at risk of again engaging in behaviors which satisfy that hunger. Thus, the treatment seems to work by suppressing sexual appetite, rather than by acting as a temporary catalyst until psychological counseling can become effective. Although psychological counseling may not diminish erotic cravings, some patients report that it does help them in their efforts to establish a more appropriate sexual pattern. Brief psychiatric hospitalization for three or four weeks at the beginning of treatment may aid subsequent compliance.

Future Research

Medroxyprogesterone acetate has not yet been subjected to a double-blind clinical trial. This should be done, possibly using intramuscular injections of fluphenazine decanoate (a medication with similar side effects that does not reduce testosterone) as a pharmacologically active control. This should provide additional information regarding the effects of testosterone levels upon sexual feelings and thoughts.

Further advances toward understanding the relationship between biology and sexual experience should come about as a result of development of the position emission scanner (PET scanner). Rather than showing brain structure, this device provides a picture which varies in color depending upon the rate of metabolic activity in various brain areas. It will be informative to learn what regions of the brain are metabolically active during sexual arousal; whether these areas differ in persons experiencing unconventional sexual desires; and what the effects of treatment with medroxyprogesterone acetate are upon brain activity.

Only by learning more about what motivates "sex offenders" will it be possible to find out how to prevent voyeurism and other improper sexual acts. Present approaches, including incarceration, have not proven helpful, and it is important to meet the need that exists within the community to deal effectively with these kinds of problems. It is hoped that the Hopkins program for studying and treating these conditions will continue to prove useful. Treating such patients can present difficulties because of stigma and prejudice sometimes directed toward persons and institutions doing so, but it is clear that many of these people, such as the patient under discussion, legitimately need and deserve help. More than 50 centers in the United States treat such patients (18).

Medicolegal Issues

The topic of sexual deviation and its treatment raises a number of medicolegal and ethical concerns. In a recent editorial in *The American Journal of Psychiatry* Seymour Halleck questioned whether a person facing incarceration can provide truly voluntary consent to receive treatment, knowing that refusal will lead to imprisonment (19). Admittedly, such decisions can be difficult. However, a person does not lose the capacity to choose just because a decision is difficult. Cancer patients sometimes have to choose between taking unpleasant chemical agents or dying. Furthermore, there is legal precedent for requiring individuals to take medication (e.g., measles vaccine), when not doing so threatens the well-being of others. Were persons incarcerated, or facing incarceration, to be denied access to antiandrogenic medications, based upon the idea that they are incapable

TABLE II

Changes in Sexually Deviant Behaviors in 20 Chronic Paraphilic Male Patients Treated With Medroxyprogesterone Acetate*

Patient	Diagnosis	Average frequency of sexually deviant behaviors before treatment†	Length of drug treatment‡	Occurrence of Deviant Behaviors	
				During treatment	After treatment
1	Homosexual pedophilia	once/week	5 years, 9 months	None	No relapse
2	Homosexual pedophilia	twice/month 1 known arrest	1 year	None	Relapsed
3	Heterosexual exhibitionism	2 times/week	10 months	None	Relapsed
4	Homosexual masochism	4 times/week	3 months	None	Relapsed
5	Bisexual pedophilia	2 times/week	3 months	None	Relapsed
6	Transvestism homosexual incest	7 times/week 2 known incidents	1 year, 4 months	None	Relapsed
7	Heterosexual sadism	once every 2 weeks for 25 years	3 years, 3 months	None	Still in treatment
8	Homosexual pedophilia	2 times/week 6 arrests in 6 years	10 months	None	Relapsed
9	Homosexual pedophilia	Once every 2 months 4 arrests in 6 years	2 years	None	Still in treatment
10	Homosexual pedophilia	once/week 14 arrests in 29 years	3 years, 9 months	Relapsed	Treatment continue
11	Homosexual pedophilia	2 times/week 7 known arrests	4 years, 2 months	None	Still in treatment
12	Voyeurism heterosexual pedophilia	2 times/week (pedophilia) 5–8 arrests	5 years, 3 months	None	Relapsed
13	Homosexual pedophilia	2 times/week since age 10	5 years, 9 months	None	No relapse
14	Homosexual pedophilia	once/month numerous arrests, 4 convictions, 4 parole violations	3 years, 8 months	Relapsed	Treatment continue
15	Homosexual pedophilia, exhibitionism	probably several incidents/year	3 years, 9 months	None	No relapse
16	Homosexual pedophilia	once/week	1 year, 1 month	None	Relapsed
17	Heterosexual voyeurism	once/month	1 year	Relapsed (while intoxicated)	Treatment continue (in prison)
18	Heterosexual exhibitionism	5 times/day since age 11 numerous arrests	2 years, 2 months	None	Relapsed
19	Heterosexual exhibitionism	2 times/week	2 years, 1 month	None	Relapsed
20	Heterosexual exhibitionism	4 times/week binges of 20/day	2 years, 3 months	None	Still in treatment

Adapted from Reference 10

* Deviant behavior was considered to have occurred if the patient was accused of having it, or admitted to it, even if it did not come to the attention of the law

† Based on institutional records and patients' statements

‡ Patients who stopped medication did so against advice, except in the cases of patients 13 and 15

of voluntary consent, it is likely that civil libertarians would protest. It can be argued that administering medication to a willing convicted person (even as part of an investigative study, provided it may directly benefit him) is very different from using him to study the effects of a drug (e.g., rabies vaccine) unrelated to his potential benefit.

Another medicolegal issue raised in considering the matter of sexual deviation relates to the concept of "free will," a concept whose meaning has been pondered by philosophers for centuries. Society, through its laws, needs to hold individuals accountable for their own behavior. Some persons are able to control their sexual behavior without help, but persons are likely to differ in the intensity and quality of their erotic desires. Many paraphilic men, prior to treatment with medication, report that their desires are so intense that they are unable to resist temptation successfully. Many of the same men report that their desires become sufficiently diminished while taking medication that they are able to stop deviant activity (and they do). Some state that while taking medication they feel for the first time that they have a choice about whether or not to act. There are other psychiatric syndromes as well (e.g., compulsive handwashing) in which, prior to treatment, persons seem to lack the capacity to stop certain behaviors on their own. Such data clearly present difficult legal and ethical dilemmas.

The psychiatric literature is sometimes misleading to guiding the law about the topic of sexual deviation. Many psychiatric texts, for example, state that rape

not a sexually motivated crime, but rather an act of anger and hostility directed toward women. While it is true that some rapists have hostile motives, and that some suffer from sexual dysfunctions such as premature ejaculation, the motivation to rape can be sexual rather than hostile. Furthermore, to argue that rape is not at least partially a sexually motivated act makes little sense when a man has obtained an erection and forces intercourse. The following verbatim excerpts from letters written by a convicted paraphilic rapist document that rape is sometimes very much a sexually motivated act (which is not to suggest that rape is nonassaultive).

> Sir, I am 32 years old and in the penitentiary for several rapes. All my life I've felt I wasn't normal ... being the sex maniac I've been ... messed up in sexual thought and behavior for God only knows how long. Since I was 4 or 5 years old, sex has been 90% of my thoughts. After I was married I would have sex with my wife every night, then I would go masturbate. Sex was all I could think of. The rapes started when I [saw] a naked woman through a window. Since that time it's been 8 or 10, maybe more. The only way to stop the thoughts was to have sex or ejaculate. Sometimes I masturbated. After (each rape) I felt ashamed. I tried to stop and could for a month or longer, but ended up doing it again. It was as if I was being driven. I know it [doesn't] sound true or logical, but at a certain point, I could not control myself. The important thing to me now is getting relief from sexual thoughts. My wife said I could have come to her with this. How could I tell a woman I have something this bad? She never denied me sex. When I was arrested, I was so glad it was finally over. The only things against the law I've ever done is because of sex. I don't like to hurt people. Some people have told me I'm just a dirty person, and I did those things because I wanted to and enjoyed it. This is not true. Maybe I did want to in a way, subconsciously or something. But I did not enjoy being that kind of a person. I have cried and hated myself. At a certain point understanding fails me. I can't comprehend. What makes a person want to do these things?

Summary

Sexual deviation syndromes (paraphilias) are diagnosable psychiatric syndromes manifested by 1) recurrent persistent deviant fantasies, 2) intense erotic cravings that are noxious when frustrated, and 3) relatively stereotyped behaviors in the sense that exhibitionists expose themselves, whereas voyeurs "prep." These syndromes follow a predictable course, often respond to biological treatments, and may have associated organic pathologies, but their etiologies are poorly understood. Sexual offenses, as defined legally, may or may not be perpetrated by persons with one of these syndromes. When offending behavior is related to such a syndrome, medroxyprogesterone acetate may be helpful, provided the patient is compliant. It is not known whether this medication can help when such behavior is unrelated to deviant sexual cravings, as when rape is committed in response to anger and hostility—something which may occur more rarely than many psychiatric texts suggest. Legal demands for justice and safety as well as medical concerns for understanding care must both be considered, because each is important. When a person seeks help, as did the patient presented, his difficulties should be appreciated rather than scorned as perversions.

ACKNOWLEDGMENT

The authors wish to thank Dr. Paul McHugh, Dr. John Money and Ms. Maggie Rider for their encouragement and kind assistance.

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THE BIOSEXUAL PSYCHOHORMONAL CLINIC
EVALUATION SERVICES

Before a patient can be accepted into the treatment program of the Biosexual Psychohormonal Clinic an evaluation appointment is necessary.

Evaluations before possible admission into the program are performed through the outpatient services, Meyer Building, of the Johns Hopkins Hospital. Appointments are made through Ms. Maggie Rider, (301) 955-6292. The service is ordinarily performed only on Wednesday mornings beginning at 8:30 a.m., and will generally be completed by noon.

The cost of this visit is currently $160 for the evaluation, plus $120 for lab fees (blood will be drawn and a number of lab tests will be performed). Payment is expected at the time of the visit. However, insurance may cover part or all of the fees. You will be expected to file a claim for reimbursement. Medical Assistance is accepted. However, if your Medical Assistance originates from another state we will need prior confirmation that your home state will cover our costs. When a service is not available in one state but is available in another the home state will frequently allow this cost to be paid from their funds. Should you have major medical insurance coverage please be sure to bring the necessary forms at the time of the appointment. If documented financial need can be provided sometimes a deferred payment plan can be arranged. A deposit is required to hold an appointment date.

Inpatient evaluations are often done for those patients who reside outside the state of Maryland. This type of evaluation consists of an in hospital stay of approximately three to four weeks. Treatment plans are formulated and begun during this time, as well as plans for continuing care after discharge, based on the individual needs and circumstances.

In some cases emergency evaluations can be arranged, performed on an outpatient basis. Costs are based on the time spent with a physician, plus the lab fees. An approximate fee would be in the vicinity of $200, plus the $120 lab fee.

Currently the waiting time before being seen for these services is approximately:

_____for outpatient evaluation, _____for inpatient evaluation, and

_____for emergency evaluation.

Below is a suggested reading list of references from the medical journals regarding the treatment of sexual disorders. On request (there is a charge of $10) we will supply reprints of the articles by Dr. Berlin).

Berlin, FS and Coyle, GS: Sexual Deviation Syndromes, Johns Hopkins Medical Journal, 149, 119-125 (1981).

Berlin, FS and Meinecke, CF: Treatment of sex offenders with antiandrogenic medication: Conceptualization, review of treatment modalities, and preliminary findings. American Journal of Psychiatry 138:601-607, 1981.

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THE BIOSEXUAL PSYCHOHORMONAL CLINIC EVALUATION SERVICES
Request for Services Information Sheet

THE JOHNS HOPKINS HOSPITAL
BALTIMORE, MARYLAND

NAME_____ ADDRESS_____

PHONE (work)_____(home)_____ _____

DATE OF BIRTH_____ S.S.#_____ MARITAL STATUS_____

FATHER'S NAME_____MOTHER'S MAIDEN NAME_____

EDUCATIONAL LEVEL_____ MEDICATIONS_____

NAMES AND ADDRESSES (If appropriate) _____

ATTORNEY:_____PHONE_____

PAROLE OFFICER:_____PHONE_____

PSYCHIATRIST (or mental health professional):
_____PHONE_____

FAMILY PHYSICIAN_____PHONE_____

WHO REFERRED YOU TO THIS PROGRAM?_____

REASON YOU WANT TO BE SEEN HERE_____
(Name specific behavior)

INSURANCE COMPANY:_____ POLICY NUMBER:_____

DO YOU WISH AN APPOINTMENT FOR ___OUTPATIENT EVALUATION, ___INPATIENT EVALUATION, OR

___ EMERGENCY APPOINTMENT (see other side of sheet for expected time of appointment)

A copy of your legal history and current charges must be forwarded to us in advance of your appointment. (If applicable) Your appointment may be cancelled if not received.

Additionally, a report from any psychiatrist or mental health professional who may have treated you in the past is required. You will need to provide a release of information to the appropriate person in order for them to forward this background to us. Please have the materials sent to the address below.
All of the information received is held in strictest confidence. It will be used to give the examiner as full a picture as possible ahead of time about what has taken place in your life before coming to us.

An appointment will be sent to you at the address listed above unless you indicate otherwise._____

Please return this sheet to:

Ms. Maggie Rider, Appointments Secretary
Meyer Building, 4-181
Johns Hopkins Hospital
600 North Wolfe Street
Baltimore, Maryland 21205

Mail this sheet back as soon as possible. Psychiatric and legal history may be forwarded under separate cover, along with a deposit of $50.

FEE SCHEDULE

CLINIC EVALUATION	$160
LAB - BLOOD WORK	135
CONSULTATIONS	90 (per hour)
RE-EVALUATION	75
GROUP THERAPY SESSION	65
DEPO-PROVERA INJECTION	27.50 (only)

(Fees are subject to change. Please inquire. Deferred payment plans considered with documented financial need.)

Treatment of Sex Offenders with Antiandrogenic Medication: Conceptualization, Review of Treatment Modalities, and Preliminary Findings

BY FRED S. BERLIN, M.D., PH.D., AND CARL F. MEINECKE

Sexual deviation disorders, or paraphilias, are diagnosable psychiatric syndromes manifested by 1) recurrent fantasies about deviant sex, 2) intense associated cravings, and 3) stereotypic behavioral responses. Pedophiles seek out children in response to their erotic thoughts and urges, whereas exhibitionists expose themselves. Paraphiliac syndromes ordinarily follow a chronic course and may be associated with biological pathology, but etiological factors are poorly understood. Treatment becomes a consideration when the well-being or rights of others are compromised. Proposed treatments have included psychotherapy, behavior therapy, surgery, and medication. Medroxyprogesterone acetate, which reduces testosterone, may diminish sexual preoccupation and urges, making self-control easier.

The sexual deviation disorders, or paraphilias, include voyerism, exhibitionism, erotic sadism, and pedophilia (sexual attraction to children). They are considered psychiatric syndromes by the medical profession and are listed as diagnostic categories in the official psychiatric nomenclature. However, persons who manifest the behaviors characteristic of these syndromes often come into conflict with society, which considers them criminal offenders. This paper examines the rationale for treating these conditions medically rather than punitively and reviews the treatments available, especially use of the antiandrogenic agent medroxyprogesterone acetate (Depo-Provera). It also alludes briefly to some of the medicolegal implications of providing treatment. Rather than detailing data from any single study, this paper will present an overview of relevant issues plus some case reports and preliminary findings.

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From the Johns Hopkins Hospital, Baltimore.
Address reprint requests to Dr. Berlin, Henry Phipps Psychiatric Clinic, 1401 North Wolfe St., Baltimore, MD 21205.

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DIAGNOSIS OF A PARAPHILIAC SYNDROME

One way of arriving at a diagnosis is to appreciate the presence of a syndrome, which is a cluster of features that appear together consistently. Historically, it has proven helpful to identify and label such syndromes. Mania, for example, can be diagnosed by recognizing a syndrome that includes delusions of grandeur, sustained mood change, hyperactivity, and prolonged insomnia. Disease syndromes such as these tend to follow a relatively predictable course and often respond in a predictable way to treatment.

According to *DSM-III*, a diagnosis of paraphilia can be made by identifying such a syndrome. This is done by examining a person's cognitive, emotional, and behavioral state. Cognitive examination reveals recurrent persistent fantasies about deviant sex. Examination of the feeling state discloses erotic cravings perceived as noxious when frustrated. The frustration can be relieved temporarily if deviant fantasies are carried out. Behavioral examination shows relatively stereotyped sexual activity because erotic pleasure is maximized only when deviant fantasies are enacted precisely. The exhibitionist, therefore, exposes himself in response to his fantasies and urges on repeated occasions, often in a stereotypic manner. The pedophile, frequently impotent in adult sexual relationships, seeks out young children, sometimes of a particular age, sex, and appearance, in keeping with his fantasies. One would not ordinarily expect a pedophile to develop some other paraphiliac syndrome, such as exhibitionism or erotic sadism, any more than one would expect an adult with conventional heterosexual desires to suddenly begin fantasizing about and seeking out young children. The expression of deviant sexual desires can be modified depending on the character traits of the individual experiencing them. Paraphiliac syndromes typically manifest themselves initially at puberty and follow a chronic course that may, however, be altered by treatment. At present their etiology is unknown, although certain types of early life experiences are thought to be possible contributory factors in some instances. The etiology of erotic desires and fantasies that influence conventional heterosexual behavior, as well as knowledge about what makes a stimulus sexually appealing, is also poorly understood.

TABLE 1
Associated Findings in 17 Consecutively Referred Male Patients with Sexual Disorders

Patient*	Sexual Disorder	Associated Findings
1	Sexual sadism	Oculomotor abnormality suggestive of basal ganglion dysfunction; unexplained gait disturbance
2	Homosexual pedophilia	Dyslexia; childhood lisp requiring speech therapy
3	Homosexual pedophilia	Cortical atrophy (history of head injury secondary to automobile accident); grand mal seizures; recurrent runs of slow delta waves and sharp activity over frontal anterior brain regions (more pronounced on right side)
4	Homosexual pedophilia	No associated abnormalities detected
5	Hypersexuality	Family history of adrenogenital syndrome; elevated testosterone (1040 ng/100 ml)†
6	Voyeurism	No associated abnormalities detected
7	Homosexual pedophilia	Klinefelter's syndrome (previously undiagnosed); XXY present in 90% of cells; elevated FSH and LH; decreased testosterone; XXY genotype
8	Homosexual pedophilia	Strabismus; childhood learning disorder (originally misclassified as mental retardation)
9	Heterosexual pedophilia	Schizophrenia
10	Homosexual pedophilia	No associated abnormalities detected
11	Exhibitionism	Elevated testosterone (912 ng/100 ml); head injury in automobile accident, comatose several months; grand mal seizures
12	Heterosexual pedophilia	Brain damage secondary to automobile accident at age four; right-sided partial hemiparesis of upper extremity with spasm
13	Homosexual pedophilia	Elevated testosterone (905 ng/100 ml)
14	Heterosexual pedophilia	Near total blindness secondary to brain damage in an automobile accident
15	Heterosexual pedophilia	Elevated testosterone (1263 ng/100 ml); mild generalized ventriculomegaly and cortical atrophy most pronounced in area of the right sylvian fissure (by CT scan); elevated 24-hour urine pregnanetriol (3.1 mg; normal<2.5 mg)
16	Homosexual pedophilia	Elevated LH (77 ng/ml; normal range is 36 to 64); generalized muscular hypotonia
17	Paraphiliac rape	Elevated testosterone (916 ng/100 ml); grand mal seizures

*Patient 2 was seen at the Maudsley Hospital in London; the others were seen at the Johns Hopkins Hospital in Baltimore.
†Testosterone was considered elevated if blood levels were more than 2 standard deviations above the mean (mean = 575 ± 130). Ordinarily, 2½% of men would be expected to have such an elevation; in this sample 29% of the men (5 of 17) had elevated testosterone.

In addition to the triad of cognitive, emotional, and behavioral findings, physical and laboratory examinations may reveal associated organic pathologies. Preliminary data from our center suggest that there may be an unusually high frequency of genetic, hormonal, or neurological anomalies (see table 1). It may be that biological vulnerabilities in some individuals predispose them to develop unconventional sexual desires (1). However, this hypothesis requires further confirmation by comparison with a control population.

Diagnosis of a paraphiliac syndrome cannot be made on the basis of sexual behavior alone because similar behaviors can occur for a variety of reasons. For example, rape could be committed in response to recurrent urges and fantasies about having coercive sex; in such cases the diagnosis of paraphilia would be appropriate. However, rape could also be initiated by a hallucinating person in response to voices telling him to do so, by a mentally retarded person with conventional rather than deviant sexual desires who "doesn't know any better," or by a hostile, angry individual to humiliate a woman. Such differential diagnosis is important because treatment may be different for a hallucinating, retarded, or impulsive angry person than it is for a paraphiliac. Not all sex offenses (a legal term) are committed by persons manifesting a sexual deviation disorder or paraphilia (a medical term).

METHODS FOR TREATING PARAPHILIAC PATIENTS

Our review of the relevant literature revealed over 230 references pertaining to treatment of sexual deviations. In addition to the medication therapies, psychodynamic therapy, behavior modification, and surgery have been tried.

Psychodynamic theory generally assumes that sexually deviant behaviors occur because of unresolved unconscious conflicts, and treatment is directed at uncovering such conflicts (2–4). To our knowledge there have been no well-controlled clinical trials to demonstrate that any of the individual or group psychodynamic methods result in sustained behavioral change in these conditions, and achieving insight into how they may have developed does not necessarily alter them. In point of fact, most of us have little understanding about why particular things arouse us sexually (5, 6). The causes of sexual cravings are probably multifactorial and are often unknown. Lichen and associates (7), for example, have shown that feelings of gender identity in some transsexuals may be correlated with the presence or absence of H-Y antigen.

Behavior therapists are often less concerned with the antecedent causes of unconventional sexual be-

havior than with what can be done about it (8–10). A number of techniques, including hypnosis and biofeedback, have been advocated. Usually the principle is to try to make an unacceptable erotic stimulus less appealing while the person is trained to become sexually aroused by a formerly neutral, or aversive, stimulus. This can be done in the case of pedophilia by following erotic thoughts about children with a mild electric shock and by instructing the patient to masturbate while looking at pictures of a nude, age-appropriate partner. Although this approach is occasionally successful, results are more often disappointing. Most of the literature on psychodynamic or behavioral treatment of sex offenders has consisted of uncontrolled individual case reports without long-term follow-up. It appears that brief changes in behavior are relatively easy to accomplish, but long-term maintenance of such change is achieved far less frequently. Nevertheless, behavior therapy has on occasion been helpful, and it should not be dismissed entirely as a form of treatment. Marks and associates (11), for example, showed good results at two-year follow-up in the treatment of transvestites but poor results with transsexuals.

Biological therapies have included surgical castration, intramuscular injections of medroxyprogesterone acetate, or oral administration of cyproterone acetate (the latter is currently unavailable in the United States) (12–14). Forced castration is clearly not acceptable as treatment in this country but has met with some success elsewhere (15–17). Castration in animals leads to a reduction of sexual behaviors and often causes total impotence. Brain surgery has also been attempted as a treatment for sexually deviant behaviors, presumably with the idea of ablating pathways thought to be involved in sexual desire, but this approach has met with only limited success (18).

When medication has been used to try to reduce sexual cravings, efforts have been made to titrate the dosage so as not to cause total impotence. The medication currently in use investigatively in the United States is medroxyprogesterone acetate (19). It is an antiandrogenic agent that can be administered once or twice per week intramuscularly to be gradually absorbed into the bloodstream, causing a reduction in circulating levels of the male sex hormone, testosterone. Effects appear to be fully reversible within a few months after the medication is stopped, although it has not yet been used widely enough for us to be sure this is entirely true. Major side effects are weight gain and mild lethargy; cold sweats, nightmares, dyspnea, hyperglycemia, hypogonadism, and leg cramps have also been reported. High doses can cause breast cancer in female beagle dogs, but the drug does not appear to do so in humans, and it does not cause men to become feminized in appearance (20). The 100 mg/ml concentration of medroxyprogesterone acetate has a higher bioavailability and is less painful when injected than the 400 mg/ml concentration. Besides decreasing testosterone secretion by the testes, the medication appears to act centrally on the brain as well. This hypothesis is supported by two observations. First, increasing doses of medication seem to decrease erotic fantasies even when serum testosterone levels remain unchanged. Second, there is no compensatory elevation of FSH or LH production by the pituitary gland as a response to lowered levels of testicular testosterone production. Because medroxyprogesterone acetate is given by injection, it is easy to monitor treatment compliance. Psychiatric counseling is ordinarily given in conjunction with the medication to help patients cope with the difficulties encountered as a consequence of their unconventional sexual desires. Most men are hospitalized during the initial phase of treatment.

EVIDENCE THAT MEDICATION CAN BE HELPFUL

Because of difficulties in carrying out research with persons whose behaviors, if untreated, can cause others distress, a controlled double-blind study on the use of medication has not been done. This is necessary before firm conclusions about therapeutic efficacy, or mode of action, can be made. Recently the Evaluation Research Group, a private corporation, was funded by the National Center for the Prevention and Control of Rape to formulate a model to evaluate the relative effectiveness of various sex offender treatment programs (21). In the meantime, there are some data available in support of the hypothesis that medroxyprogesterone acetate can reduce the intensity of deviant sexual urges and the frequency of accompanying erotic fantasies. Evidence from some of the major studies conducted at this center will be reviewed briefly.

In one study (22) conducted at Johns Hopkins Hospital under the direction of Dr. John Money, 10 paraphiliac men were given medroxyprogesterone acetate intramuscularly approximately once per week. Data were gathered from structured personal interviews with patients and family members who made themselves available and from social agencies and institutional records. Evaluations made before and after treatment suggested that medroxyprogesterone acetate decreased the reported frequency of erotic imagery, as well as the frequency of erection and ejaculation. In addition, some men stopped offensive sexual behavior entirely, sometimes for as long as a couple of years, reporting relief from the psychological pressure to act on their paraphiliac urges. Presumably the decreased frequency of erotic thoughts comes about, at least in part, as a consequence of lowered levels of testosterone.

In a follow-up study to the one just cited, 20 men with histories of chronically recurrent paraphiliac be-

TABLE 2
Changes in Sexually Deviant Behaviors in 20 Chronic Paraphiliac Male Patients Treated with Medroxyprogesterone Acetate[a]

Patient	Age (years)	Diagnosis	Average Frequency of Sexually Deviant Behaviors Before Treatment[b]	Drug Treatment[c]: Length	Drug Treatment[c]: Maximum Dosage	Occurrence of Sexually Deviant Behaviors: During Treatment	Occurrence of Sexually Deviant Behaviors: After Treatment
1	34	Homosexual pedophilia	Once/week	5 years, 9 months	500 mg/week	None	Treatment dropout; no relapse less than 1 year after treatment
2	31	Homosexual pedophilia	Twice/month; 1 known arrest	1 year	300 mg/week	None	Treatment dropout; relapsed less than 1 year after treatment
3	30	Heterosexual exhibitionism	Twice/week	10 months	250–300 mg/week	None	Treatment dropout; relapsed more than 1 year after treatment
4	34	Homosexual masochism	4 times/week	3 months	200 mg/week	None	Treatment dropout; relapsed less than 1 year after treatment
5	27	Bisexual pedophilia	Twice/week	3 months	400 mg/week	None	Treatment dropout; relapsed more than one year after treatment
6	43	Transvestism; homosexual incest	7 times/week; 2 incidents	1 year, 4 months, intermittently	150 mg every other week	None	Relapsed less than 1 year after treatment
7	52	Heterosexual sadism	Once every 2 weeks for 25 years	3 years, 5 months	600 mg/week	None	Treatment continues; no relapses
8	29	Homosexual pedophilia	Twice/week; 6 arrests in 6 years	10 months	500 mg/week	None	Treatment dropout; relapsed less than 1 year after treatment
9	36	Homosexual pedophilia	Once every 2 months; 4 arrests in 6 years	2 years	500 mg/week	None	Treatment continues; no relapses
10	56	Homosexual pedophilia	Once/week; 14 arrests in 29 years	3 years, 9 months	300 mg/week	Relapsed	Treatment continues
11	40	Homosexual pedophilia	Twice/week; 7 known arrests	4 years, 2 months	400 mg/week	None	Treatment continues; no relapses
12	45	Voyeurism; heterosexual pedophilia	— Twice/week; 5–8 arrests; numerous institutionalizations	5 years, 3 months	300 mg/week	None	Relapsed less than 1 year after treatment; treatment now resumed
13	27	Homosexual pedophilia	Twice/week since age 10	5 years, 9 months	200 mg/week	None	Treatment completed; no relapse more than 1 year after treatment
14	41	Homosexual pedophilia	Once/month; numerous arrests; 4 convictions; 4 reported parole violations	3 years, 8 months	500 mg/week	Relapsed	Treatment continues
15	37	Homosexual pedophilia; exhibitionism	Record unclear; probably several incidents/year	3 years, 9 months	350 mg/week	None	Treatment completed; no relapse less than 1 year after treatment
16	26	Homosexual pedophilia	Once/week	1 year, 1 month	200 mg/week	None	Treatment dropout; relapsed more than 1 year after treatment
17	24	Heterosexual voyeurism	Once/month	1 year	400 mg/week	Relapsed after alcohol consumption	Treatment continues; in prison
18	40	Heterosexual exhibitionism	Five times/day since age 11; first arrest at age 21; numerous others	2 years, 2 months	200 mg/week	None	Treatment dropout; relapsed less than 1 year after treatment
19	29	Heterosexual exhibitionism	Twice/week	2 years, 1 month	250 mg/week	None	Treatment dropout; relapsed less than 1 year after treatment
20	46	Heterosexual exhibitionism	Four times/week; binges of 20/day	2 years, 3 months	300 mg/week	None	Treatment continues; no relapses

[a]Sexually deviant behavior was considered to have occurred if the patient was accused of having or admitted having a deviant sexual contact (for example, an episode of public genital exposure). Any recurrence of such behavior was scored as a relapse once treatment had been initiated, even if it did not come to the attention of the law as an official complaint.
[b]Based on institutional records and patients' statements.
[c]Study participants who stopped taking medroxyprogesterone acetate did so against medical advice, except in the cases of patients 13 and 15. Some patients were irregularly compliant with medication even during the period it was being prescribed.

havior were placed on medroxyprogesterone acetate for varying lengths of time. Details of the study protocol itself are described elsewhere (23). Additional data obtained by subsequent interview and review of the records of the same 20 men who participated in that study are detailed here for the first time (see table 2). Only 3 of the 20 patients showed recurrences of sexually deviant behavior while taking medication, in

one such case, relapse was clearly related to alcohol abuse. The recidivism rate jumped dramatically when patients discontinued their medication regimen. Of the 11 patients who discontinued medroxyprogesterone acetate against medical advice, 10 relapsed. Two who discontinued treatment with approval have thus far not relapsed. Whether the marked number of patients in this study who eventually relapsed would have remained symptom free had they been required to continue taking medication (perhaps, for example, as a condition of parole) is not known. Reasons for the high attrition rate have yet to be analyzed, although it is clear that some patients found the routine of weekly injections and frequent investigational blood tests burdensome.

The preliminary impression based on these data and other cases now being analyzed is that in general, these men appear to do well in response to antiandrogenic medication as long as they continue taking it and as long as their problems are rather clearly confined to unconventional sexual cravings. They seem to do less well if they have been noncompliant about taking the medication or if in addition to having such cravings they abuse drugs and alcohol, are sexually impulsive, or have a history of other sorts of sociopathy or violence. Some paraphiliacs are concerned about the consequences to others of their unconventional cravings, whereas some are not. Thus, prognosis may depend not only on the effects of medication on the deviant thoughts and cravings comprising the syndrome, but also on other features of the person manifesting the syndrome, such as his attitude about treatment and commitment to it.

Although anecdotal clinical reports are of limited research value, three brief case examples are presented here to help illustrate the types of patients who have been receiving medication.

CASE REPORTS

Case 1 (sadistic paraphilia). Mr. A, a 47-year-old man, complained of being unable to obtain sexual satisfaction unless he hurt his wife. His preoccupation with sadistic fantasies made it difficult for him to concentrate, even at work. He believed his actions to be wrong and consistently felt disgusted and remorseful afterward, often working overtime to avoid the opportunity to harm her. However, every few weeks his cravings would build up to a point where he could not control them. During 25 years of marriage, he had frequently handcuffed his wife, shaved her head, stuck pins in her back, and struck her—although never so forcefully as to require medical or legal attention. Alternative means of obtaining sexual satisfaction such as masturbation led to erection, but ejaculation could not be achieved unless he hurt her. Neurological examination showed evidence of nonprogressive basal ganglia dysfunction, and he had a mild gait disturbance.

Mr. A began treatment voluntarily 4 years ago after he became frightened he might seriously harm or even kill his wife. Since that time there has not been even a single recurrence of the sexual sadism that had occurred previously for nearly 25 years. Conventional sexual activities have become a regular part of Mr. A's marriage, and as before, there has been no extramarital involvement. He believes he can control his paraphiliac desires, which he said have become much less intense, only with help from antiandrogenic medication. He has found considerable relief from the obsessive erotic urges that he had previously experienced as noxious rather than pleasurable. With treatment his serum testosterone has been maintained at below-normal levels.

Case 1 was an example of sadistic sexual desire qualitatively deviant from accepted cultural norms. Case 2 is an example of quantitative deviance, that is, of significantly heightened sexual drive.

Case 2 (hypersexuality). Mr. B, a 17-year-old, stated that he was preoccupied with erotic fantasies to such a degree that they interfered with work and family relationships. His wife confirmed his report that he sometimes demanded intercourse as often as 15 times in a single day. There was a family history of andrenogenital syndrome, and his mother had taken thyroid medication when pregnant. The patient's serum testosterone level was 880 ng/100 ml, above the normal (i.e., more than 2 SD) postpubertal range of 225–875 ng/100 ml as reported by the laboratory performing the assay. No cause could be detected, although receptor site sensitivity to testosterone has not yet been tested (24). Treatment with 400 mg per week of medroxyprogesterone acetate reduced the elevated testosterone level to a prepubertal value of 70 ng/100 ml. The patient reported relief from intrusive fantasies, as well as improved work and interpersonal relationships.

Case 3 (paraphiliac rape). Mr. C, a 32-year-old man with adult-onset idiopathic epilepsy since age 19 but seizure free for the past 3 years, was referred for treatment after committing two rapes. Although never charged previously, he admitted to a lengthy history of similar behavior satisfying legal criteria for rape, beginning at age 20. His first sexual experience was at the age of 6 or 7 with a 14-year-old babysitter who had asked him to watch her masturbate while clothed in her undergarments. Since then, he has fantasized several times daily about similar encounters, often masturbating while doing so. At the age of 15 he broke into the office of a gynecologist who had been dating his sister to steal textbooks to "learn more about the female body." He had a steady girlfriend at the time of hospital admission but he had never found sexual activities with her sufficiently satisfying. He usually masturbated about four or five times per day while fantasizing about various women performing autoerotic acts. In his fantasies he would always imagine forcing a woman previously unknown to him to masturbate while clad in her undergarments. He had been too embarrassed to ever tell any of his regular girlfriends about his erotic preoccupation, and he rarely sought a second encounter with any women whom he had forced to have sex, feeling compelled instead to repeat the episode with a fresh partner.

The patient maintained an apartment separate from his girlfriend. Three or four times per week he would try to meet a new woman (preferably slim and wearing pants rather than a skirt) whom he would persuade to join him at his apartment to smoke marijuana; he never used threats up to that point. Subsequently, however, he would threaten to harm the woman unless she removed all the clothing from below her waist except her panties and masturbated while he watched and masturbated himself. On some occasions he would have intercourse, but this was the exception rather than the rule. Each episode invariably followed this same pattern: he estimated that there had been more than 60 such episodes since he was age 20. On some occasions he would threaten his victim with a knife as well as verbally, but in those instances when she refused to be intimidated, he always allowed her to leave without becoming physically assaultive. As far as we could determine, on no occasion did he injure a woman physically, and none of his erotic fantasies was sadistic in the sense of wanting to inflict pain. After each episode he would escort the woman out, "trying to be kind, apologizing, and making sure she was okay," with no further threats. He reported that he would then invariably vomit, feeling "disgusted, sick, and remorseful" and vow never again to act in such a manner. However, in a few days his fantasies and urges would recur with renewed intensity and the whole pattern would be repeated.

Mr. C believed coercion of another person was wrong. Worried about the troubles his actions could cause him, and appeared to have some concern for his victims. Nevertheless, he stated that his erotic thoughts and cravings consistently proved to be more than he could resist. In his words, "It's like an insatiable drive, like a pressure that is always on me. Sometimes I can push it off by masturbating, but eventually I feel driven to repeat this thing over and over." His serum testosterone level was found to be 916 ng/100 ml (well above the reported normal 3 SD range of 275 to 875). Because we are only now beginning a careful, rigorously supervised treatment protocol, it is too soon to know whether success can be achieved.

DISCUSSION

Persons who engage in dangerous or offensive sexual behaviors pose a variety of medicolegal problems, especially if juveniles or nonconsenting adults are involved. Some persons undoubtedly misuse other people with little concern for them and may require quarantine or punishment. Others (just as is true of some drug addicts, cigarette smokers, or overeaters) may be in a sense victims of intense cravings that are quite resilient and therefore difficult, if not impossible, to resist. Such persons must still assume responsibility for their own actions, but when they seek medical help they should be treated with an appreciation for their difficulties rather than with stigmatization, scorn, or contempt (25). This requires that helping professionals be able to deal with their own feelings. Although many treatments, including psychodynamic and behavioral therapies, have been tried in the past, only recently has the potential for help in the form of medication become available. Some might argue that in a way paraphiliac behavior is no more a reflection of disease than is conventional sexual activity. In a nonjudgmental sense, this may be true. However, syndromes are often labeled diseases when they impair functioning or cause suffering. Since paraphiliac behaviors can infringe on the rights and well-being of nonconsenting persons, causing suffering, it seems proper to make a value judgment about them, that is, that they must stop and because the cravings associated with such behavior can often be alleviated by medication, the term "treatment" still seems appropriate. Unconventional sexual activities between consenting adults that cause no harm do not ordinarily require psychiatric care.

Preliminary data on the use of medroxyprogesterone acetate to treat sex offenders clearly suggest that a means must be found to ensure continued compliance with the treatment regimen before one can feel relatively confident about efficacy. There is precedent, however, for solving compliance problems by requiring persons to take medication by legal mandate (e.g., smallpox vaccine), when not doing so poses a threat to the well-being of others. Exploration of such a solution, should it be considered, would have to be done with due care so as not to infringe on human rights by imposing treatment. Nonetheless, one would not want to deny a convicted offender the right to receive treatment, when this could be done safely, as an option to imprisonment. In trying to provide treatment to patients, protection of potential victims must be considered. However, society as well as the sex offender will likely benefit if the offender can be treated successfully rather than being imprisoned and then released unchanged. There is no evidence, except in the case of the paraphiliac sadist or rapist, that having a paraphiliac syndrome increases the probability of physical violence, and some paraphiliacs seem reasonably well adjusted at work and in other spheres of social endeavor (26).

People do not decide voluntarily what will arouse them sexually. Data presented here suggest that nonlearned biological as well as learned environmental factors may play an etiological role in the development of sexually deviant behaviors. Better understanding of causal factors may eventually lead to more specific forms of treatment. At a symposium at the Massachusetts Institute of Technology Goy and McEwen (27) reviewed evidence suggesting that nonlearned biological factors may be more important determinants of human sexual behavior than is generally appreciated. Improved understanding of possible genetic, hormonal, or neurochemical bases for human sexual pathology should be sought in pursuing further the rationale for treatment with medication. The new positron emission tomographic scanner may help provide additional clues regarding brain functioning during sexual arousal. Currently, treatment with medroxyprogesterone acetate involves using it as a suppressant of sexual desire in general. It seems to decrease the intensity of sexual urges but does not change them qualitatively. If there is an unlearned biological basis for deviant

sexual activity, an ideal medication might suppress deviant sexual cravings alone without affecting more conventional erotic interests. When medroxyprogesterone acetate is discontinued, allowing the sexual appetite to heighten or return, behaviors engaged in to satisfy that appetite are also likely to be reinstituted. Thus, when not taking medication, many paraphiliac men report being unable to use willpower to stop deviant sexual behaviors, and do not. While receiving injections, many of the very same men report that they are then able to stop, and do.

Given our present level of knowledge of the paraphilias, it is still too soon to predict with confidence the future of hormonal treatment programs. It is unclear whether the compliance problems evidenced by some patients can indeed be solved. It is possible that even with improved compliance, future results may yet fail to support preliminary impressions of good therapeutic efficacy. Certainly many more data are needed. Even so, it is already clear that several patients have experienced marked reductions in sexually deviant activity and fantasy while taking medroxyprogesterone acetate. This suggests that the idea of considering at least some sexual offenses to be a behavioral manifestation of intense aberrant drives, possibly related to a dysfunction in brain and representing a condition that is potentially treatable with medication, merits continued investigation. It is hoped that legal demands for justice can be reconciled with medical concerns for understanding care.

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THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
THE JOHNS HOPKINS HOSPITAL

DEPARTMENT OF PSYCHIATRY and BEHAVIORAL SCIENCES

The Henry Phipps Psychiatric Clinic
601 N. Broadway
BALTIMORE, MARYLAND 21205

BIOSEXUAL PSYCHOHORMONAL CLINIC

The Biosexual Psychohormonal Clinic is designed to treat patients with the following problems:

Homosexual Pedophile — Voyeurism — Exhibitionism
Sexual Sadism — Heterosexual Pedophile — Hypersexuality
Transvestism — Other Psychosexual Disorders

Clients usually come to treatment because they are court-referred, self-referred or via other sources, i.e., family or community agencies.

The patient is evaluated by a team of professionals (social workers, nurses, physicians) in our Wednesday A.M. clinic. This assessment may or may not include a physical exam, lab work, and use of information from other agencies. Some of our recommendations may include long term care in a structured facility, inpatient care on our unit at the Johns Hopkins Hospital, referrals to other agencies, outpatient psychotherapy, followup residence at a psychiatric half-way house, vocational rehabilitation referral, and/or Depo-Provera injections.

If, as a result of our evaluation, the patient is admitted to our inpatient service the client is subject to a more complete psychiatric evaluation, physical exam, blood chemistry and may be started on Depo-Provera on a trial basis. (See Dr. Berlin's publication for explanation of Depo-Provera and how the medication is used). The patient is observed closely regarding progress and prognosis. Standard insurances such as Blue Cross/Blue Shield will often cover costs of inpatient or outpatient care and assessment.

When the patient is discharged from our inpatient service he is followed by our outpatient department and Depo-Provera plus psychiatric counseling and continuing reassessment is given weekly or bi-weekly, according to patient needs. Our other responsibilities may also include testifying in court, keeping in contact with probation officers and referring families for counseling.

Currently we are in our "infancy" in our research and investigational treatment of sex offenders. We are interested in knowing about other programs also.

Please send any information to:

Ann Falck, HN or Melinda Stein, RN
Meyer 5
Johns Hopkins Hospital
600 N. Wolfe Street
Baltimore, Maryland 21205

BIOSEXUAL PSYCHOHORMONAL CLINIC

Hours: 9:00 - 12 noon
Wednesdays only

By Appointment Only. For further information and/or appointment, contact Ms. Maggie Rider at (301) 955-6292.

THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
THE JOHNS HOPKINS HOSPITAL

DEPARTMENT OF PSYCHIATRY
and
BEHAVIORAL SCIENCES

The Henry Phipps Psychiatric Clinic
600 N. Wolfe Street
BALTIMORE, MARYLAND 21205

Antiandrogenic and Counseling Treatment of Sex Offenders

RATIONALE FOR DEPO-PROVERA TREATMENT OF SEX OFFENDERS (PARAPHILIACS)

Studies begun at Johns Hopkins in 1963 have shown that sex offenders or paraphiliacs, for example, pedophiliacs, treated with the antiandrogenic hormone, Depo-Provera, plus counseling have gained in self-regulation of sexual behavior. Depo-Provera suppresses or lessens the frequency of erection and ejaculation and also lessens the feeling of libido and the mental imagery of sexual arousal. To illustrate: for the pedophiliac there will be a decreased erotic "turn-on" to children. Metaphorically, this medication can be thought of as an appetite suppressant for the sex drive, intended to make self-governancy easier, usually with the help of adjunctive individual or couple counseling.

ANTIANDROGENIC EFFECT OF DEPO-PROVERA

Depo-Provera, a long-acting, injectable form of medroxyprogesterone acetate manufactured by Upjohn, is a synthetic progestin which is classified pharmacologically as an antiandrogen. Antiandrogen inhibits the release of androgen, the so-called male hormone, from the testicles. Some progestinic hormone is normally present in the male body but at a very low level. Increasing the level allows progestin to compete with androgen and to take over. Androgen is a sexual activator. Progestin is sexually inert. It therefore induces a period of sexual quiescence in which the sex drive is at rest.

MODE OF ENDOCRINE ACTION

In terms used by endocrinologists, Depo-Provera inhibits, through its effect upon neural pathways in the brain, the release of luteinizing hormone (LH) from the pituitary gland. LH is the chemical messenger which normally stimulates the testicles to produce androgen. Hence, the ultimate effect of Depo-Provera is to reduce the level of androgen, especially testosterone, in the blood stream. Typically, in the adult male, Depo-Provera reduces the blood level of testosterone to that of a normal prepubertal boy (from approximately 575 nanograms/100milliliters to 125/nanograms/100 milliliters).

BRAIN EFFECT

In addition to lowering the level of testosterone, Depo-Provera like all progestinic hormones, acts on the brain. In small doses, as in the treatment of sex offenders, the influence on sexual pathways in the brain, though mild, has the great advantage of being sexually calming or tranquilizing. The patient feels relief from an urge that was formerly insistent, commanding, and not subject to voluntary control.

PERIPHERAL PHYSIOLOGICAL EFFECTS

Depo-Provera, through decreasing the testosterone level, temporarily decreases penile erection and ejaculation, and the production of sperm (spermatogenesis). This means that a man probably could not father a child while taking the medication. The medicine is not feminizing (men do not grow breasts). In addition, the sexual

accessory organs, the prostate and seminal vesicles, temporarily shrink. Increased drowsiness, and weight gain, as well as increased blood pressure can occur. Other occasional side effects are discussed in papers published as a result of work in this clinic. Those papers are available.

REVERSIBILITY OF CHANGES — The changes attributed to the medication are reversible upon cessation of treatment; within 7 - 10 days erectile and ejaculatory capacity begin to return, along with the subjective experience of more sexual drive. However, as use of this medication is still relatively new for sex offenders (first use was in 1966), the possibility of irreversible or more long-term side effects cannot be completely excluded.

DOSAGE LEVEL — Tailored for the specific patient, intramuscular injections of Depo-Provera range from 100 milligrams to 800 milligrams every seven days. The typical weekly maintenance dosage of Depo-Provera for sex offenders is 500 milligrams.

HORMONAL MONITORING — Hormonal measures of testosterone and LH (Luteinizing Hormone) initially can be monitored periodically to gauge the effectiveness of the dosage. The recent application of radioimmunological techniques to the assay of testosterone and LH has made such endocrine monitoring precise, reliable, rapid, and relatively inexpensive, as compared to prior methods.

NO INCREASED TOLERANCE — Most patients do not require a progressively increasing dosage, because there is no tolerance build-up to Depo-Provera. However, some may require dosage changes.

COMPARISON WITH SURGICAL CASTRATION — Prior to the discovery, manufacture, and medical use of antiandrogen, the method of reducing the level of testosterone in men was surgical castration. Used in many societies throughout history, castration is disfavored in contemporary American legal-medical management of sex offenders. Obviously, surgical castration is irreversible. It is also less effective than hormonal antiandrogenic therapy. Castration also increases levels of LH from the brain whereas medication lowers these levels.

BEHAVIORAL EFFECTS OF DEPO-PROVERA TREATMENT — In some cases, it is possible for patients to be weaned off Depo-Provera. Since the weaning is a step-by-step lowering of the hormone dosage, it is possible for the patient to discover how completely he has become relieved of the tendency to engage in the sex offending behavior, both in actuality and imagination. In some cases, there is long-lasting remission, so that the patient is no longer compelled to commit sex offenses, but is enabled to have a sex life with a socially suitable consenting partner instead. Some patients prefer to continue on a low, maintenance dosage of the medication so as to ensure a maximal guarantee of no relapse. Those patients who establish a strongly pair-bonded relationship with a permanent partner appear to be additionally guaranteed against relapse. The counseling component of treatment facilitates this achievement and is essential. If for some patients the medication aids only as a sexual appetite suppressant, then stopping the medication would increase the risk of relapse. If the person should again become tempted to repeat his strong, unconventional sexual compulsion (eg; for children, or to expose publicly), then resumption of treatment would be advised.

COMPLIANCE — Some patients, as in all specialties of medicine, are more faithful than others in adhering to medication schedules. Some overly confident patients drift into non-compliance. Other patients neglect specific instructions about their medication schedule. For this reason, it is advisable that as a condition of probation or parole, supervision be legally required so as to ensure strict compliance in adhering to the treatment schedule.

STATISTICAL ASSESSMENT — Sex offenders treated with Depo-Provera at Johns Hopkins are kept in long-term follow-up. Twenty have now been followed for between 5 months and 15 years. Of this group, 17 have proved able to self-regulate their sexual behavior while receiving the medication, and 3 have had relapses. Almost all who stopped medication against medical advise subsequently relapsed.

COUNSELING THERAPY — Counseling sessions are provided weekly, at first, and then may be tailored to individual needs. These sessions are intended to help the patient to establish a new life-style. They are also intended to help the patient cope with problems that have developed as a consequence of his prior life style. Therapy may occur either individually or with groups.

BIOSEXUAL PSYCHOHORMONAL CLINIC
Department of Psychiatry and Behavioral Sciences
The Johns Hopkins University School of Medicine

John Money, PhD
Professor of Medical Psychology
Associate Professor of Pediatrics
Co-Director, Biosexual Psychohormonal Clinic

Fred S. Berlin, MD, PhD
Assistant Professor of Psychiatry
Co-Director, Biosexual Psychohormonal Clinic

Ann Falck, RN
Head Nurse
Co-Director, Biosexual Psychohormonal Clinic

Melinda Stein, RN
Clinical Coordinator,
Biosexual Psychohormonal Clinic

THE BIOSEXUAL PSYCHOHORMONAL CLINIC
EVALUATION SERVICES

Before a patient can be accepted into the treatment program of the Biosexual Psychohormonal Clinic an evaluation appointment is necessary.

Evaluations before possible admission into the program are performed through the outpatient services, Meyer Building, of the Johns Hopkins Hospital. Appointments are made through Ms. Maggie Rider, (301) 955-6292. The service is ordinarily performed only on Wednesday mornings beginning at 8:30 a.m., and will generally be completed by noon.

The cost of this visit is currently $160 for the evaluation, plus $120 for lab fees (blood will be drawn and a number of lab tests will be performed). Payment is expected at the time of the visit. However, insurance may cover part or all of the fees. You will be expected to file a claim for reimbursement. Medical Assistance is accepted. However, if your Medical Assistance originates from another state we will need prior confirmation that your home state will cover our costs. When a service is not available in one state but is available in another the home state will frequently allow this cost to be paid from their funds. Should you have major medical insurance coverage please be sure to bring the necessary forms at the time of the appointment. If documented financial need can be provided sometimes a deferred payment plan can be arranged. A deposit is required to hold an appointment date.

Inpatient evaluations are often done for those patients who reside outside the state of Maryland. This type of evaluation consists of an in hospital stay of approximately three to four weeks. Treatment plans are formulated and begun during this time, as well as plans for continuing care after discharge, based on the individual needs and circumstances.

In some cases emergency evaluations can be arranged performed on an outpatient basis. Costs are based on the time spent with a physician, plus the lab fees. An approximate fee would be in the vicinity of $200, plus the $120 lab fee.

Currently the waiting time before being seen for these services is approximately:

_____for outpatient evaluation, _____for inpatient evaluation, and

_____for emergency evaluation.

Below is a suggested reading list of references from the medical journals regarding the treatment of sexual disorders. On request (there is a charge of $10) we will supply reprints of the articles by Dr. Berlin).

Berlin, FS and Coyle, GS: Sexual Deviation Syndromes. Johns Hopkins Medical Journal, 149, 119-125 (1981).

Berlin, FS and Meinecke, CF: Treatment of sex offenders with antiandrogenic medication: Conceptualization, review of treatment modalities, and preliminary findings. American Journal of Psychiatry 138:601-607, 1981.

Berlin, FS: Sex Offenders: A Biomedical Perspective and a Status Report on Biomedical Treatment, in "The Sexual Aggressor: Current Perspectives on Treatment", Greer, JG and Stuart, IR, eds. Van Nostrand Reinhold Co., New York 1983.

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THE BIOSEXUAL PSYCHOHORMONAL CLINIC EVALUATION SERVICES
Request for Services Information Sheet

THE JOHNS HOPKINS HOSPITAL
BALTIMORE, MARYLAND

NAME _____ ADDRESS _____

PHONE (work) _____ (home) _____

DATE OF BIRTH _____ S.S.# _____ MARITAL STATUS _____

FATHER'S NAME _____ MOTHER'S MAIDEN NAME _____

EDUCATIONAL LEVEL _____ MEDICATIONS _____

NAMES AND ADDRESSES (If appropriate)

ATTORNEY: _____ PHONE _____

PAROLE OFFICER: _____ PHONE _____

PSYCHIATRIST (or mental health professional):
_____ PHONE _____

FAMILY PHYSICIAN _____ PHONE _____

WHO REFERRED YOU TO THIS PROGRAM? _____

REASON YOU WANT TO BE SEEN HERE _____
(Name specific behavior)

INSURANCE COMPANY: _____ POLICY NUMBER: _____

DO YOU WISH AN APPOINTMENT FOR ___OUTPATIENT EVALUATION, ___INPATIENT EVALUATION, OR

___ EMERGENCY APPOINTMENT (see other side of sheet for expected time of appointment)

A copy of your legal history and current charges must be forwarded to us in advance of your appointment. (If applicable) Your appointment may be cancelled if not received.

Additionally, a report from any psychiatrist or mental health professional who may have treated you in the past is required. You will need to provide a release of information to the appropriate person in order for them to forward this background to us. Please have the materials sent to the address below.
All of the information received is held in strictest confidence. It will be used to give the examiner as full a picture as possible ahead of time about what has taken place in your life before coming to us.

An appointment will be sent to you at the address listed above unless you indicate otherwise. _____

Please return this sheet to:

Ms. Maggie Rider, Appointments Secretary
Meyer Building, 4-181
Johns Hopkins Hospital
600 North Wolfe Street
Baltimore, Maryland 21205

Mail this sheet back as soon as possible. Psychiatric and legal history may be forwarded under separate cover, along with a deposit of $50.

FEE SCHEDULE

CLINIC EVALUATION	$160
LAB - BLOOD WORK	120
CONSULTATIONS	90 (per hour)
RE-EVALUATION	75
GROUP THERAPY SESSION	35
DEPO-PROVERA INJECTION	27.50

(Fees are subject to change. Please inquire. Deferred payment plans considered with documented financial need.)

THE SEXUAL AGGRESSOR

Current Perspectives on Treatment

JOANNE G. GREER, Ph.D.
Office of the Inspector General
Department of Health and Human Services
Washington, D.C.
formerly, Deputy Chief,
National Center for Prevention and Control of Rape
National Institute of Mental Health
Rockville, Maryland

IRVING R. STUART, Ph.D.
Department of Psychology
Lehman College of the City University of New York
New York, New York

VAN NOSTRAND REINHOLD COMPANY
NEW YORK CINCINNATI TORONTO LONDON MELBOURNE

5

Sex Offenders: A Biomedical Perspective and a Status Report on Biomedical Treatment*

Fred S. Berlin, M.D., Ph.D.

Individuals may be considered sex offenders if they behave in particular ways, for example, by becoming sexually intimate with a child. In general, behavior, whether sexual or nonsexual, is a reflection of one's state of mind, as persons tend to act in response to their thoughts and feelings. Some states of mind can be considered pathological, for example, when an individual loses the capacity to determine whether heard voices are coming from the environment or are imaginary. This type of psychological impairment can occur in a variety of psychiatric syndromes such as schizophrenia, dementia, delirium, or manic depressive illness–each of which requires a different form of treatment. Persons mentally ill in these ways sometimes commit sex offenses. On the other hand, some persons commit sex offenses in response to intense, unconventional sexual hungers (e.g., for children). Individuals with deviant or unconventional sexual orientations may also require psychiatric help. Properly diagnosing whether a sex offense is the manifestation of a specific psychiatric syndrome such as schizophrenia, dementia, mania, exhibitionism, or pedophilia can be important in trying to provide optimal care. The etiological determinants of conventional, as well as of unconventional, erotic interests are undoubtedly multiple, but there is evidence that biological factors such a hormone levels or chromosomal makeup sometimes play a major contributory role with respect to the nature of an individual's sexual desires. Biological treatments which alter the physical milieu of the brain, for example, by decreasing the amount of the "male sex hormone" testosterone that is present, may sometimes be able to facilitate better self-control of sexual behavior. This, might be the case, for instance, if treatment that lowers testosterone levels results in a pedophile experiencing a decrease in the subjective intensity of his unconventional sexual appetite. There may be implications regarding how society through its laws should view some sex offenders if (a) it is the case that biological factors, such as

*The author gratefully acknowledges the kind and invaluable assistance of Ms. Maggie Rider, Ms. Claudia Halko, Ms. Deborah Holifield, Ms. Nancy Mace, Mr. Timothy Rider, and Dr. Phillip Slavney in the preparation of this manuscript.

chromosomal abnormalities, contribute to the development of unconventional erotic desires that may tempt persons to want to commit sex offenses, and if (b) it is also the case that surgical or antiandrogenic medication treatments can result in biological and psychological changes that provide such individuals with an increased capacity for self-control not previously present.

PART I: SYNDROMES AND THE IMPORTANCE OF DIFFERENTIAL DIAGNOSIS

Introduction

The present chapter discusses the importance of making a proper differential diagnosis in assessing "sex offenders" for potential treatment. It also explores the relationship between biological factors, such as hormone levels or chromosomal anomalies, and sexual phenomenology (i.e., the mental experiences, thoughts, lusts, and fantasies that constitute states of erotic desire). Currently available treatments are briefly reviewed from a biomedical perspective, with a particular emphasis on the use of surgery and medications. The idea of using pharmacological agents to treat sex offenders is relatively modern, although surgical procedures such as castration which, like some medications, diminish androgen levels have been employed for this purpose for quite a while. The following is a brief case vignette which serves as an example of the type of patient for whom medication treatment may be appropriate, as well as a basis for the subsequent discussion of the various issues and considerations, diagnostic and otherwise, which must be reflected upon in trying to provide optimal understanding and care.

Case Presentation

Mr. A., a 40-year-old white male, was referred by his attorney for assessment as a consequence of the patient's sexual involvement with a 13-year-old boy. Having been charged five years earlier with a similar offense, at the time of his assessment the patient was on court-mandated probation. Though apprehended only once before, he had been sexually active almost exclusively with young males, most ranging between the ages of 14 and 17 (but some as young as age 8), since he himself was 7 years old.

Sexual activity, which included undressing, fondling, mutual masturbation, and oral-genital contact occurred frequently with a variety of partners, sometimes as often as several times per month. In almost all cases the children were persuaded rather than coerced, but in two instances, while intoxicated, Mr. A. threatened the victims with a paring knife. The patient indicated that he had begun to drink frequently "to get up the courage to approach potential partners."

After each incident the patient felt ashamed and guilty, vowing that he would try not to act similarly in the future. However, in time, as his sexual urges began once again to intensify, he would give in to temptation. The mere happenstance of watching young boys in television commercials would sometimes elicit a strong urge to focus his attention towards the child's genital area. In describing the mental experiences that led him to act in these ways, the patient, in an interview with Dr. John Money, made the following comments:

> If I have seen an exceptionally nice looking boy I get aroused. I want to go over there, but then again I don't. I see him, and I want to get out of there because I know I am going to start fantasizing. I have noticed that the first thing is I drop my eyes to his genitals. It gets more intense, the fantasies, that is. I dream about a South Sea island, nothing but boys on the island. It is kind of like a fight between the good side and the bad side, like Dr. Jekyll and Mr. Hyde. Sometimes the way to cure it is to masturbate, and that takes care of it. There are other times when I get so aroused I just have to get it sexually together. It worries society. It worries me very much. I know it is wrong. I know what the legal issues are, but at the time I am not thinking of legal issues. All I can think about is getting the boy. I want to keep doing it, and doing it, and doing it. No matter how. Getting the boy. Sometimes I think, "Hey, what are you doing? I don't want to hurt anyone." I really do not want to hurt these children, but I am very afraid that I might.

In attempting to understand his condition, the patient made the following comments:

> What starts a person like myself doing what I do? Why me? Why can't I be normal like everybody else? You know. Did God put this as a punishment or something towards me? I am ashamed. Why can't I just go out and have a good time with girls? I feel edgy when a female is present. An older "gay" person would turn me off. I have thought about suicide. I think after this long period of time I have actually seen where I have an illness. It is getting uncontrollable, to the point where I can't put up with it anymore. It is a sickness. I know it's a sickness, but as far as they [society] is concerned, you are a criminal and should be punished. Even if I go to jail for 12 or 15 years, or whenever, I am still going to be the same when I get out.

This last statement was not meant to be defiant.

Physical and laboratory examination of the patient revealed a number of biological pathologies (see Table 5-1). These findings suggest that the patient has Klinefelter's syndrome, the significance of which will be discussed subsequently.

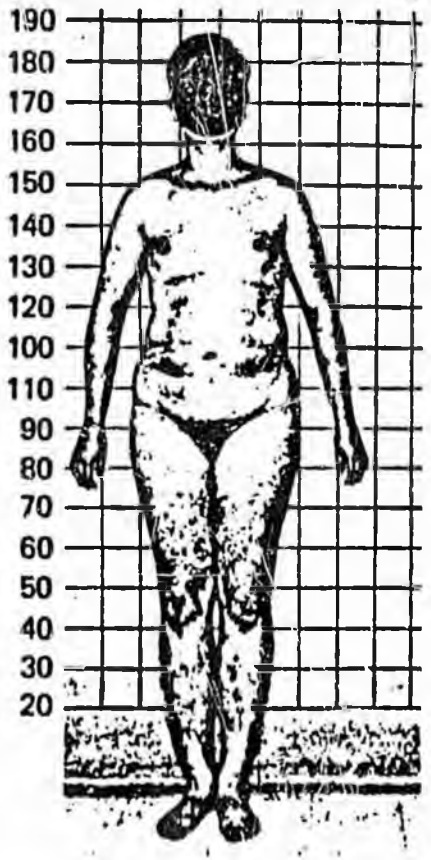
Table 5-1. Abnormal Physical and Laboratory Findings on Mr. A.

Physical Findings:

1. Scars on chest from previously performed bilateral mastectomies, done because of gynecomastia (enlarged breasts) which developed at puberty
2. Hypogonadism (small testicles)
3. Abnormally long arms and fingers

Laboratory Findings:

1. Low sperm count
2. Elevated luteinizing hormone (148 ng/ml); normal LH in adult males = 36–64 ng/ml
3. Elevated follicle stimulating hormone (638 ng/ml); normal FSH in adult males = 98–276 ng/ml
4. Low testosterone (153 ng/100 ml); normal (s.d. = 2) range in adult males = 275–875 ng/ml
5. 47 XXY chromosome pattern; normal male pattern = 46 XY



Typical patient with Klinefelter's syndrome. Note the gynecomastia and female distribution of adipose tissue. (Photo courtesy of Dr. John Money.)

Pedophilia as an Example of a Diagnosable Sexual Deviation Syndrome

The case just presented is an example of homosexual ephebophilia, which means that the patient is a man whose sexual orientation, interests, and preferences are directed predominantly towards postpubertal boys. Were he interested mostly in prepubertal boys, a diagnosis of pedophilia, rather than ephebophilia, would be more accurate. For purposes of the present discussion, the term pedophilia will be used when referring to persons sexually oriented towards children, regardless of whether the children are pre- or postpubertal.

According to the 3rd edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III), there are three criteria which must be satisfied in order to make such a diagnosis.[1] First, it is necessary to establish that the patient becomes erotically excited by the act or fantasy of engaging in sexual activities with children. Secondly, if the patient is an adult, rather than an adolescent, the children must be at least ten years his junior. Finally, it must be clear that any sexual acts engaged in with children are not either due to other mental disorders such as schizophrenia, dementia, or drug intoxication, or due to lack of an suitable age-appropriate partner, which occurs in some cases of incarceration or incest.

As is true of persons with conventional heterosexual interests, the onset of sexual behavior in persons with unconventional, or "deviant," erotic desires usually begins around the time of puberty. Related fantasies, however, may have been experienced much earlier. In the absence of appropriate treatment, the course of such syndromes tends to be chronic, which is not surprising because the sex drive is maintained over time.

In terms of reported cases, pedophilia appears to be almost exclusively a male problem, although its exact prevalence is unknown. The majority of cases in the literature have involved heterosexual pedophilia (men attracted towards little girls), but more recently some centers have reported a higher frequency of homosexual involvements.[2] In ancient Greece, homosexual pedophilic behavior was considered acceptable. Socrates, for example, wrote, "A valued company might be composed of boys and their lovers . . . for of all men they would be ashamed to desert one another."[3] Judeo-Christian beliefs, however, based in part upon the biblical story of Sodom and Gomorrah (hence, the term sodomy), clearly consider it to be immoral.[4–6] In some states, a possible legal sentence for engaging in sex with a minor is the death penalty.[7] Although in American society a child can clearly become quite distressed by involvement with a pedophile (hence the importance of applying effective interventions to stop such behavior), it is also the case that some children become even more upset by the reactions of well-intentioned adults who find out about their sexual involvements.[8] Tragically, sometimes children also feel guilty and responsible for any punishment imposed upon a former partner, a person (perhaps even a relative) whom they may actually like a great deal.

Sexual activity by pedophiles with children rarely involves physical assaultiveness and is usually the result of persuasion rather than coercion, although the series of brutal slayings in Atlanta, Georgia, during 1980 and 1981 represented an exception.[9] A study in Detroit, Michigan, of over 1752 sex offenses against children found that physical injury occurred in less than 9% of the cases.[10] When a pedophile craves sadistic sexual involvement with children, a second diagnosis of erotic sadism should also be made. Though most children are warned to be leery of strangers, the victims of pedophiles, unlike the victims of exhibitionists, usually know their partners well, and sexual activity (which is often mutual fondling and masturbation rather than intercourse) frequently occurs in the home of either the victim or the perpetrator.[1,8] Whereas some pedophiles merely lust after children, some seem to fall in love with them, which may make treatment more difficult.

Why persons differ from one another in sexual orientation and in the nature and intensity of their erotic desires is unknown. It is unclear why most men find women sexually appealing whereas some are erotically attracted towards young boys. Nor is it clear why still others experience recurring urges to expose themselves publicly or to rape repeatedly. In some instances, certain types of early childhood experiences seem to play a contributory factor in determining adult sexual interests. Many pedophiles, for example, were themselves sexually involved with adults as youngsters.[11] In other cases, biological pathologies such as structural brain damage, hormonal dysfunctions, genetic anomalies, or electrical disturbances of the brain seem to play a role.[2,12] Persons who meet the diagnostic criteria for a sexual deviation syndrome, of which pedophilia is an example, may be appropriate candidates for treatment with antiandrogenic medications.

Diagnosing a Sexual Deviation Syndrome

The term used in DSM III to categorize sexual deviation syndromes is paraphilia, which means attraction to deviance.[1] Diagnosis of a sexual deviation syndrome can be made by inquiring about a person's thoughts, feelings, and behaviors. Individuals with deviant sexual interests ordinarily experience repeated erotic fantasies about engaging in unconventional forms of sexual activity. Asking an individual about his masturbatory fantasies can be revealing in this respect because erotic arousal for the purpose of masturbation may be difficult in the absence of erotic mental imagery.[13,14] The homosexual pedophile frequently fantasizes about young boys, whereas the heterosexual exhibitionist has recurring thoughts about exposing himself to women. The male transvestite is preoccupied with the idea of cross-dressing in female clothing. Rather than depending solely upon introspective reports, Dr. Gene Abel of the New York State Psychiatric Institute suggests that the rate of change in the diameter of the pupil of the eye can also be used as a means of determining whether a particular stimulus, such as the picture of a nude child, is sexually arousing (see Figure 5-1). Measures of penile tumescence and other forms of polygraphic data have also been used to try to document unconventional sexual interests.[13]

Accompanying the unconventional sexual fantasies experienced by persons who can be diagnosed as having a sexual deviation syndrome are intense erotic cravings. These cravings are experienced as frustrating and discomforting when deviant fantasies cannot be enacted. Karl Jaspers, the eminent German phenomenologist (who was probably influenced in his thinking by Krafft-Ebing and Havelock Ellis), characterized deviant sexual cravings as intolerable states, similar to addictions, that demand action in order to be alleviated.[16] However, many persons with conventional heterosexual interests can also feel discomforted if sexually frustrated; such frustration may motivate a person to seek out a consensual sexual partner. The individual with a pedophilic sexual orientation, however,

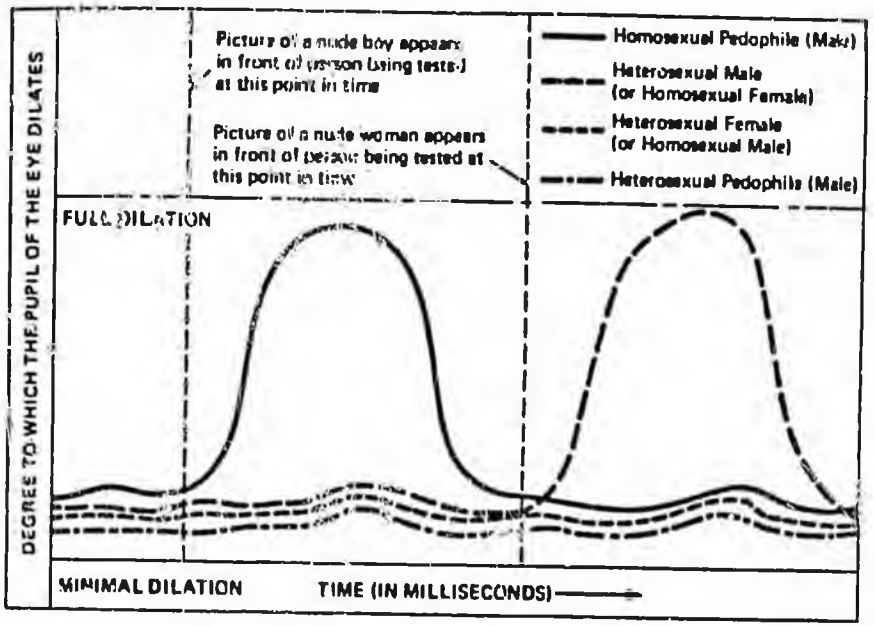


Figure 5-1 Schematic representation of the pupillary responses of four persons with different sexual orientations.

faces much greater difficulties in the sense that all those whom he may find naturally appealing (i.e., children) are forbidden as partners. Living in a world where all those who are sexually appealing are forbidden as partners must be difficult—a situation heterosexual adults can, perhaps, empathize with by imagining living in a world where one was expected to have sex only with children.

People do not decide voluntarily what will arouse them sexually. Rather, they discover within themselves what sorts of persons and activities are sexually appealing to them. Sexual behavior in general tends to be in part a response to one's erotic desires and fantasies. Thus a man with conventional heterosexual interests tends to seek out adult women, just as the homosexual pedophile (who may be impotent with women) seeks out boys. The heterosexual voyeur repeatedly seeks out situations where he can "peep" upon unsuspecting naked or partially clad females in response to his sexual cravings, whereas the male transvestite repeatedly cross-dresses.

DSM III lists nine major diagnostic subcategories of paraphilia (see Table 5-2).[1] In earlier, outdated classification schemes, sexual deviation syndromes were often considered to be a subdivision of the so-called sociopathic personality type. It is important to appreciate that sexual orientation can be assessed independently of character traits. Some men with unconventional sexual orientations show no other evidence of "sociopathic personality traits," such as disrespect for authority, other

kinds of criminal behaviors, truancy, vocational irresponsibility, or lack of concern for others. On the contrary, men with unconventional sexual orientations such as pedophilia can manifest a range of character traits, just as is true of persons with conventional heterosexual orientations."[17] Thus, terms such as pedophilia refer to the nature of a person's sexual orientation or to the nature of his sexual desires, and not to his traits of character. A paraphiliac man who has been consistently nonviolent in temperament would not ordinarily be expected to undergo a sudden change in personality so as to become a physical danger to others.

Table 5-2. Major Diagnostic Subcategories of Paraphilia.

1. Pedophilia
2. Exhibitionism
3. Transvestism
4. Voyeurism
5. Zoophilia
6. Fetishism
7. Erotic sadism
8. Erotic masochism
9. Other (includes paraphiliac or compulsive rape)

Differential Diagnosis as a Basis for Determining Appropriate Psychiatric Treatment

Many persons are referred for psychiatric assessment and possible treatment by virtue of the fact that they have behaved in a particular way (e.g., by having sexual involvement with a child) and, thus, they carry the label "sex offender." Not all sex offenses (a legal term), however, are the reflection of a sexual deviation disorder or paraphilia (a medical term). In assessing a sex offender for possible treatment, the psychiatrist or evaluator must try to ascertain (1) the state of mind the individual was experiencing that led him to act in a particular way, and (2) whether the behavior in question was the manifestation of a diagnosable and potentially treatable psychiatric syndrome.

A sex offense could represent the expression of any of a number of psychiatric conditions. Schizophrenia, for example, is a syndrome comprised of (1) delusions, which are rigidly held, idiosyncratic, false beliefs that cannot be corrected by reason (e.g., the belief that one has a bomb inside one's head); (2) auditory hallucinations ("hearing" voices when no one is speaking); (3) disorganized thinking (in both logic and syntax); (4) insomnia; (5) agitation; (6) emotional apathy; (7) loss of initiative; and (8) bizarre behavior.[18] The term schizophrenia refers to the cluster of associated features comprising the syndrome and not to the person manifesting the condition.[19] Schizophrenia must be differentiated from other psychiatric syndromes such as dementia, delirium, and affective illness because delusions, hallucinations, and bizarre behavior may occur in these disorders as well. In dementia and delirium, however, delusions and hallucinations when present are accompanied by disorientation and intellectual decline, whereas in affective illness these symptoms occur within the setting of a sustained mood change. The age of initial onset of schizophrenia is almost always in the late teens or early twenties, and like a variety of other medical conditions (such as juvenile onset diabetes), its course is chronic. There is evidence that this form of mental illness, in which persons lose the capacity to perceive accurately whether heard voices are real or imaginary, may be associated with a genetic predisposition.[18] Thus, schizophrenia seems to occur most frequently within certain families. An associated biological pathology may be the presence of heightened levels of various chemical neurotransmitter substances (such as dopamine) in the brain.[20]

Mr. B. was a patient who developed the delusion that he needed to drink the blood of women in order to remain alive. Initially, in response both to this rigid false belief and to "voices telling him to do so," he sacrificed several animals and drank their blood. Subsequently, he physically assaulted several women in an effort to obtain blood from them, which resulted in his being charged with a second degree sex offense. In this case, the offense in question was clearly a behavioral manifestation of his schizophrenic condition, and his sexual orientation and erotic desires were apparently quite conventional. Appropriate treatment for the symptoms of schizophrenia includes the use of phenothiazine medications or other sorts of neuroleptic drugs.[21] However, just as is the case when insulin is employed to treat diabetes, present-day pharmacological therapy does not represent a complete cure for this illness.

Sex offenses can also be a reflection of other psychiatric conditions such as manic-depressive illness.[22] In addition to delusions of grandeur (e.g., the belief that one is Christ) and elated mood, one of the other symptoms of the manic syndrome is often an increase in sexual appetite. Mr. C. is a 54-year-old man who would repeatedly expose himself to middle-aged women only when in the midst of such an episode. At other times, when his mood was stable and his capacity to perceive reality intact, he would never act in such a fashion. The appropriate treatment in his case, as a prophylaxis against future recurrences of this psychiatric illness (whose natural course, like asthma, is episodic rather than chronic), is lithium carbonate. When well, this patient experienced perfectly conventional erotic interests and, thus, would not satisfy the diagnostic criteria of a sexual deviation syndrome.

Sex offenses can be perpetrated by persons with conventional sexual desires and orientations while intoxicated with drugs or alcohol. Here psychological counseling (plus, perhaps, Antabuse—a medication that makes a person feel physically ill if he consumes alcohol while taking it) would likely be the treatment of choice. A mentally retarded person with conventional erotic interests who "didn't know any

better" might also commit a sex offense and possibly require counseling plus sex education. Mr. D. is an intelligent man with conventional sexual interests who began an incestuous relationship with his sister before either of them was old enough to appreciate the implications of such behavior. Here, counseling to help them deal with their guilt and family concern was the treatment employed. Finally, a self-centered, self-indulgent person with conventional sexual desires, but with no concern for the well-being of others, might also commit a sex offense. An example would be the criminal who rapes a woman in the midst of a robbery because he feels he can get away with it. Such a person might well have no diagnosable psychiatric illness, and a proper disposition might include quarantine in the form of incarceration.

Rationale for Treatment When a Sex Offense Is the Manifestation of a Sexual Deviation Syndrome

Based upon the preceding discussion it should be clear that some sex offenses are committed by men who are not simply self-indulgent individuals with conventional erotic interests misbehaving. Unlike the homosexual pedophile, most men (including homosexual men) experience absolutely no desire to engage repeatedly in sexual involvements with young boys.[23] Rather, the average man would be repulsed by such an idea. Whereas the exhibitionist lusts for the opportunity to repeatedly expose himself publicly, most men would be embarrassed or humiliated at the prospect of behaving in such a fashion. Though many men might indeed turn their gaze towards a partially clad woman visible through a nearby window, few experience recurrent urges to "peep" repeatedly at the risk of job, reputation, family, and incarceration as does the voyeur.[24,25] The average man would feel foolish dressed in woman's clothing, whereas the male transvestite finds this erotically arousing. Although many men find themselves capable of being sexually stimulated by descriptions or scenes of coercive sexual acts, the average man certainly does not experience repeated ruminations and cravings to rape. Nor, as is the case with the paraphiliac (or compulsive) rapist, does he repeatedly have to resist the temptation to rape in order to remain out of trouble.[2] Thus, the assumption that paraphiliac behavior is little more than misbehavior is a conceptually invalid oversimplification. This kind of oversimplification leads to interventions that are rehabilitatively ineffectual. The recidivism rate is extremely high when punishment is the "treatment" of choice, as punishment does virtually nothing to make it any easier for a man to resist deviant sexual cravings. One hears of numerous instances in which a paraphiliac rapist, recently freed from prison on work release, has already raped again repeatedly. Quarantine, as opposed to punishment, may indeed be necessary so long as an individual poses a threat to others (as is sometimes true of some persons with contagious diseases), but if effective treatment that assures public safety can be applied, the need for isolation from the community may be obviated.

PART II: BIOLOGICAL PATHOLOGIES AND ETIOLOGIES

Klinefelter's Syndrome as an Example of a Biological Condition Possibly Predisposing towards Sexual Deviation

Mr. A., whose case was discussed earlier, was found to have Klinefelter's syndrome. Dr. Harry Klinefelter and his colleagues described this condition for the first time in 1942 in the *Journal of Clinical Endocrinology*.[26] Klinefelter's syndrome is a condition characterized by (1) the development of gynecomastia (enlarged breasts) at the time of puberty, (2) aspermatogenesis (low sperm production), and (3) an increased excretion of follicle stimulating hormone (FSH) by the pituitary gland in the brain.

Normally a person without Klinefelter's syndrome has 23 pairs, or a total of 46, chromosomes—each of which contains millions of genes. One-half of each chromosome pair is obtained from the mother, and the other half from the father, at the moment of conception. Twenty-two of the 23 chromosome pairs are termed autosomes, and as far as is known they are not directly related to the determination of the body's gender appearance.

In most cases, every cell in a person's body contains a replica of all 46 chromosomes. Any cell can be obtained from an individual, prepared in a special way, and then looked at under a microscope, to actually visualize them. When this is done, ordinarily by looking at a white blood cell, the chromosomes can be lined up and numbered as shown in Figure 5-2. Usually these chromosomes look the same in every cell. When this is not so, as when some cells contain 46 chromosomes but others 45, this is known as a mosaic pattern. The top part of each chromosome pair is called the p-section, and the lower part the q-section. If a chromosome abnor-

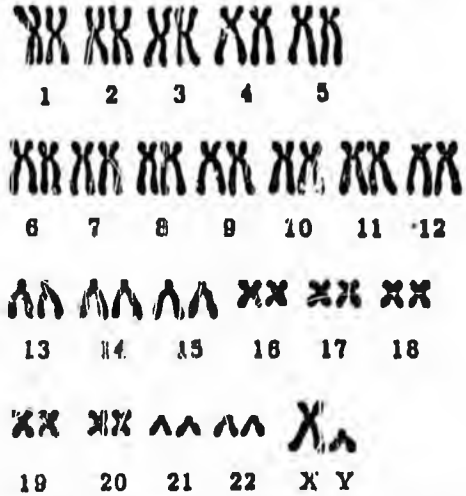


Figure 5-2. Normal male (46 XY) chromosome pattern.

mality were to consist of extra genetic material being present on the top part of chromosome pair number 9, this would be indicated by the notation 9 (p+).

If one of the 23 pairs of chromosomes looks like a small X matched with another small X, a person will look like a female at birth (barring certain medical complications).[27] On the other hand, if that chromosome pair looks like a small X matched with a small Y, the person will usually look like a male because the presence of a Y-shaped chromosome ordinarily instructs the body to take on a male appearance. On rare occasions, a woman may be found to have an XY rather than an XX chromosome pattern, if chemical receptors in the cells in her body lack the capacity to respond to genetic messages sent out via hormones from the Y chromosome.[28]

In Klinefelter's syndrome, instead of having 23 pairs of chromosomes for a total of 46, 47 chromosomes are present, one of which is an extra X. Thus, although due to the presence of a Y chromosome, the Klinefelter's child ordinarily appears to be a boy at birth; genetically speaking, the child can be thought of either as a male (XY) with an extra X chromosome or as a female (XX) with an extra Y chromosome. Although most Klinefelter's patients have only one extra X chromosome and are therefore said to have a 47 XXY karyotype pattern, some have even greater numbers of additional X chromosomes present.

Besides the XX or XY pattern, other physical indices have been used to try to ascertain biological gender. Although most women have two X chromosomes in every cell, one of these two is ordinarily partially inactivated.[29,30] As a result, if a cell is taken from a woman, by gently scraping the buccal surface of her tongue, and it is then properly prepared and looked at under a microscope, a clump of stained chromatin will be seen within this cell's nucleus. Lyon was the first to suggest that this "chromatin positive material," also known as a Barr body, is actually a partially inactivated and clumped up extra X chromosome.[31] Since the "normal" (XY) male has only one rather than two X chromosomes, he has no extra one present to clump, and thus he will test chromatin negative. The Klinefelter's male, however, because he does have two X chromosomes will stain chromatin positive and thus, on the basis of this test, appear to be a female.

Another test sometimes used to identify biological gender involves looking at neutrophils, a type of white blood cell, under a microscope. Ordinarily the nucleus inside a neutrophil obtained from a woman contains a drumstick-like appendage (see Figure 5-3).[31] This "drumstick" is not seen in neutrophils obtained from "normal" (46XY) males, but it is seen in Klinefelter's patients.

As early as 1957, Money and Hampson suggested that sex differences can be looked at in a variety of ways besides physical appearance (see Table 5-3).[32] When this is done using Klinefelter's patients as an example, it becomes clear that questions as to whether an individual is a man or a woman, and questions about what sexual orientation and gender identity should be, become much more difficult to answer than is ordinarily appreciated. Because Klinefelter's patients are born looking like males, their parents naturally enough routinely assign them a male sex role, and they are raised as boys. However, in terms of gender identity, some of

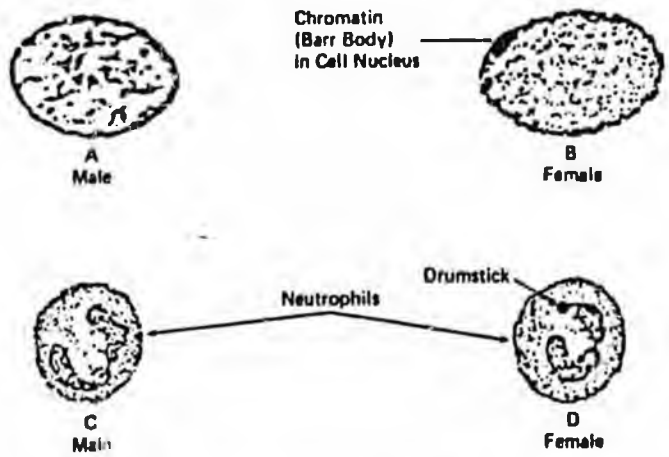
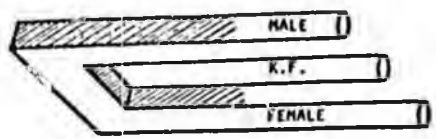


Figure 5-3. (A) Cell nucleus from buccal smear of "normal" male. (B) Cell nucleus from buccal smear of "normal" female. (C) Neutrophil from "normal" male. (D) Neutrophil from "normal" female.

Table 5-3. Male versus Female Sexual Characteristics in Klinefelter's Patients.

	IN KLINEFELTER'S SYNDROME (K.F.)
1. Sex of assignment and rearing	*Male*
2. Feelings of gender identity	May be *male* or *female*
3. (a) Sexual orientation (b) Sexual behavior	May be towards members of the same or opposite sex (which sex is the opposite sex in K. F. syndrome?)
4. External anatomical sex (phenotype)	*Male* at birth; then becomes both *male* and *female* (e.g., enlarged breasts) at puberty
5. Hormonal sex	Hormonal profile (of testosterone, FSH, and LH) is similar to postmenopausal *females*
6. Gonadal (and internal anatomical) sex	Male, but *hypogonadal*
7. Chromosomal sex (genotype)	*Male/female* — karyotype (XXY) *Female* — Barr body *Female* — neutrophilic drumstick



them, as early as age 7, have felt themselves psychologically to be girls.[33] Dr. John Money described the case of an otherwise normal 8-year-old boy brought for psychiatric assessment by his frustrated parents because he insisted he felt more comfortable dressed in girls' clothing. Chromosomal analysis revealed that he had Klinefelter's syndrome. As demonstrated by the case of Mr. A. discussed earlier, a number of Klinefelter's patients are sexually attracted to little boys rather than to members of the opposite sex, but in some ways it is unclear which sex is the opposite sex when it comes to Klinefelter's syndrome. Why some Klinefelter's patients find children rather than adults appealing is unclear. It is clear, however, that the sight of an infant usually elicits some feeling (albeit asexual) in most people. The possibility that feelings towards children (including the so-called maternal instinct) may be at least partially influenced by genetic factors cannot be excluded.[34] Although body phenotype is masculine during childhood, 80% of Klinefelter's patients grow large breasts and develop a "female distribution of adipose tissue" at the time of puberty (see Table 5-1).[35,36] The "hormonal sex" of these patients as measured by levels of FSH, LH, and testosterone is somewhat similar to that of a postmenopausal woman. Although Klinefelter's patients have testes rather than ovaries, their testes are very small, and produce little testosterone and virtually no sperm. As noted earlier, in terms of (1) chromosomal karyotyping, (2) Barr body testing, and (3) assessment of neutrophils for the presence of "drumsticks," Klinefelter's males produce the same test results as females. Thus, perhaps it should come as no surprise when one discovers that a patient like Mr. A. who has Klinefelter's syndrome also has problems in terms of sexual orientation and in terms of the nature of his erotic desires.

Although Klinefelter's patients have been well studied medically, little epidemiological data surveying the prevalence of sex-related disturbances in the Klinefelter's population as a whole are available.[37] In many studies, pertinent questions regarding sexual phenomenology and experience were never asked.[38] Furthermore, the prevalence of sexual deviation, gender dysphoria, and related phenomena amongst the general public has not been well documented and therefore is unavailable for comparison purposes. For these reasons, in spite of the case of Mr. A. presented earlier, conclusions regarding the relationship between Klinefelter's syndrome and sexual deviation must be evaluated cautiously. Nevertheless, review of the literature (despite some disagreements[35,39,40]) suggests that the prevalence of sexual deviation syndromes in Klinefelter's patients may indeed be higher than it is amongst non-Klinefelter's men.[41–50] Baker and Stoller, for example, reviewed over 100 pertinent articles and arrived at such a conclusion.[33] Since most Klinefelter's patients appear to be essentially normal boys until puberty, it is difficult to account for this apparently high prevalence of sexual deviation on the basis of child rearing practices or other types of early life experiences.

Not all patients with Klinefelter's syndrome show evidence of sexual deviation; rather some are hyposexual instead. In such cases, testosterone has sometimes been administered to increase rather than decrease sexual capacity. When this has been done, these patients have reported a heightening of erotic desire, which again demonstrates the apparent relationship between testosterone levels and sexual phenomenology.[51–53]

Although most Klinefelter's patients have low testosterone levels, often the levels are not so low as to obliterate sexual desire significantly. Therefore, when sexual desires are deviant, as is the case with pedophilia, attempts to further reduce sexual appetite may still be warranted. This highlights the fact that the rationale for utilizing testosterone-depleting methods to treat paraphiliacs is based upon appreciation of the nature and intensity of the individual's erotic cravings, and not upon documentation of a biological abnormality. However, just as lung cancer is more likely to occur if a person smokes than if he does not, the likelihood of sexually deviant urges may be greater in the presence of certain kinds of biological abnormalities than in their absence.

Etiology of Conventional and Unconventional Sexual Desires—Associated Biological Pathologies

Mr. A., whose case of homosexual pedophilia was discussed earlier, was also diagnosed as having Klinefelter's syndrome. This, coupled with the fact that medications may sometimes be used in treatment, raises the question of whether one should routinely look for possible biological contributors to sexual behavior. In animal species other than man, biological factors clearly contribute significantly to such behavior. Female dogs, for example, become sexually responsive to male dogs only while in heat (estrus). At such times, in response to the odor of chemical substances emitted from the females, the males themselves become sexually much more assertive. In many species of birds, only the male sings. If a female zebra finch is given estradiol as an embryo, plus androgen hormones as an adult, she will sing a male courtship song without having heard it previously.[54] In addition, she will display typically male mating behavior and, like normal males (but unlike normal females), will have an increased number of cells in the nucleus robustus archistratialis and other brain regions (see Figure 5-4a).

In most species of rat, normally only males mount. "Mounting" is a behavior that involves placing the forepaws on the back of another animal while posturing the body in a fashion conducive to intercourse. Adult female rats given testosterone at a specific time in utero will also show this behavior which normally predominates in males.[55] Male rats do not normally build nests or care for their young, but they will build nests and show other kinds of "maternal behavior" if electrical stimulation is applied to certain brain areas.[56] Male Siamese fighting fish are preprogrammed genetically to respond aggressively to the sight of another male. Tinbergen described in great detail how specific configurations of visual stimuli can elicit (or "release") specific sexual behaviors in stickleback fish.[57] The same is true of spiders and blowflies[58] (see Figure 5-4b). In some cases, animals are pre-

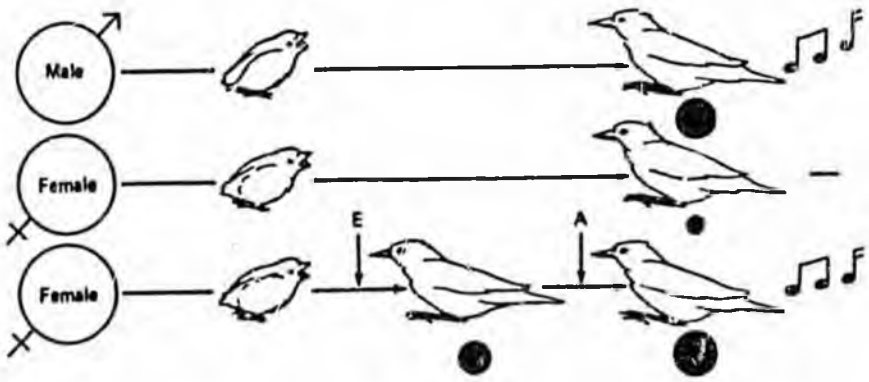


Figure 5-4a. Sex differences in male and female finches. Male birds sing; females do not. However, females treated with estradiol (E) just after hatching, and with androgen (A) in adulthood, do sing and exhibit other male behavior. Shaded disks represent the relative size of one brain region involved in song production. (From reference 54.)

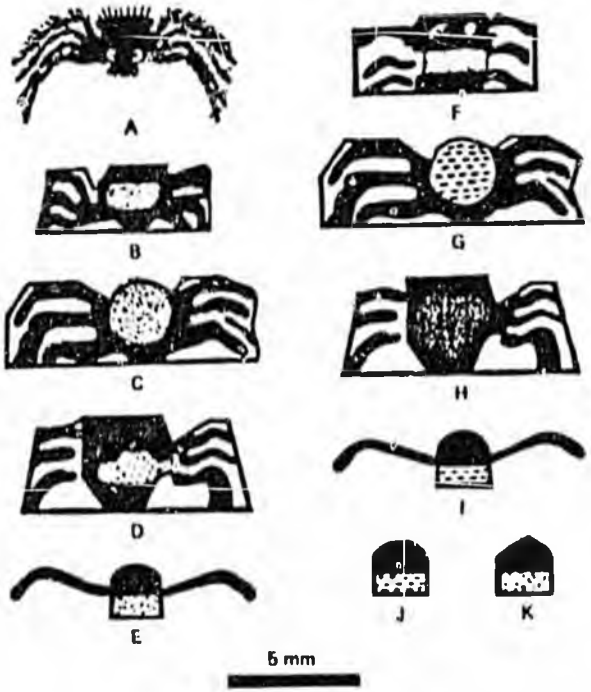


Figure 5-4b. Visual specificity of the sexual responsiveness of spiders. Male spiders with no prior sexual experience may attempt to mate (or attack) moving colored objects shaped like those on the left, but they will not do so with those on the right. (From reference 58.)

programmed genetically to respond sexually to sounds rather than vision. The sound of the wing beat of the female is the stimulus which attracts male crickets and mosquitos.[58] Some animals have an innate predisposition to follow, and become psychologically attached to, the first large object they see moving during a "critical time period" in early life. Attractions acquired in this fashion are said to be "imprinted."[59] Lorenz described young ducks who became so imprinted towards him that they tried to feed him live worms—a drive apparently so strong that they would try to force them into his ears if he closed his mouth.[60] Early life imprinting can influence the nature of an adult animal's sexual attractions.

In 1978, researchers reported a study in the *New England Journal of Medicine* documenting the observation that some women initiate sexual behavior most frequently during the ovulatory period (days 12 through 17) of their menstrual cycles.[61] This is a time in the cycle when the androgenic hormone androstenedione is ordinarily at its peak.[62] When estrogen and progesterone hormones were given to these women in the form of birth control pills, the result was a suppression of the ovulatory peak of female-initiated sexual behavior. Since regular menstrual cycling, including monthly menstruation, continued normally, this decrease in the frequency of female-initiated sexual behavior around the time of ovulation was apparently attributable, either directly or indirectly, to the altered hormonal status of the women in question.

Human males do not have to be taught how to obtain an erection. Instead, at some time in their lives, presumably because they are genetically preprogrammed to do so, they begin to have erections in response to specific kinds of tactile, mental, olfactory, or visual stimuli (such as the sight of a shapely female) Even human infants seem to respond instinctively in specific ways to certain stimuli such as a loud sound (which causes a startled reaction), the visual perception of height (which causes hesitation), or the sight of a familiar face (which causes smiling).[58] Goy and McEwen at a symposium at the Massachusetts Institute of Technology in 1977 suggested that biological factors may contribute more than previously appreciated to human social and sexual experience.[63] Recently, Pillard and co-workers summarized data suggesting that there may be a genetic predisposition towards male homosexuality.[64]

In humans (as well as in animals), structural and functional differences in the brain between males and females seem to depend upon exposure to various "sex hormones" during particular phases of embryonic development.[65–70] Females exposed prenatally to high doses of androgens tend, as adults, to show patterns of psychosexual development more typically seen in males.[71,72] Prenatal exposure to progesterone may have a "feminizing effect."[73,74] Exposing a male human fetus to medications containing estrogen may lead to a pattern of adult psychosexual behavior more frequently seen in women.[75,76] Oral administration of 10 mg per day of testosterone to adult women can increase sexual responsiveness and libido without causing masculinizing bodily changes.[77]

Because it seemed possible that biological factors might contribute significantly to human sexual behavior, a variety of laboratory tests were performed on a group of paraphiliac patients.[2] These data, which have recently been updated, are presented in Table 5-4. Although it will be important to perform similar tests on an appropriately matched group of persons with conventional sexual desires, for comparison purposes, there does appear to be a very high frequency of biological pathologies in these patients. These pathologies include structural brain damage, hormonal abnormalities, electroencephalographic dysfunctions, and chromosomal anomalies (such as Klinefelter's syndrome).

Thus far, the possible role of biology as an etiological contributor to sexuality has been discussed. However, Stoller hypothesized that whereas biological factors may become a compelling determinant of sexual experience and function in the presence of significant organic anomalies (Stoller's "biological force" hypothesis), sometimes environmental influences such as early life experiences may play a more dominant role.[33] In this connection, Dr. John Money has discussed the case of a pair of genetically identical twins, one of whom required a total penectomy (surgical removal of the penis) a few days after birth, due to trauma suffered during circumcision. Subsequent to that penectomy, plus additional reconstructive surgery (and hormone supplementation at puberty), the child in question was reared as a girl. Although perhaps somewhat "tomboyish" in interests and play during childhood, this 46 XY female, now a teenager, feels herself psychologically to be a woman. Her sexual orientation and interests are directed towards age-appropriate males, and someday she hopes to marry and adopt children. Her genetically identical twin feels himself to be masculine, and he finds females appealing. Thus, it is clear that both biological and environmental factors can influence sexual phenomenology and behavior.

PART III: THERAPIES

Psychotherapy and Behavior Therapy as Treatments—Biological and Syndromal Considerations

Four major types of treatment have been proposed to try to help sex offenders. They are psychotherapy, behavior therapy, medication, and surgery. Unfortunately, recognition that optimal treatment may depend upon proper differential diagnosis has often been unappreciated. Sometimes the goals of therapy are stated explicitly, for example, to help a person gain greater capacity for self-control, but this is not always the case.

Most psychodynamic theories make the assumption that conventional heterosexuality alone is natural, and that other orientations and preferences are pathological variants which only occur when proper development goes awry. These theories see sexual deviation as a reflection of "unconscious" psychological conflicts and postulate that such conflicts come about as a result of unsatisfactory early life experi-

Table 5-4. Associated Findings in a Group of Male Patients with Sexual Disorders.

PATIENT DIAGNOSIS	ASSOCIATED FINDINGS
1. Erotic sadism	Oculomotor abnormality suggestive of basal ganglion dysfunction. Unexplained gait disturbance.
2. Homosexual pedophilia	Dyslexia; childhood lisp requiring speech therapy.
3. Homosexual pedophilia	Cortical atrophy; grand mal seizures; recurrent slow delta waves and sharp activity over frontal brain regions on EEG.
4. Hypersexuality	Elevated testosterone; family history of adrenogenital syndrome.
5. Homosexual pedophilia	Klinefelter's syndrome, mosaic (90% 47 XXY, 10% 46 XY). Elevated FSH and LH. Low testosterone.
6. Homosexual pedophilia	Strabismus; childhood learning disorder.
7. Heterosexual pedophilia	Schizophrenia.
8. Exhibitionism	Elevated testosterone; prior history of coma several months following head trauma; grand mal seizures.
9. Heterosexual pedophilia	Cortical atrophy (2° to trauma); right-sided partial hemiparesis; visual spatial deficits.
10. Homosexual pedophilia	Elevated testosterone.
11. Heterosexual pedophilia	Near total blindness due to brain damage.
12. Heterosexual pedophilia	Elevated testosterone; mild ventriculomegaly and cortical atrophy most pronounced in area of right sylvian fissure (by CAT scan); elevated 24-hour urine pregnanetriol (3.1 mg — normal is less than 2.5 mg).
13. Homosexual pedophilia	Elevated LH. Generalized muscular hypotonia.
14. Paraphiliac rape	Elevated testosterone; grand mal seizures.
15. Homosexual pedophilia	Elevated testosterone.
16. Hypersexuality	Cortical atrophy; cortical blindness; mild mental retardation.
17. Voyeurism	Elevated LH.
18. Homosexual pedophilia	Dyslexia.
19. Homosexual pedophilia	Mosaic chromosomal pattern (97.5% XY, 2.5% XX); large heterochromatic region at centromere of autosome number 19 (polymorphic variant); low LH.
20. Homosexual pedophilia	46 XY, inversion 9(p+ q−) chromosome pattern. High LH.
21. Homosexual pedophilia	47 XYY chromosome pattern. Elevated testosterone, FSH, and LH.
22. Paraphiliac rape	Elevated FSH.
23. Exhibitionism	Elevated LH.
24. Homosexual pedophilia	Low LH.
25. Heterosexual pedophilia	Elevated testosterone, FSH, and LH.
26. Homosexual pedophilia	Klinefelter's syndrome; elevated FSH and LH. Low testosterone.
27. Heterosexual pedophilia	Elevated testosterone.
28. Homosexual pedophilia	Elevated testosterone.
29. Voyeurism	Elevated testosterone and LH.
30. Hypersexuality	Elevated testosterone; structural brain damage.
31. Homosexual pedophilia	Elevated testosterone, FSH, and LH. EEG abnormality.
32. Transsexualism	Klinefelter's syndrome. Low testosterone.
33. Homosexual pedophilia	Elevated testosterone.
34. Homosexual pedophilia	Klinefelter's syndrome. Elevated FSH and LH. Low testosterone.

NOTE: Normal (s.d. = 2) testosterone range in men = 275–875 ng/100 ml. Normal FSH in males = 98–276 ng/ml. Normal LH in males = 36–64 ng/ml. No associated abnormalities were detected in seven other patients with sexual disorders who were also assessed.

ences. However, in the author's opinion, they rarely explain adequately why such experiences should be expected to result in specific problems such as exhibitionism, rather than pedophilia or juvenile delinquency. Usually the intent of therapy is to try to "uncover" conflicts so that an individual can rework his developmental problems. In point of fact, there is reason to doubt whether sex offenders come to fully understand or change their sexuality by such means.

In an investigation published in *Lancet* in 1979, Eicher studied a group of transsexuals (persons who feel themselves to be psychologically "trapped in the body of the wrong sex").[78] He examined the white blood cells of these persons, looking for the presence or absence of a cell surface substance known as H-Y antigen.[28] Ordinarily (as depicted schematically in Figure 5-5), H-Y antigen is present on the surface of cells taken from men, but absent in women. In some transsexuals, Eicher found that the gender the individual felt himself (or herself) to be corresponded with the presence or absence of H-Y antigen, rather than with that individual's bodily appearance. If Eicher's observations can be replicated, this suggests that "sex change operations," which have been performed on some transsexuals, may actually serve to correct body phenotype (external appearance) to conform with H-Y antigen genotype.[79,80] Such knowledge is clearly not accessible via introspective methods alone. Even if a person could come to such an understanding, this would not necessarily make it any easier for him to change his behavior. There is little solid evidence that traditional psychotherapies, when used alone, are consistently effective in treating paraphiliac syndromes.

Behavior therapists tend to be less concerned with the historical antecedents of unconventional sexual behavior than with the question of what can be done about it. The feature common to most behavior therapies is that the therapist prescribes a course of action for the patient to follow which is intended to help decrease his attraction towards previously erotic deviant stimuli, such as children. Often a simultaneous attempt is made either to teach the patient more appropriate ways of achieving sexual satisfaction or to condition him to become sexually arousable by an age-appropriate consensual partner. This is clearly a formidable task.

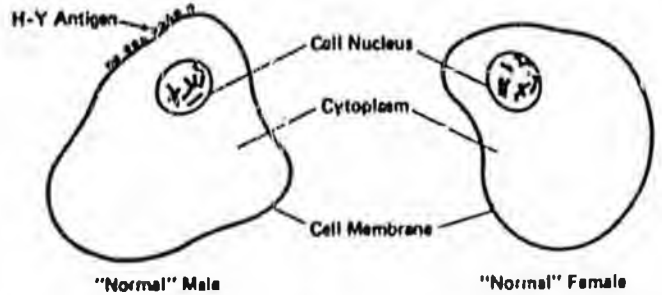


Figure 5-5. H-Y antigen is ordinarily present on the surface of cells taken from men but absent in women, as shown schematically in this figure.

Much of the literature regarding the behavioral treatment of sex offenders is anecdotal. However, Isaac Marks at the Maudsley Insitute in England documented good therapeutic results at two-year follow-up in treating transvestites (men who become erotically aroused by dressing in women's clothing), but the very same behavioral approach failed with transsexuals (men who feel themselves to be women).[81,82] Blair and Lanyon obtained good results in using behavior therapy to treat some exhibitionists.[83] Behavior therapy has not proven consistently effective in treating pedophilia. This suggests that some sexual deviation syndromes may be responsive to behavioral therapy treatments, whereas others may not. Perhaps more attention needs to be paid to differences amongst these syndromes, in addition to studying their common features.

Medication to Treat Sexual Deviation Syndromes

The purpose of utilizing medication to treat sexual deviation syndromes is to try to decrease sexual libido. The rationale for doing this is based upon the assumption that if one experiences sexual hungers of the sort that might cause problems, for example, a hunger for children, one is better off being less hungry. Because the various medications used for this purpose are not intended to make a man impotent and incapable of sexual activity, they may be most helpful in facilitating self-control in cooperative persons whose "offending behavior" is an expression of unconventional sexual tastes. They may be less helpful when the "offending behavior" is a manifestation of diminished intellect, psychosis, personality problems, or drug-induced intoxication—though such as hypothesis requires validation.

In utilizing drugs as a possible treatment method, one can address the issue of the relationship between biological factors, such as testosterone levels, and states of mind, such as those related to sexual desire. It is important to recognize, however, that the use of biological methods to successfully treat a condition does not prove that the condition and the treatment are directly and simply related. Aspirin can be used to treat a fever, but fever is not due to, or precipitated by, aspirin deficiency.

Amongst the drugs that have been used investigatively to try to treat sexual deviation syndromes are certain of the major tranquilizers such as benperidol.[84–86] Initially, use of these drugs for this purpose was based upon the observation that patients taking them for other reasons sometimes reported diminished libido. However, there is little substantive evidence to support the notion that these drugs can be used successfully in the treatment of paraphiliacs.

A class of drugs not yet utilized which may play a future role in treating these conditions are the gonadotropin releasing hormone (Gn-RH) agonists.[87] Again, rationale for their use is based upon the theory that the hormone testosterone "fuels" the sex drive in men. It is the increased production of testosterone by the testes around the time of puberty which correlates with (a) masculinizing bodily

changes such as deepening of the voice and growth of facial hair and (b) an increased psychological interest in sex. Prolonged (as opposed to brief) administration of Gn-RH agonists, for reasons that are poorly understood, paradoxically inhibits the release of follicle stimulating hormone (FSH) and luteinizing hormone (LH) from the anterior pituitary gland in the brain (see Figure 5-6). This, in turn, results in decreased testosterone output by the testes, which require stimulation from FSH and LH in order to produce testosterone. The adrenal gland, which also

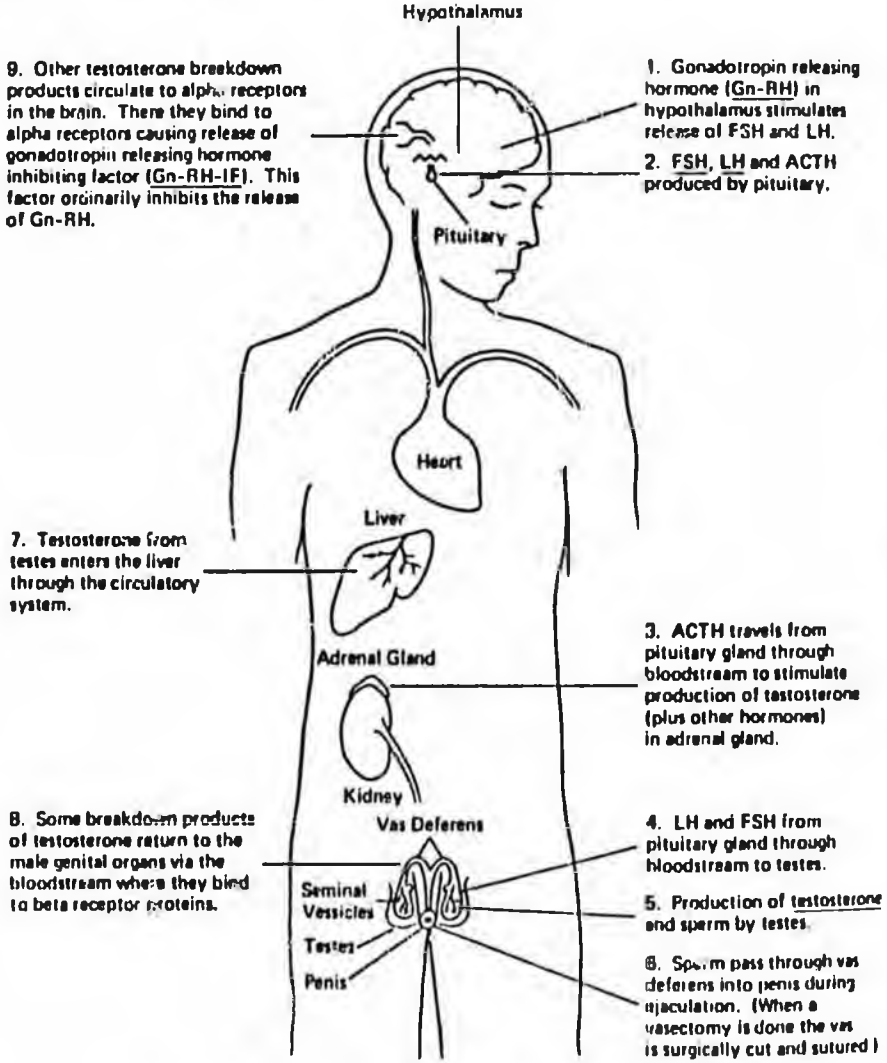


Figure 5-6. Relationships among various "male sex hormones."

produces testosterone in very small amounts, does not depend upon FSH and LH stimulation for this purpose. ACTH, another hormone produced by the pituitary gland, on the other hand, can influence adrenal testosterone output. A recently identified substance, Gn-RH inhibiting factor (see Figure 5-6), which may someday be useful in decreasing sex drive, has not yet been synthesized and therefore is unavailable for therapeutic purposes at present.[88]

Two other drugs that reduce testosterone levels which have been used in an attempt to treat sexual deviation syndromes are cyproterone acetate (CPA) and medroxyprogesterone acetate (MPA). Cyproterone acetate, which must be taken daily in pill form, is currently unavailable in the United States. A controlled double-blind clinical trial performed in Canada concluded that this medication could successfully reduce sexual interest and libido in a group of paraphiliac patients.[89] This investigation did not use a pharmacologically active substance with similar side effects for comparison purposes, however, thereby leaving doubt about whether study participants were indeed "blind" as to when CPA was or was not actually being administered. This raises the possibility that patients may have reported reduced libido as a psychological reaction to feeling "drugged" and that their feelings of diminished sexual interest may not have been attributable entirely to a pharmacologically induced decrease in testosterone levels.

When cyproterone acetate is administered, the pituitary gland does not increase production of FSH in response to decreased testosterone levels as occurs when an individual is castrated. This suggests that the drug has an effect not only upon the testes but upon the brain as well, presumably in areas relevant to sexual phenomenology and function. The same is true of medroxyprogesterone acetate.

None of the drugs used in the treatment of sexual deviation syndromes acts specifically to decrease deviant sexual desires while leaving conventional sexual interests intact. Thus, currently available medications do nothing to change sexual orientation; rather, if successful, they simply suppress sexual appetite in general.

Two major options are possible as a means of trying to reduce the presumed sex drive stimulating effects of testosterone. One is to try to interfere with testosterone production, whereas the other is to try to block the effects of testosterone (or more accurately, of its breakdown products) upon the brain. In the future, it may be possible to block the central effect of testosterone breakdown products upon the brain without interfering with levels of circulating testosterone peripherally. However, this cannot yet be done safely in humans.

The theoretical rationale for using testosterone-depleting medications to treat paraphiliacs would be strengthened if it could be shown empirically that intensity of sexual desire is indeed correlated with testosterone level. Davidson and colleagues showed that administration of testosterone to men whose plasma levels were below 150 ng per 100 ml led to a prompt increase in sexual appetite and activity.[90] However, Brown and others, in a study involving 101 men, demonstrated that variations in testosterone level within the intermediate range (275 to

875 ng per 100 ml in many laboratories) did not necessarily correlate with self-reports of sexual interest.[91] In animal studies, moderate decreases in testosterone level due to CPA administration failed to decrease sexual activity as significantly as had been expected.[92] Thus, in order to achieve therapeutic sex drive reduction, a significant decrease in testosterone level may be essential.

According to Laschet and Laschet, 80% of the men involved in a nonblind clinical trial reported significant reductions in sex drive in response to a daily oral dose of 100 mg of cyproterone acetate.[93] Twenty percent of the men required 200 mg per day orally, or 300 to 600 mg intramuscularly every week to ten days, in order to achieve a comparable effect. Follow-up of over 300 men for periods as long as eight years revealed few serious side effects when these dosages were employed.[94]

Stern and Eisenfeld showed that administration of radioactive-labeled testosterone to castrated rats pretreated with CPA did not result in its being bound to peripheral target tissues such as the seminal vesicles.[95] Thus, CPA appears to prevent the binding of testosterone to peripheral target organs. However, CPA does not block testosterone uptake in central hypothalamic brain regions thought to mediate sexual behavior.[96] In contrast, medroxyprogesterone acetate does, but it does not prevent testosterone binding peripherally. MPA inhibits FSH more than LH, whereas CPA inhibits only LH (see Figure 5-6). Thus, these two antiandrogenic drugs appear to exert an effect in slightly different ways. Both, however, reduce production of testosterone from its chemical precursors.[97,98] Antiandrogens may also exert an effect by preventing the rise in testosterone which ordinarily occurs as a consequence of sexual stimulation.[99]

Medroxyprogesterone Acetate (Depo-Provera). In the United States, medroxyprogesterone acetate is the drug that has been used most frequently to treat paraphiliac patients.[2] This medication is available in depot form, which means that it is prepared in such a fashion that it can bind to muscle, from where it is gradually released into the bloodstream. Injecting a depot drug into muscle accomplishes the same purpose as taking pills daily, in that both keep medication constantly present within the bloodstream so that it can act on appropriate tissue and organ receptors (see Figure 5-7). Some of the medication travels through the circulation bound to carrier proteins, whereas the remainder circulates in an unbound (or free) form. The customary starting dosage of MPA has been 500 mg per week of the 100 mg per ml solution. No more than 250 mg is given into a single injection site. The 100 mg per ml solution has greater bioavailability (i.e., it produces higher blood levels at a given dosage) and is less painful than the 400 mg per ml concentration. Periodic blood tests can be performed to document decreases in serum testosterone levels, and the medication is not feminizing (e.g., it does not cause breast enlargement). Dosage can be titrated so as not to cause total impotence, but studies to determine optimal dosage levels have yet to be performed.

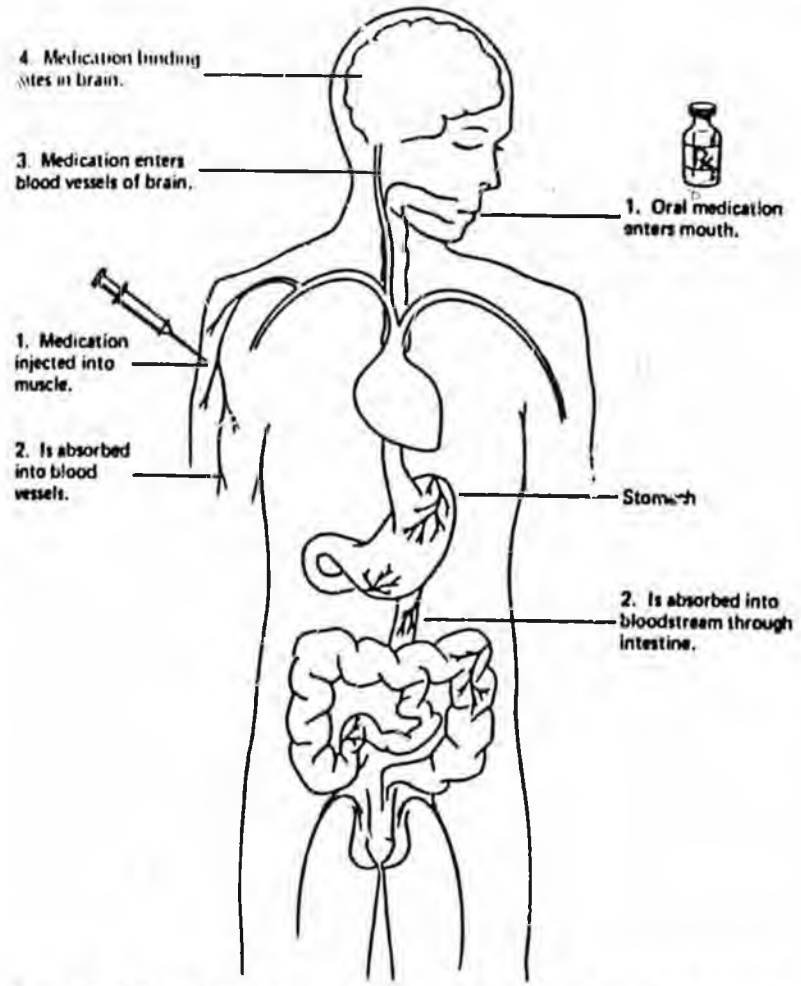


Figure 5-7. Comparability of oral and intramuscularly injected medication treatment.

The major side effects of MPA include weight gain, mild lethargy, cold sweats, nightmares, and hot flashes. Hypertension is common. Elevated blood glucose, dyspnea (shortness of breath), hypogonadism (shrunken testicle size), and malignant breast tumors (in female beagle dogs) have also been reported. The drug causes a decreased sperm count which makes impregnation unlikely, but the remaining sperm can be atypical which suggests that the fetus might be deformed were a man to father a child while taking the drug. It is believed that these major side effects are reversible if medication is stopped.

Table 5-5 shows changes in sexually deviant behavior in a group of 20 chronic paraphiliac patients treated with medroxyprogesterone acetate.[2] Of these patients,

Table 5-5. Changes in Sexually Deviant Behaviors in 20 Chronic Paraphiliac Male Patients Treated with Medroxyprogesterone Acetate.*

PATIENT	AGE (YEARS)	DIAGNOSIS	AVERAGE FREQUENCY OF SEXUALLY DEVIANT BEHAVIORS BEFORE TREATMENT†	DRUG TREATMENT‡		OCCURRENCE OF SEXUALLY DEVIANT BEHAVIORS	
				LENGTH	MAXIMUM DOSAGE	DURING TREATMENT	AFTER TREATMENT
1	34	Homosexual pedophilia	Once/week	7 years, 9 months	500 mg/week	None	Treatment dropout; no relapse less than 1 year after treatment
2	31	Homosexual pedophilia	Twice/month; 1 known arrest	1 year	300 mg/week	None	Treatment dropout; relapsed less than 1 year after treatment
3	30	Heterosexual exhibitionism	Twice/week	10 months	250–300 mg/week	None	Treatment dropout; relapsed more than 1 year after treatment
4	34	Homosexual masochism	4 times/week	3 months	200 mg/week	None	Treatment dropout; relapsed less than 1 year after treatment
5	27	Bisexual pedophilia	Twice/week	3 months	400 mg/week	None	Treatment dropout; relapsed more than 1 year after treatment
6	43	Transvestism; homosexual incest	7 times/week; 2 incidents	1 year, 4 months, intermittently	150 mg every other week	None	Relapsed less than 1 year after treatment
7	52	Heterosexual sadism	Once every 2 weeks for 25 years	3 years, 5 months	600 mg/week	None	Treatment continues; no relapses
8	29	Homosexual pedophilia	Twice/week; 6 arrests in 6 years	10 months	500 mg/week	None	Treatment dropout; relapsed less than 1 year after treatment
9	36	Homosexual pedophilia	Once every 2 months; 4 arrests in 6 years	2 years	500 mg/week	None	Treatment continues; no relapses
10	56	Homosexual pedophilia	Once/week; 14 arrests in 29 years	3 years, 9 months	300 mg/week	Relapsed	Treatment continues
11	40	Homosexual pedophilia	Twice/week; 7 known arrests	4 years, 2 months	400 mg/week	None	Treatment continues; no relapses
12	45	Voyeurism; heterosexual pedophilia	Twice/week; 5–8 arrests; numerous institutionalizations	5 years, 3 months	300 mg/week	None	Relapsed less than 1 year after treatment; treatment now resumed
13	27	Homosexual pedophilia	Twice/week since age 10	5 years, 9 months	200 mg/week	None	Treatment completed; no relapse more than 1 year after treatment
14	41	Homosexual pedophilia	Once/month; numerous arrests; 4 convictions, 4 reported parole violations	3 years, 8 months	500 mg/week	Relapsed	Treatment continues
15	37	Homosexual pedophilia; exhibitionism	Record unclear; probably several incidents/year	3 years, 9 months	350 mg/week	None	Treatment completed; no relapse less than 1 year after treatment
16	26	Homosexual pedophilia	Once/week	1 year, 1 month	200 mg/week	None	Treatment dropout; relapsed more than 1 year after treatment
17	24	Heterosexual voyeurism	Once/month	1 year	400 mg/week	Relapsed after alcohol consumption	Treatment continues; in prison
18	40	Heterosexual exhibitionism	Five times/day since age 11; first arrest at age 21; numerous others	2 years, 2 months	200 mg/week	None	Treatment dropout; relapsed less than 1 year after treatment
19	29	Heterosexual exhibitionism	Twice/week	2 years, 1 month	250 mg/week	None	Treatment dropout; relapsed less than 1 year after treatment
20	46	Heterosexual exhibitionism	Four times/week; binges of 20/day	2 years, 3 months	300 mg/week	None	Treatment continues; no relapses

*Sexually deviant behavior was considered to have occurred if the patient was accused of having or admitted having a deviant sexual contact (e.g., an episode of public genital exposure). Any occurrence of such behavior was scored as a relapse once treatment had been initiated, even if it did not come to the attention of the law as an official complaint.

†Based on institutional records and patients' statements.

‡Study participants who stopped taking medroxyprogesterone acetate did so against medical advice, except in the cases of patients 13 and 15. Some patients were irregularly compliant with medication even during the period when it was being prescribed.

15% (3 of the 20) showed recurrences of deviant activity while taking the medication, indicating that it is not 100% effective. On the other hand, 85% of these men were without further legal involvements while receiving medication, sometimes for periods as long as several years. The number of patients reported upon was small, and additional studies with larger numbers of patients need to be conducted. Some of the patients were self-referred and had no legal charges against them.

Most of the patients reported upon in Table 5-5 were not hospitalized to initiate treatment and were not required to take medication as a condition of probation. In time, many became noncompliant, sometimes because they believed themselves cured. Currently, most patients are briefly hospitalized for three or four weeks at the beginning of treatment, and subsequent outpatient compliance has improved dramatically.

The data presented in Table 5-5 show clearly that in most cases, when paraphiliac patients discontinue medications they relapse. This supports the hypothesis that this form of treatment is not a cure or a temporary catalyst to be used until psychotherapy can become effective. Rather, for the majority of patients, the medication appears to act as a sexual appetite suppressant. If deviant hungers are allowed to return, most patients seem again to be at risk of giving into temptation by satisfying those hungers. In a few cases, patients have reported that MPA fails to significantly decrease their sexual drive. Why this should be so is not known.

In the future, it will be important to conduct a controlled double-blind study in which neither the patient nor the evaluator is aware of whether MPA or a placebo with similar side effects has been administered. Fluphenazine, a drug with a similar intramuscular route of administration and similar side effects, which does not lower testosterone could be utilized for this purpose. Such a study could help document that any reduction in the frequency of sexual fantasies and in the intensity of erotic cravings experienced while receiving MPA was indeed related to lowered testosterone levels, rather than to psychological expectation or other factors independent of testosterone level. Such a study is now being planned. If it can be shown conclusively in this way that MPA does indeed decrease sexual appetite, changes in long-term recidivism rates could then also be ascertained amongst sex offenders treated with MPA, whose offending behavior either was, or was not, thought to be the manifestation of a sexual deviation syndrome.

Ancillary Care. Treating patients with antiandrogenic medications involves considerably more than simply providing injections. Although psychological counseling has not been shown to be a method capable of reducing sexual desire, such counseling may well be beneficial in other ways to the person who has been experiencing such desires. Although medication may decrease the lust a homosexual pedophilic man experiences for little boys, it cannot replace feelings of companionship, intimacy, affection, devotion, or love that may previously have been provided by children. Thus, once deviant erotic urges have been diminished by medication, an individual may also find counseling helpful in his effort to adopt a new life-style. For those who fail to respond to medication, supportive therapy and guidance to encourage efforts to resist temptation should be tried.

In initiating medication treatment, a brief period of psychiatric hospitalization lasting three to four weeks may be useful for three reasons, in addition to affording an opportunity for more comprehensive assessment. First, it removes the patient from unsupervised situations in which he might succumb to temptation before medication can begin exerting its anticipated effect. Secondly, many patients seem to develop a stronger alliance with potential help givers when living in hospital than when treatment is initiated on an outpatient basis. It is perhaps for this reason that brief hospitalization has sometimes been found to significantly increase subsequent outpatient compliance. Finally, while hospitalized, patients can speak with a group of other men having similar difficulties, which often brings a sense of relief and of being accepted as a person, thereby opening up the opportunity for greater candor. Many of these men have never before had a chance to talk openly with others without fearing that they would be perceived, and dealt with, in a demeaning way. Although the hospital staff in no way condones their behavior—quite the contrary—they do attempt to appreciate the basis for it, and they treat patients respectfully and kindly. The families of these patients can also be seen at this time, which can be important given the nature of their problems. How does a wife tell the neighbors that her husband has been arrested for exhibitionism or for sexually fondling the child next door? Patient confidentiality is maintained, but noncompliance is reported to the courts when appropriate. Rehospitalization may be required if outpatient treatment, which can include group therapy, is proceeding poorly. It is made clear to patients that a goal of therapy is to try to help them discontinue sexual behavior that violates the rights of others—not to make them feel better or less guilty about continuing it.

Surgery as Treatment for Sexual Deviation

The use of surgery to treat paraphiliac patients is well summarized in an article entitled "Therapeutic Sex Drive Reduction" written in 1980 by Dr. Kurt Freund of the Clark Institute of Psychiatry in Toronto.[100] The two major types of surgical procedures which have been used are (1) orchidectomy (castration) and (2) stereotactic neurosurgery. Stereotactic neurosurgery is performed with the aid of microscopic-sized surgical instruments capable of producing minimal-sized brain lesions. The effects of surgery (and of electrical and chemical stimulation or ablation of potential surgical sites) have been studied in both animals and men. Obviously, surgery should be considered as a therapeutic option for sex offenders only under extraordinary circumstances.

Castration. There are few well-controlled studies assessing the effects of castration upon an animal's tendency to approach a potentially available sexual partner.[100] Nevertheless, there appears to be little doubt that removal of the gonads

eventually decreases sexual interest significantly in most animals. In comparison to the rate of testosterone depletion, however, the corresponding postsurgical fading out of sexual behavior in castrated animals can be very slow. Furthermore, sexual interest may wane more slowly than sexual capacity as evidenced by the observations that (1) ejaculatory capacity often disappears before the animal loses the ability to sustain an erection and (2) the animal may continue attempting to mount receptive females even after erections have become rare.[101]

Individual differences amongst castrated animals are frequent. Pheonix and colleagues observed a substantial overall decline in virtually all aspects of sexual behavior in ten castrated monkeys.[102] However, while some of the animals ceased ejaculations immediately following surgery, others did not do so until over a year later. These postsurgical differences could not be attributed to presurgical differences in frequency of sexual behavior. The causes of individual variations in the rapidity with which various animals cease sexual behavior following orchidectomy are not clear, just as it is unclear why some humans continue to have apparently high libidos even after treatment with testosterone-depleting agents.

A number of studies have looked at the recidivism rate of sex offenses following castration in humans. Sturup and others conducted over 4000 follow-up examinations of 900 castrated sex offenders in Denmark over a 30-year period between 1929 and 1959.[103,104] There was definite recidivism of only 1.1% after castration, and if unclear cases were included, the recidivism rate was 2.2%. Wiffels reported comparable findings.[105] Ficher Van Rossum reported a 1.3% recidivism rate amongst 237 Dutch cases, and Kinmark (and Oster) reported similarly low rates on 307 Swedish patients.[103] Bremer found a 7.3% recidivism rate after five years in a group of 41 castrated sex offenders who, prior to treatment, had a recidivism rate of 58%.[106] Reported recidivism rates of castrated German sex offenders were also low.[107] This study also reported on normal German men forcibly castrated under Hitler.

Comu, in Switzerland, compared 121 castrated sex offenders with 50 offenders who had refused recommended castration.[108] Follow-up ranged between 5 and 30 years. The recidivism rate of castrated offenders was 5.8%, indicating that castration does not make further sexual offenses impossible. However, the recidivism rate of the 50 offenders who had refused castration was 52% (15 committed one additional offense, while 11 others committed between two and seven additional offenses each). Presumably, these differences in recidivism rate were a reflection of whether or not castration had been performed, although the possibility that the voluntarily castrated group contained more patients genuinely motivated to stop offending behavior cannot be entirely excluded. Prior to castration, both groups had a comparable frequency of offending behavior.

Freund pointed out that the degree to which sexual drive decreases after castration appears to depend upon the length of time of testosterone depletion.[100] Thus, if it is the case that some repeat sex offenses occur a short time after surgery, even further lowering of the recidivism rates might be possible by keeping patients in the hospital longer following castration.

Besides documenting changes in recidivism rate, a number of investigators obtained self-reports from sex offenders regarding potency. In many cases following castration, some degree of erotic desire and the capacity to perform sexually remained.[107–109] Hackfield pointed out that this does not present a problem in terms of treatment since the surgery fulfills its intent if it decreases sex drive sufficiently to enable the patient to refrain from acting upon unacceptable erotic urges.[110] Sturup described several cases in which pleasurable intercourse was successfully practiced for many years following castration in response to advances from consensual female partners.[104] Although a castrated man could reverse his condition by undergoing testosterone treatment, few cases have been detected in which this has occurred without medical approval.

Testosterone appears to be a prehormone which is broken down in the liver to form other metabolically active substances. Some of these bind to receptor sites in the brain, presumably stimulating areas related to erotic desire. Other testosterone breakdown products bind to receptors on peripheral tissues likely related to physical capacity to obtain erection and to ejaculate (see Figure 5-6). Freund suggests that someday it may be possible to administer active breakdown products of testosterone to castrated sex offenders, which will enhance their sexual capacity by affecting peripheral receptors without increasing sexual desire (via central brain stimulation) to a level where it becomes difficult to resist temptation.[100]

Neurosurgery. The second type of surgical procedure used in the treatment of sex offenders is stereotactic neurosurgery. In order to try to determine whether such surgery might be feasible in humans, a great deal of animal experimentation has been performed. That work has attempted to identify structures in the brain (1) that accumulate relatively large amounts of sexual hormones, (2) that lead to changes in the output of sexual hormones in response to either stimulation or ablation, or (3) that lead to changes in sexual behavior in response to either stimulation or ablation. Some researchers have also studied "experiments of nature" by looking at alterations in sexual behavior that correlate with human brain pathology.[111]

It is clear from studies done upon animals that lesions in some brain regions can readily decrease the frequency of sexual behavior without affecting either perceptual-motor capacity or circulating testosterone levels.[112,113] The area preoptica in the hypothalamus is one such region.[113] It seems to be particularly rich in sex hormone receptors. Other areas of the brain such as the limbic system accumulate sexual hormones to a lesser degree or not at all.

Exposing various areas of the brains of live animals to sex hormones to see whether sexual behavior will occur is another method used in an attempt to identify potential neurosurgical sites. This has produced some intriguing observations. Estrogen applied locally to specific hypothalamic sites in male rats leads to a lordotic

response—a backward elevation of the pelvis that facilitates intercourse in females.[112] Testosterone implants in certain hypothalamic sites can reactivate mating behavior in castrated male animals, but similar implants in other brain sites cannot.[114] Electrical stimulation in the dorsal part of the lateral area preoptica causes almost uninterrupted mounting and frequent ejaculations in male rats.[115]

In 1939, Kluver and Bucy described a syndrome in cats, produced by bilateral temporal lobectomy, that included intensified indiscriminate sexual behavior.[116] In 1954, Schreiner and Kling showed that this hypersexual activity could be abolished by castration but reinstituted with testosterone replacement therapy—which suggests that the behavior in question was sex hormone related.[117] They demonstrated that lesions to specific sites in the ventromedial nucleus of the hypothalamus could also abolish this hypersexual activity.

In 1966 a team of neurosurgeons performed stereotactic brain surgery on a homosexual pedophile, making a lesion in the ventromedial nucleus of the hypothalamus in the same area that had seemed to decrease hypersexuality when it had been ablated in Kluver-Bucy cats.[118] The patient subsequently indicated that his erotic fantasy life was virtually abolished and that he had lost his pedophilic urges. In 1979, Orthner (and others) reported that substantial therapeutic sex drive reduction had been achieved in 34 sex offenders treated neurosurgically in a similar way.[111,112,119] Although no formal instruments were used to confirm the validity of the patients' self-reports, in many cases follow-up extended over several years with no known rearrests. Major side effects were increased appetite, weight gain, and reported absence of dreaming. Freund feels that this surgical team may have obtained genuine success and that if it can be more conclusively established that neurosurgery appreciably lowers the recidivism rate of sex offenders, none of the reported side effects appeared disproportionate.

Schmidt and Schorsch cautioned that psychosurgery of this sort has sometimes been performed without proper safeguards with poor results.[120] They cited a study by Muller involving ten paraphiliac patients. Three years after surgery, four of the ten patients were lost to follow-up, three were said to be significantly improved, and two unimproved. Of the two unimproved patients, both subsequently underwent castration. The tenth patient in this series, a pedophile with sadomasochistic fantasies, was relased from prison after neurosurgery and was administered antiandrogenic medication until he complained of impotence with an age-appropriate girlfriend, at which time medication was stopped. Several weeks later he was accused of murdering a 10-year-old child.

A recent governmental task force appointed to consider the topic of psychosurgery in the United States concluded that it does hold therapeutic promise but recommended that its use be confined to designated research centers to try to assure proper safeguards.[121,122] Some authorities feel that brain surgery to attempt to decrease troublesome sexual appetites should for the time being be discontinued until further data from animal experimentation become available.[123]

Future Research

Figure 5-8 shows pictures obtained by means of a CAT scan and a PET scan. The term CAT scan is an abbreviation for computer assisted tomography. The equipment involved in producing these X-rays is manufactured by the EMI Corporation; thus, EMI scan is also sometimes employed.

When first marketed, the CAT scan represented a significant improvement over previously available X-ray procedures because not only could it show the presence of hard structures such as bones or tumors, but it was also capable of depicting the details of softer tissues such as kidney, lung, or brain. Furthermore, with the aid of computer analysis it could safely produce pictures of these structures corresponding to various depths within the tissue being X-rayed. X-rays of the brain taken by CAT scan depict structure but not function.

The term PET scan is an abbreviation for positron emission tomography. This test, like thyroid scanning, requires that the patient be administered a small amount of radioactive material—in this case glucose—which emits positrons. A computer attached to Geiger counter type sensors placed around the patient's head then produces a series of cross-sectional pictures of the brain at various depths. These pictures vary in color according to the amount of glucose being utilized as a source of energy at a given anatomical site. In this manner, the PET scanner can provide a picture showing which areas of the brain are most active metabolically at a given time—for example, during sexual arousal. Because the half-life (decay time) of radioactive glucose labeled in this fashion is short, the test is believed to be safe; it is no more dangerous than conventional thyroid scanning procedures which have been used medically for many years.

The PET scanner may help provide answers to the following questions. What areas of the brain are metabolically active during sexual arousal? Do these areas differ in persons with unconventional sexual orientations or interests? Do these areas differ in persons with organic anomalies such as Klinefelter's syndrome? What are the effects of testosterone-diminishing medications, which given in low or higher dosage forms, upon brain activity during sexual arousal?

PART IV: MEDICOLEGAL ISSUES AND SUMMARY

Medicolegal Issues

In considering the treatment of sex offenders with surgery or with antiandrogenic medications, a number of ethical and medicolegal issues must be addressed. Recently, in an editorial in the *American Journal of Psychiatry*, Dr. Seymor Halleck called for the establishment of guidelines regarding the use of antiandrogenic medications.[124] Two issues of concern to him related to (1) maintaining the constitutional rights of citizens, even those convicted of sex offenses and (2) the question

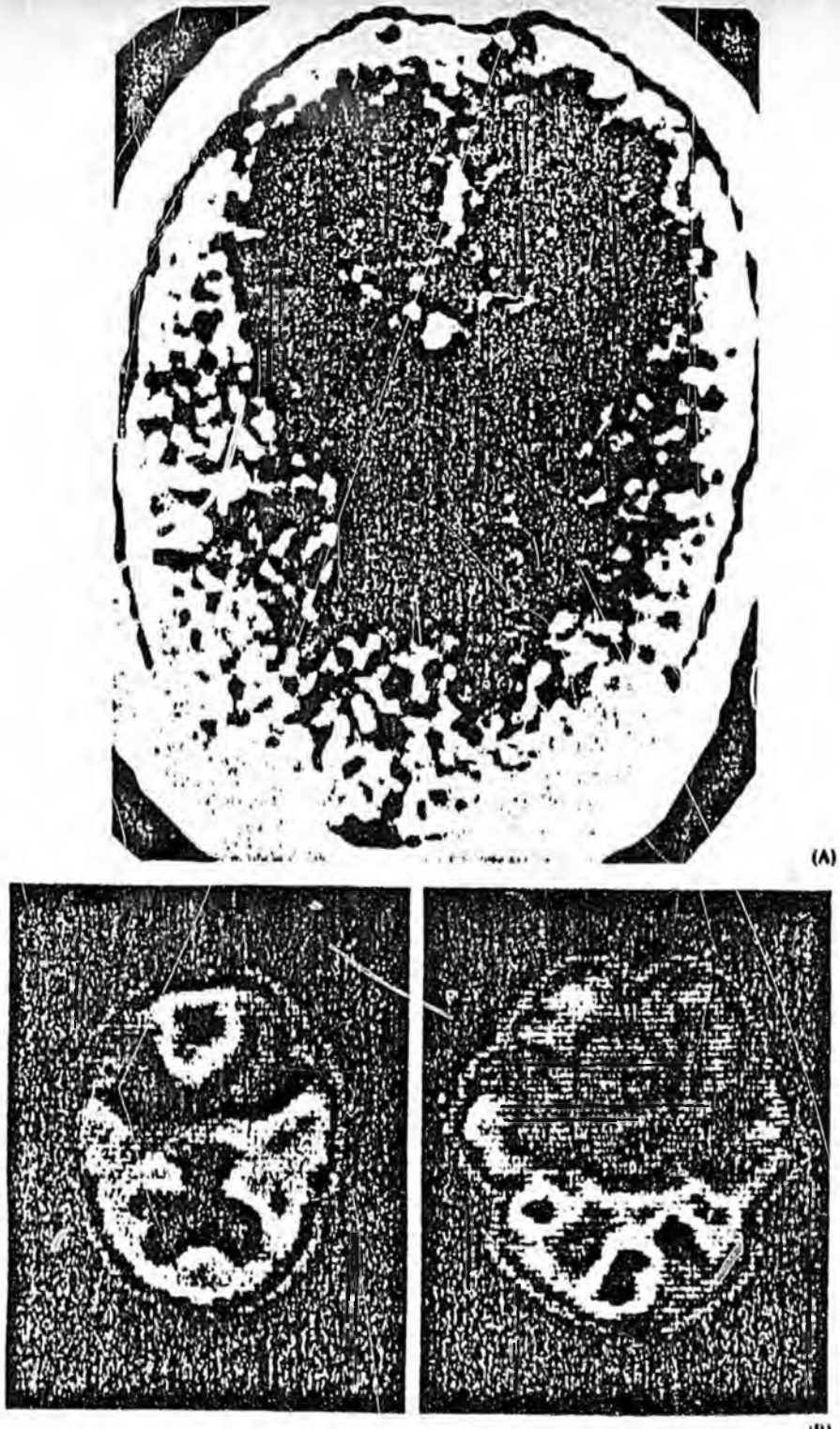


Figure 5-8. (A) CAT scan. (B) PET scan.

of whether persons facing prolonged incarceration are capable of giving informed consent regarding the use of this form of treatment.

In most democratic societies, individuals are generally free to do whatever they choose, as long as in doing so they do not interfere with the rights and well-being of others. When a person's behavior does pose a threat to the well-being of others, as clearly occurs when an individual rapes, for example, his freedom and rights are diminished for the common good. Thus, a convicted sex offender does not possess all the rights of a person who has not violated the law.

When an individual represents a threat to the safety of others, there is legal precedent for requiring him to take medication (e.g., measles vaccine). In this sense, then, requiring a convicted sex offender either to take antiandrogenic medications as a condition of probation or to go to prison may not be an unconstitutional violation of his rights.[125] Admittedly, making such a decision can be difficult, but just because the consequences of a decision may be difficult does not mean that one loses the capacity to choose. Cancer patients often have to choose between taking medication and dying.

Paraphiliac patients should not be denied access to antiandrogenic medications they wish to take which might be helpful in their treatment. Recently, a prisoner in Maryland successfully petitioned the court for the right to receive such treatment. Administering a properly informed, convicted person medication that may directly benefit him is very different from using him to study the effects of a drug, such as rabies vaccine, unrelated to his personal well-being. Paraphiliacs taking antiandrogenic medications can benefit if (1) they gain greater capacity for self-control, (2) they obtain relief from intrusive erotic obsessional fantasies, or (3) they avoid the necessity for quarantine from the community.

The medical profession needs to make clear the nature of the effects of psychiatric medications in general. They are not administered to control attitudes or behaviors such as those relating to political affiliations. They are not "mind controlling." Rather, they are usually given with the intent of increasing the capacity for self-control and restoring function (such as the ability to determine whether "heard" voices are real or imaginary).[126] Antiandrogenic medications are given in an attempt to increase rather than decrease self-control.[126]

Summary

Sexual deviation syndromes (paraphilias) are diagnosable psychiatric conditions manifested by (1) recurrent deviant fantasies, (2) intense erotic cravings, and (3) relatively stereotyped behaviors as a response to those cravings. The behaviors are stereotyped in the sense that exhibitionists expose themselves, whereas pedophiles seek out children and transvestites cross-dress. Paraphiliac syndromes are not necessarily mutually exclusive, but like conventional heterosexuality, their course is chronic. They may respond to biological treatments and may have associated

organic pathologies (such as Klinefelter's syndrome), but their etiologies are poorly understood.

Sexual offenses, as defined legally, may or may not be perpetrated by persons with one of these syndromes. When offending behavior is related to such a syndrome, (1) intramuscularly administered medroxyprogesterone acetate, (2) orchidectomy to diminish testosterone, or (3) cyproterone acetate may be helpful. However, antiandrogenic medication can only help if the patient is compliant. Orally administered medroxyprogesterone (at a daily dosage of 150 mg) has not been shown to be helpful.[128] It is not known whether antiandrogenic medication can help when offending behavior is unrelated to deviant sexual cravings, as when rape is committed opportunistically or in response to anger and hostility. Stereotactic psychosurgery is still a somewhat controversial procedure that is not yet widely enough available to be considered a practical treatment option for sexual deviation syndromes at this time. Behavior therapy may help some patients learn how to better resist their urges, but it may work less well with some paraphiliac syndromes than with others. When a sex offense is the reflection of a psychiatric illness such as schizophrenia or manic-depressive syndrome, medication treatment appropriate to that condition should be instituted. Legal demands for justice and safety as well as medical concerns for understanding care must both be considered, because each is important. When a person seeks help, his difficulties should be appreciated rather than scorned as perversions.

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SOLDOTNA OPTOMETRY CLINIC
JOHN A. DEMSKE, O.D.
DOCTOR OF OPTOMETRY
WOODRUEF BLDG. - SUITE 202, 155 SMITH WAY
SOLDOTNA, AK 99669

TELELPHONE (907) 262-3168

February 2, 1984

Representative Mae Tischer
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Tischer,

Per your request during the teleconference hearing in regard to HB 225, I offered to send you the names of individuals involved with the written national exam for therapeutic drug usage by optometrists. I have spoken with Dr. Norman Wallis, who holds the dual role of president of the International Association of Boards of Optometry(IAB) and the executive director of the National Board of Examiners in Optometry(NBEO). Dr. Wallis informed me that the exam is in the planning stages and that he expects it to be ready for use by Spring of 1985. If you have any further questions, you could contact Dr. Wallis at 5530 Wisconsin Avenue, N.W., Suite 950, Washington, D.C. 20815. PH (301)652-5192.

Dr. Wallis was out of his office until today and that is why it has taken me so long to get this information to you.

Much of the testimony concerned optometrists using drugs with supervision by a physician. Of the 38 states where optometrists use drugs, only North Carolina has any type of regulation regarding supervision, and this supervision is informal where the physician acts as a consultant. Unlike a nurse practicioner or physicians assistant , the North Carolina optometrist is solely responsible for the prescription. That is the way I would want to prescribe drugs and I'm sure that the majority of O.D.s in the state feel the same.

Several times during the teleconference the situation in Bethel was mentioned as an ideal situation regarding supervision. Since I worked there for five years, I think I can shed some light on the conditions. The optometrists have standing orders which specify drugs, their dosages and uages.

The standing orders are approved after a trial period in which the doctor of optometry demonstrates his knowledge and proficiency. After the trial period, the optometrist can use these drugs in-office and write precriptions without consultation or supervision. If the optometrist wishes to use a drug that is not listed on the standing orders, then a consultation is required and the consultants name is noted on the prescription.

In my opinion, the North Carolina law is a far superior model in terms of administration, logistics,and interprofessional communication. If you have any further questions on the North Carolina model, I suggest that you contact Dr. John Robinson, Sec.-Treas.-N.C. State Board of Optometry, P.O. Drawer 609, Wallace, N. C. 28466.

In closing, I apologize for the lateness and length of this letter, but I feel that this is information of which you should be aware. If you have any further questions, don't hesitate to contact me.

Sincerely,

J. A. Jemska OD

5-3

1) Dr. [illegible]
272-5353
276-8120
to offer his support to substitute HB 225 - wishes not to have bill "watered down"

2) Dr. [illegible]
486-5782
486-6117
to voice support for HB 225 in order to increase facilities of eye care to bush areas

3) Dr McLaughlin - Dillon
an old family friend - called to support HB 225

Dr. Thompson
pro HB 225

Dr Curtis Johnson
supports provisions to HB 225

Dr. Maynard Falconer
support pro bono HB 225
279-8422

Dr. John Monk - Portland
supports Rep. Hall's
provisions to HB 225

HB225

OPTOMETRISTS

MAE –

This cut & paste of HB225 makes it internally inconsistent –

Section 1 authorizes prescription & use of legend drugs, but the definition of legend drugs is DELETED on p. 3.

Both DIAGNOSIS & TREATMENT is limited to the ANTERIOR SEGMENT of the eyes & eyelids. Someone would have to explain what is significant about the ANTERIOR PORTION of EYES AND EYELIDS.

⇒ The proposal doesn't limit INJECTIBLES or CONTROLLED SUBSTANCES as the summary suggests.

The CS for Senate bill will be available by the HEARING time. It allows use of DRUGS FOR DIAGNOSTIC NOT TREATMENT purposes and sets out the Rules Board to establish what drugs may be prescribed – They MUST be approved by the Board of Medical Examiners.

I haven't read it yet – That's from Senate HESS STAFF.

10:15 AM

Dave

Tragger – Dept of Econ Development
Opposes "Legend" drugs term
means Controlled

Dr Graves – Dir written testimony favors
Dr. Swanson – Substitute Bill: favors
Dr Harmon – Opthomologists. Opposed
1. Drugs
2. yes

Dr Swarner – Kenai – optometrist – favors
Dr Sam McConkey – physician opposed
1. no pharmacology training
2. failure rate of [illegible] [illegible] very high
3.

Dr. John Cobbitt – Optometrist. favors. North Pole
Tom McLaughlin – Sitka – Optometrist favors
Ed Smith – Ketchikan – optometrist – favors
Dr Phil Bach – Optometrist – favors
"Narrowly trained" is not the case
Professions wouldn't ask for something that would endanger their profession
John Dempsey – Bethel – Optometrist – favors
has administered drugs & diagnosed diseases
West Virginia has 7 year unmarked track record in drug [illegible]

(*) Dr John Weatherby – Clinical – Bethel – Gen Practice
favors bill. Says Bethel has good experience giving optometrists therapeutic authority.

WHILE YOU WERE AWAY

FOR Mac DATE 5-2 TIME ____ A.M. P.M.

FROM Dr. Jim Falkner

OF ____

PHONE 272-2557 (AREA CODE / NUMBER / EXTENSION)

MESSAGE

supports substitute bill to HB 225

Not necessary to call back.

SIGNED

- TELEPHONED
- RETURNED YOUR CALL
- PLEASE CALL
- WILL CALL AGAIN
- CAME TO SEE YOU
- WANTS TO SEE YOU

TOPS FORM 4002

WHILE YOU WERE AWAY

FOR _____ DATE 3:25 TIME 3/2 A.M. P.M.

M Dr. Titzel

OF Arch Optometrist

PHONE _____
AREA CODE NUMBER EXTENSION

MESSAGE Please Support Substitute bill 225

X	TELEPHONED
	RETURNED YOUR CALL
	PLEASE CALL
	WILL CALL AGAIN
	CAME TO SEE YOU
	WANTS TO SEE YOU

SIGNED

TOPS FORM 4002

WHILE YOU WERE AWAY

FOR Mom DATE 5/2 TIME 3:55 A.M. P.M.

M Dr. Bolson

OF Optometrist

PHONE ____ AREA CODE ____ NUMBER ____ EXTENSION ____

MESSAGE Please support the substitute bill on optometry that Rep. Hall will introduce tomorrow.

Cathy

SIGNED

- [x] TELEPHONED
- [ ] RETURNED YOUR CALL
- [ ] PLEASE CALL
- [ ] WILL CALL AGAIN
- [ ] CAME TO SEE YOU
- [ ] WANTS TO SEE YOU

TOPS FORM 4002

Dr Deremus Opthomologist
(V. A Hospital patient)

military professionals
mentioned at least twice.

Really not credible

Summary of changes in the substitute bill

1. Excludes injectibles and controlled substances

2. Limits scope of therapeutics practice to anterior segment. Defines anterior segment.

3. Sets specific training requirements (conforms to current educational practice)

K.B

Dr Abramus - FBhs Optomologist - Asst. Official Surgeon

Opposed

Dr - Mike Franklin - G.P. Opposes - diagnosis w/ drugs okay but treating injuries, etc not okay.

Dr Richard Perry - Pres. BMA - opposes Page 2 Line 20-22. says there is no need to expand services.

MAY 10 1983

May 5, 1983

Representative Mae Tischer
Co-chairman House HESS Committee
Pouch V
Juneau, AK 99811

Dear Ms. Tischer:

I am writing you in support of the bill which would allow optometrists to use pharmaceutical agents in their clinical practice in the State of Alaska. I know this topic is an emotional issue, however, I feel that careful review of other states, etc. will substantiate the fact that with proper education and training it is safe. As well, in the present day of astronomical health care costs I feel it would be cost efficient. I also feel it can be demonstrated that better and more appropriate referrals to physicians can be made with the use of pharmaceutical agents by optometrists.

I write to you with a personal background of graduating from both optometry school and medical school. I am very comfortable presently and have no axe to grind, rather simply wish to express my personal heart felt opinion.

Let me now address some specific aspects of optometric and medical education by my own first hand experience.

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

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

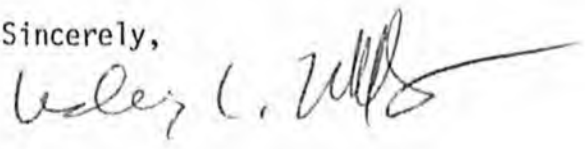
On the other hand, optometry school is mostly devoted to ocular training. There are courses in general pathology and ocular signs of systemic disease because the optometrist is responsible to detect systemic diseases with ocular manifestations and to make appropriate referrals. The detailed ocular anatomy, ocular physiology, ocular pathology, and ocular pharmacology training in optometry school is far superior to the same ocular topics in any general medical school course in the country. This is not to slight medical education, there simply is not enough medical school curriculum time to devote to the eye because of training in vital organ systems such as the heart, lung, vascular system, etc.

Secondly, I will discuss my personal experience with side effects of ocular pharmacologic therapy. This section will be very brief as I have never had a patient with anything other than a very minor side effect from ocular pharmaceutical agents. I have seen a few mild allergic reactions and none of these serious and none had any evidence of systemic reactions such as elevated blood pressure, rapid heart rate, arrhythmias of the heart, etc. None ever required hospitalization and certainly there were no deaths. I saw very few significant side effects and all which did occur were very minor in nature.

In summary I would like to point out that ophthalmologists are vitally needed. The medical profession would be in sad shape without them because of their expertise in the area of ocular trauma, cataract surgery, retinal surgery, serious ocular infections, etc. However, in a rural state the ophthalmologists are primarily in large and medium sized cities with a poor distribution in the rural communities.

I also strongly feel that optometrists are vitally needed. Optometrists are well distributed in rural communities and by definition serve as primary care professionals. In my opinion, the patient, particularly in the rural areas and small town, will be the beneficiary of modern optometric practice. With the use of pharmaceutical agents, disease detection will be facilitated thus making the referral system into medicine more efficient. As well, this will save the patient a lot of inconvenience and time. I feel optometrists should be allowed to practice modern optometry which includes pharmaceutical agents. I believe the key to utilizing these medications by health care professionals is education and training.

Sincerely,



Lesley L. Walls, O.D., M.D.
P.O. Box 78
Glenpool, OK 74033

cc Representative Adelheid Herrmann
Representative Mike Davis
Representative Peter Goll
Representative M.W. Miller
Representative Niilo Koponen

LLW/jjm

Alaska State Legislature

District 11
3305 Oregon Drive
Anchorage, Alaska 99503

While In Juneau
Pouch V
Juneau, Alaska 99811
(907) 465-3759

Representative Mae Tischer

May 10, 1983

Lesley L. Walls, O.D., M.D.
P.O. Box 78
Glenpool, OK 74033

Dear Lesley:

Thank you for your letter and comments on HB 225 relating to optometrists and authorization for their prescribing ophthalmic drugs. I agree that this authority, properly regulated, would reduce costs and increase service to Alaskan residents. I will support this bill.

Sincerely,

Mae Tischer

Representative Mae Tischer
District 11

MT/cw

MEMBER: Rules
CO-CHAIR: Health, Education & Social Services
VICE-CHAIR: Community & Regional Affairs
FINANCE SUBCOMMITTEES: Health & Social Services • Rural Education Budget Oversight • Corrections

Official Business

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

To: HESS Committee
From: Dave Palmer
Subject: HB 225, SB 189, Optometrist Diagnostic drugs
Date: April 28, 1983

Attached is a copy of a working draft of a CS for SB 189.
The bill is different from the bill before the committee in several ways:

-The Board of Examiners in Optometry is expanded by one member, who is a physician.

-The Board is authorized to adopt regulations concerning the use of diagnostic drugs.

-The state medical board shall provide "advice and guidance" to the Board of Examiners in Optometry in developing a list of diagnostic druge and their dosages.

-provides for continuing education

-requires an optometrist to advise the patient and refer the patient to a medical specialist if a pathological condition is found.

-When using the term "Dr." or "Doctor", the word Optometrist must be used also,

-specifies requirements for an optometrist to be licensed to prescribe diagnostic drugs.

-optometry is defined to allow the use of diagnostic drugs.

-defines diagnostic drugs: cycloplegic, mydriatic or topical anesthetic....

-

Heard 4/27 Hearing

TESTIMONY IN SUPPORT OF HOUSE BILL 225

Health, Education and Social Services Committee

Alaska State House of Representatives

April 27, 1983

Steve Dobson, O.D.

Gentlemen of the Committee, my name is Steve Dobson. I am an optometrist in private practice in Anchorage. I am a 1980 graduate of the Southern California College of Optometry, and in 1981 completed a one year residency in rehabilitative optometry at an outpatient clinic of the Veterans Administration hospital in Los Angeles.

My testimony will focus on optometric education, for the most frequent charge raised by ophthalmologists in opposing this type of legislation is that optometrists do not have a physician's broad medical background, which they say is necessary in order to do competant diagnosis and treatment.

It so happens, like many propaganda arguments, that this one has a grain of truth in it. What may appear to be a local inflammation can actually be a manifestation of infection or dysfunction elsewhere in the body. Experience in administering a variety of drugs in a variety of modes makes it easier to learn new drugs and new treatment protocols.

However if the argument is carried too far, it begins to break down. One can say that it is useful to be trained as a general physician before treating specific parts of the body. But is it absolutely necessary? Ophthalmologists, who are trained on the physician-specialist model, would say that a physician's background is necessary even to be able to judge when to treat a case and when to refer it for more specialized care. However it takes no special expertize to realize that if that were the case, then dentists and podiatrists, who are not trained as physicians, would be incompetant or only marginally competant.

Let's take a closer look at the alternative model of education, on which dentists, podiatrists and optometrists are trained. For convenience, I will consider just dentistry and optometry, but podiatry follows similar principles. Dentists and optometrists have at least as many hours of training in anatomy as physicians. But that training is structured differently. Their studies in gross human anatomy give somewhat less emphasis to the body below the neck but more emphasis in the head and neck region, as compared with medical students. This is followed by intensive study of organ systems of special interest - the teeth and oral cavity for dentists, the eye and adnexa for optometrists. This is a level of detail that physicians do not encounter until they enter specialty residencies. Other courses, such as general

physiology, microbiology and general pathology, are also slightly less detailed than those given medical students. But again, when corresponding studies in the target organ systems are added in, the hours exceed those of the medical student. If we take the process one step further and add the hours of the medical student and the resident together, the total hours in any given subjedt would now be greater than those for the dentist and optometrist. For optometry and dental students, classroom and laboratory time in these subjects, called basic science, totals about a thousand hours, or 25% of the total clock hours in the curriculum. The remainder is given over to specialized theory and procedures courses, and experience in the clinic.

At this point, let me interject that in case it should be supposed or alleged that optometric courses are not of the same quality as dental courses, I would point out that where optometry and dental schools are co-located, as at the University of Alabama in Birmingham and the University of Houston, optometry and dental students not only take the same courses but sit together in the same classrooms and laboratories whenever there is enough commonality in content to make this practical. For example, general physiology and microbiology in the case of Birmingham. In both optometry and dental schools, physicians are used in their areas of greatest expertise, primarily pathology and therapeutics. Pharmacology is taught by pharmacologists and physiology is taught

by physiologists.

Courses in the whole body emphasize unifying principles, which serve as a foundation for understanding all regions. At the stage of target organ study, specific interrelationships between target organ pathology and systemic pathology are learned. It is also at this stage that the student learns what effects a drug may have on other organs of the body.

Without putting too fine a point on it, it is hopefully evident from this that someone who will be working with a portion of the body and dealing with a specific set of interrelationships between this portion and the rest of the body does not have to have the same kind of whole body training as someone who will be treating many different parts of the body. The specializing physician model of education is a good one, but is it enough better than the dental model to justify the increased costs?

With respect to drugs, however, optometry has differed from dentistry until recent years. When the optometry laws were enacted in the first quarter of the century, restrictions against drug use were inserted into nearly every statute as a compromise with the physicians and oculists of the day, who opposed enactment of the optometry laws. In the succeeding years, optometry developed strong capabilities in the detection and diagnosis of ocular

pathology, but its lack of access to prescription drugs effectively limited its therapeutic services to conditions treatable with over the counter drugs, compresses and mechanical procedures. During the same period, ophthalmology developed from a primitive extension of general medicine into a recognized specialty. In the 1970s general and ocular pharmacology were removed from their positions within other courses in the optometric curriculum, and expanded into full fledged, free standing courses. Concurrently, optometrists introduced bills that would allow them to use drugs to aid in diagnosis, on the theory that such limited legislation would be easier to pass. There began a slow, state by state process of passing legislation, against fierce ophthalmological opposition. As of now, 36 states allow some form of drug use by optometrists. In 1976, West Virginia became the first state to enact legislation allowing optometrists to use drugs for both diagnostic and therapeutic purposes. In 1977, North Carolina passed a similar measure and Florida received an attorney general opinion favorable to the use of therapeutics. In 1980, Oklahoma passed enabling legislation. In support of these states, nearby optometry schools strengthened their programs in therapeutics. At present, drug-based therapeutics is taught at an undergraduate and postgraduate level by Pennsylvania College of Optometry in Philadelphia and Southern College of Optometry in Memphis, and by the University of Alabama at Birmingham School of Optometry on a postgraduate basis. Other schools are planning similar programs. Pennsylvania's therapeutics course was taken by a

majority of Alaska's ODs last year. Opportunities for additional clinical experiences in therapeutics developed quickly and dramatically. Federal law in 1976 formally established Optometry Services within the Veterans Administration hospital system. These Optometry Services provide primary eye care therapeutics, usually under the prescription signing arrangement noted by Dr. Demske. A number of the Services have developed 1 year residency programs for optometrists, such as the one I went through. Opportunities are also available for ODs and undergraduate optometry students to study at these hospitals for shorter periods of time. In Atlanta, there is a three year old optometric clinic that does nothing but treat ocular pathology on referral from physicians and optometrists in the area. Students from four optometry schools do semester rotations there, and similar centers are being planned in other cities. There is thus developing a spectrum of training opportunities, both basic and advanced, for optometrists in therapeutics.

It appears that at long last the quirks of the original optometry laws are being removed and optometry will be allowed to undergo a more natural evolution. Optometry will continue to compete with ophthalmology, as podiatry competes with orthopedic surgery, though in the case of optometry, surgical training is not on the horizon. While the medical branches may not like it, such competition is good for the public. Optometry, like podiatry, can now offer quality, cost effective services in areas where specialists are overtrained

and general practitioners are undertrained. Dentistry has no competition from medicine, but its training is also based on the more cost effective model.

One more thing needs to be said. Ophthalmologists have criticized other aspects of optometric education, saying that there are too few MDs teaching in optometry schools and that clinical experiences are not adequate. In point of fact, ophthalmologists have actively tried to hinder the education of optometrists. There is a great deal of peer pressure on ophthalmologists, and through them, on their colleagues in other branches, not to teach in optometry schools. In 1955, the American Medical Association, at the request of the Section on Ophthalmology, adopted a resolution declaring it unethical for a doctor of medicine to teach in a school or college of optometry. Such resolutions have more than nominal influence upon physicians, for unethical behavior can serve as the basis for denial of hospital privileges by individual hospital medical staffs. Some physicians ignored the directive and continued to teach, and schools filled in the gaps by using osteopaths, who were not affected. The resolution was rescinded 11 years later, in 1966.

Ophthalmology has also opposed virtually every piece of legislation that would facilitate the professional development

of optometry, including funds for construction of optometry school buildings and clinics, Health Professions Student Loans, and capitation grants. Fortunately, most Congressmen and legislators saw the value of optometry to society, and the efforts of ophthalmology to block funding were largely unsuccessful. From 1964 to 1980, ophthalmologists were able to prevent reimbursement to optometric patients for services covered under Medicare. As a result, optometry lost 30% of its patient population over age 65. It also deprived optometry school clinics of a prime source of pathology for teaching purposes. It is not fair to criticize something when you are actively trying to bring about that which you criticize.

In conclusion, I would ask that you allow optometry in Alaska to take full advantage of the educational opportunities that are unfolding, so as to maximally benefit the public which it serves. Overly restrictive compromises will simply result in further legislative battles down the road. The bill in its present form conforms to the framework for decision making that has stood the test of time in other professions. It makes no legislative sense to take a responsible profession out of one box and place it in a slightly larger box. Given the opportunity, optometry will exercize the same good judgment as the other professions. And the public will be the beneficiary.

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

M E M O R A N D U M

May 9, 1983

SUBJECT: Optometry
(HB 225)

TO: Representative Milo Fritz
Co-Chairman, House Health, Education
and Social Services Committee

Representative Mae Tischer
Co-Chairman, House Health, Education
and Social Services Committee

FROM: Russ Josephson
Legislative Counsel

I would like to bring to your attention Sec. 6 of HB 225, as introduced. In this section, AS 08.64.360 is amended by adding the words "an optometrist" to those excepted from practicing medicine without an appropriate license. It is my feeling that the amendment of AS 08.64.360 in Sec. 6 would provide us with a "cleaner" statute if it read, "Except as provided under AS 08.64.170" rather than as it is amended in Sec. 6 of HB 225. You will note that in Sec. 1 of the bill we have excepted those practicing optometry by amending AS 08.64.170(a). Therefore, I would recommend that Sec. 6 of the introduced bill be amended.

If you have any questions about this matter, please do not hesitate to call.

RJ:ljb
18/013

POSITION PAPER
HOUSE BILL NO. 225

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

This Bill would permit the use of legend drugs by certain optometrists and would delete from the definition of optometry the restriction against the use of drugs. Legend drugs as defined in Section 5 of the Bill "means drugs whose containers must bear a label prohibiting dispensing without a prescription". The Bill also specifically permits optometrists to engage in the "diagnosis and treatment, including the use of drugs, of inflammations, infections and injuries of the eyes and eyelids".

A majority of states now allow optometrists to use diagnostic topical drugs, either through specific enabling legislation or through the lack of specific prohibitions. Few, if any, permit the use of therapeutic drugs. This Bill, as now written, would apparently permit the use of any drug, whether topical or systemic, in the diagnosis and treatment by an optometrist of inflammations, infections and injuries of the eyes and eyelids. Arguably, the proposed legislation may be construed to permit the practice of opthalmologic surgery by optometrists since surgery is not specifically prohibited.

Even the use of diagnostic topical drugs by optometrists, i.e., drugs which cause the pupil to open or to close down or which paralyze the muscles which control the shape of the lens, has been controversial. 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 use of diagnostic drugs rarely causes adverse effects.

Those opposing such 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 judgements 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 diagnostic 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 mydriatic drugs could possibly precipitate an attack. The potential use of therapeutic drugs can be expected to raise even greater concern.

Limitations are placed on the use of certain diagnostic drugs by legislation in some states. 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.

Some states define the type of training in pharmacology which would be required before an optometrist would be permitted to use even diagnostic drugs. HB 225 contains no such provisions.

The Department of Health and Social Services does not support HB 225 in its present form because of the overly broad definition of the types of drugs which would be authorized, vagueness with regard to the limits of optometric practice and lack of provisions with regard to the educational qualifications required for use of drugs. If the Legislature chooses to authorize use of certain drugs by optometrists, the Department 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: E. S. Rabeau

E. S. Rabeau, M.D., Director
Division of Public Health

Date: 2/25/83

Approved by: Robert London Smith

Robert London Smith, Ph.D.
Commissioner
Dept. of Health & Social Services

Date: 3/1/83

STATE OF ALASKA
PRELIMINARY STATEMENT OF FISCAL IMPACT

Bill No: House Bill No. 225 Date on Bill: February 23, 1983
Title: "An Act relating to the practice of optometry and authorizing the use of prescription drugs by optometrists."
Sponsor: Hurlbert
Requestor:

1. Estimated fiscal impacts on:

a. Expenditures:

(Thousands of Dollars)

			FY 83	FY 84	FY 85	FY 86		
Capital			0	0	0	0		
Operating			0	0	0	0		
Total			0	0	0	0		

B. Revenues:

Revenue								

2. Source of funds to offset fiscal impact of bill:

3. Assumptions:

4. Disclaimer:
This statement has not been reviewed by OMB in the Office of the Governor. It does not represent the policy of the Sheffield Administration or the final estimate of fiscal impact.

Prepared by: Dean F. Tirador, M.D. Phone: 465-2113
Division: Public Health Date: February 25, 1983

Approved by Commissioner: Robert London Sheffield, Ph.D. Date: 3/1/83
Department: Health & Social Services

5. Distribution:
Original to Legislative Finance
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2/8/83

STATE OF ALASKA
FISCAL NOTE

Revision Date 4/12 , 1983

I. REQUEST

Bill/Resolution No.: HB 225
Title: "Optometrist - Use of Drugs"
Sponsor: Hurlbert
Requestor: HESS Committee

II. FISCAL DETAIL

Agency Affected: Commerce & Econ. Devp.
Program Category Affected: Public Prot.
BRU, Program of Subprogram(s) Affected: Occupational Licensing

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
OPERATING						
100 PERSONAL SERVICES		31.6	33.1	34.6	36.2	37.9
200 TRAVEL		2.0	2.1	2.2	2.4	2.5
300 CONTRACTUAL		1.5	1.6	1.7	1.7	1.8
400 COMMODITIES		0.5	0.5	0.6	0.6	0.6
500 EQUIPMENT		2.7	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL OPERATING		38.3	37.3	39.1	40.9	42.8
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND		38.3	37.3	39.1	40.9	42.8
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS:

FULL-TIME		1	1	1	1	1
PART-TIME						
TEMPORARY						

III. SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

Not identified by sponsor.

IV. ANALYSIS: Attach a separate page for any Analysis

Prepared By: Darrell Miller
Division: Occupational Licensing
Phone: 465-2535
Date: 4/12/83

Approved by Commissioner: Richard A. Lyon
Department: Commerce & Economic Development
Date: 4/13/83

Distribution:
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3/8/83

HB 225 FISCAL IMPACT

(Note: 5% inflation factor projected for FY '84 through FY '88 for operating cost)

100 PERSONAL SERVICES - (FY '83 salary schedule plus 5% inflation factor)

1 Licensing Examiner, Range 12A, General Government, 12 months, to be located in Juneau	$31,602.00

200 TRAVEL

4 board meetings annually (2 days each @ $80.00/day per diem = $160.00 x 4)	$ 640.00
Transportation - board meetings annually ($350.00 each x 4)	1,400.00
	$ 2,040.00

300 CONTRACTUAL

Postage, telephone, printing, publications and operating costs	$ 1,500.00

400 COMMODITIES

Stationery, typewriter ribbons, pens, pencils, and other miscellaneous desk top supplies	$ 500.00

500 EQUIPMENT (One time cost, FY '84 only)

1 desk, double pedestal, 60" x 30"	$ 427.00
1 chair, swivel w/arms	202.00
1 typewriter, IBM Selectric II	1,129.00
1 typewriter table	94.00
1 chair, side, without arms	104.00
1 desk calculator	332.00
1 book case	138.00
1 file cabinet, 4 drawer, legal with lock	306.00
	$ 2,732.00

One position total:	$38,374.00

SPECIFIC LEGISLATION: 32 States

The list (and dates of enactment) of the 32 states with current legislation specifically authorizing optometrists to utilize pharmaceutical agents is as follows:

STATE	DATE OF ENACTMENT
Rhode Island	July 16, 1971
Pennsylvania	March 1, 1974
Tennessee	May 8, 1975
Oregon	May 20, 1975
Maine	June 24, 1975
Louisiana	July 6, 1975
Delaware	July 10, 1975
West Virginia*	March 4, 1976
California	July 9, 1976
Wyoming	February 17, 1977
New Mexico	March 4, 1977
Montana	April 12, 1977 (at 10:10 a.m.)
Kansas	April 12, 1977 (at 2:00 p.m.)
North Carolina*	June 3, 1977
Kentucky	March 29, 1978
Wisconsin	April 29, 1978
Nebraska	February 13, 1979
South Dakota	March 15, 1979
Utah	March 21, 1979
North Dakota	March 22, 1979
Arkansas	April 2, 1979
Nevada	May 25, 1979
Iowa	June 8, 1979
Georgia	February 14, 1980
Arizona	April 25, 1980
Idaho	March 23, 1981
Oklahoma	April 6, 1981
Washington	April 23, 1981
Missouri	July 24, 1981
Minnesota	March 8, 1982
Mississippi	March 17, 1982
Virginia	February 25, 1983

*both diagnostic and therapeutic use

NOTE: None of these laws has ever been repealed. However, a July 30, 1982 opinion of the Texas state attorney general has rendered that state's unusual provision (an amendment to the medical practice act), which was enacted on August 5, 1981, inoperative.

SOURCE: Dennis Swarner O.D & Robert O'Connell, O.D.

GENERAL LEGISLATION: 4 states

There are four states which authorize the use of pharmaceutical agents by optometrists by extant general law or favorable attorney general opinion:

Alabama	(diagnostic use)
Florida	(diagnostic and therapeutic use)
Indiana	(diagnostic use)
New Jersey	(diagnostic use)

NOTE: In addition, in Michigan, while there is no statutory prohibition of the use of pharmaceutical agents by optometrists, there is a negative opinion of the state attorney general.

For your information we are including an updated map showing, geographically, the utilization of pharmaceutical agents by optometrists.

Note: Section 39, chapter 842, Oregon Laws 1977, is operative July 1, 1986, and provides:

Sec. 39. ORS 683.010, 683.020, 683.030, 683.035, 683.040, 683.050, 683.060, 683.070, 683.080, 683.100, 683.110, 683.120, 683.130, 683.140, 683.155, 683.170, 683.180, 683.190, 683.210, 683.250, 683.260, 683.270, 683.275, 683.280, 683.290 and 683.990 relating to optometrists are repealed.

GENERAL PROVISIONS

683.010 Definitions. As used in this chapter, unless the context requires otherwise:

(1) "Board" means the Oregon Board of Optometry.

(2) "Practice of optometry" means the employment of any means other than the use of drugs, except diagnostic agents, topically applied, known generically as cycloplegics, mydriatics, topical anesthetics, dyes such as fluorescein, and, for emergency use only, miotics, for the measurement or assistance of the powers or range of human vision or the determination of the accommodative and refractive states of the human eye or the scope of its functions in general or the adaptation of lenses or frames for the aid thereof, subject to the limitations of ORS 683.040.

(3) "Trial frames" or "test lenses" means any frame or lens used in testing the eye which is not sold and not for sale. [Amended by 1971 c.102 §1; 1975 c.175 §1]

683.020 Certificate of registration required to practice optometry. No person shall engage in the practice of optometry or display a sign or in any other way advertise or hold himself out as an optometrist without having first obtained a certificate of registration from the board as provided for in this chapter. In any prosecution for the violation of this section, the use of test cards, test lenses or of trial frames is prima facie evidence of the practice of optometry. [Amended by 1971 c.102 §2]

683.030 Persons and practices not affected. This chapter shall not be construed to prevent any person duly licensed to practice medicine and surgery from treating or fitting glasses to the human eye, nor to prohibit the sale of complete ready-to-wear eye glasses as merchandise from a permanent place of business in good faith and not in evasion of this chapter by any person not holding himself out as competent to examine and prescribe for the human eye.

683.035 Discrimination against optometrists prohibited. No official, board, commission or other agency of the state or of any of its political subdivisions or municipalities shall discriminate between duly licensed optometrists and any other person authorized by law to render professional services which a duly licensed optometrist may render, when such services are required. Such services shall be paid for in the same manner and under the same standards as similar professional services. [1963 c.121 §1]

LICENSING

683.040 Qualifications of applicants. (1) Every person desiring to commence the practice of optometry in this state must show by satisfactory evidence that he is of good moral character and has graduated from a school of optometry which is recognized and approved by the board and which maintains a standard of four school years of at least nine months each.

(2) Every person desiring to commence the practice of optometry after January 1, 1976, or employ the use of diagnostic agents shall in addition to the requirements of subsection (1) of this section have satisfactorily completed a course in pharmacology, as it applies to optometry, by an institution accredited by a regional or professional accreditation organization which is recognized or approved by the National Commission on Accrediting or the United States Commissioner of Education, with particular emphasis on the topical application of diagnostic agents to the eye for the purpose of examination of the human eye and the analysis of ocular functions, approved by the Oregon Board of Optometry. [Amended by 1971 c.102 §3; 1975 c.175 §2]

683.050 Persons licensed in another state. In lieu of the educational requirements of ORS 683.040, it shall be deemed equivalent if an applicant submits satisfactory proof to the board that he:

(1) Has passed an examination in optometry before a state board of examiners in another state of the United States and that the certificate granted in token thereof is then in force; and

(2) Was actually engaged in the practice of optometry in such state for the full period of three years subsequent thereto.

Rep Tischer

POSITION PAPER

COMMITTEE SUBSTITUTE FOR HOUSE BILL NO. 225 (HESS)

"An Act relating to the practice of optometry and authorizing the use of certain drug by optometrists."

The Committee Substitute makes several changes to existing statute and to the original bill: (a) membership in the Board of Examiners in Optometry is expanded to six to include a physician licensed in the state; (b) duties of the board are broadened to include development, with the advice and guidance of the state medical board, of a list of prescription and non-prescription drugsand dosages which may be used in the practice of optometry in the state and requirements for continuing education of optometrists desiring to use drugs; (c) registration or licensure of an optometrist to practice beyond the scope of the individual's training is prohibited; and (d) language is added to require an optometrist to clarify the nature of his or her practice when using the prefix "Dr." or "Doctor".

The Department recommends that the board size remain an odd number by reducing the number of optometrist members to three while retaining the public member and the physician member.

There is a minor difference in the language of the original and committee substitute bills with regard to the types of drugs which would be permitted. The original version uses the adjective "legend" while the substitute refers to "legend", "prescription" and "non-prescription" drugs. It is assumed that "non-prescription" refers to commonly available over-the-counter preparations.

Both versions include in the definition of optometry the "diagnosis and treatment, including the use of drugs, of inflammations, infections, and injuries of the eyes and eyelids". This provision remains the most controversial element of the Bill although the provision for approval of the types of drugs by the optometric board with the advice and guidance of the medical board may reassure, to some extent, those concerned with the apparently unrestricted access to drugs permitted in the original version.

While the committee substitute is an improvement over the original version of the bill, the Department still considers the definition of optometry to be too broad, e.g., it would not prohibit the use of surgery nor the use of systemic drugs. **At a minimum the inclusion of surgery within optometric practice should be prohibited and drug use should be limited to topical diagnostic preparations and anesthetics approved by the optometric board with the advice and guidance of the medical board.**

practice - by statute would not the bill, which optometrists would be legal to perform surgery.

POSITION PAPER/Department of Health and Social Services

While the vast majority of health care practitioners are prudent and sincere, the Department does not believe that individual practitioners should be left entirely free to define the scope of their practices. The Department does not believe a user of health services should have to rely solely on the professioal integrity of the provider for assurance of quality of care. This is one of the functions of the licensing statutes of the state.

The Department is opposed to the use of therapeutic drugs by optometrists. The possibilities of problems because of systemic effects, idiosyncratic or allergic reactions and drug interactions, while not common, require diagnostic and therapeutic responses which cannot be guaranteed though training courses in pharmacology.

Recommended by: E. S. Rabeau

E.S. Rabeau, M.D.
Director
Division of Public Health

Date: May 13, 1983

Approved by: _____

Robert London Smith, Ph.D.
Commissioner
Department of Health and
Social Services

Date: _____

STATE OF ALASKA
FISCAL NOTE Revision Date , 1983

I. REQUEST
Bill/Resolution No.: CSHB 225
Title: Practice of Optometry
Sponsor: Hurlbert and Martin
Requestor:

II. FISCAL DETAIL
Agency Affected: Health & Social Services
Program Category Affected: Public Health
BRU, Program of Subprogram(s) Affected:

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LANDS & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	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 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. SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

IV. ANALYSIS: Attach a separate page for any Analysis

Prepared By: Dean F. Tirador, M.D. Phone: 465-3090
Division: Public Health Date: 5/13/83

Approved by Commissioner: Date:
Department: Health and Social Services

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3/8/83

STAFF REPORT

HB 225, Relating to Prescription of
Drugs by Optometrists
April 25, 1983
Dave Palmer

HB 225 authorizes optometrists to use and prescribe legend drugs in diagnosis and treatment of conditions of the eyes and eyelids. It also requires the Board of Examiners in Optometry to provide for continuing education.

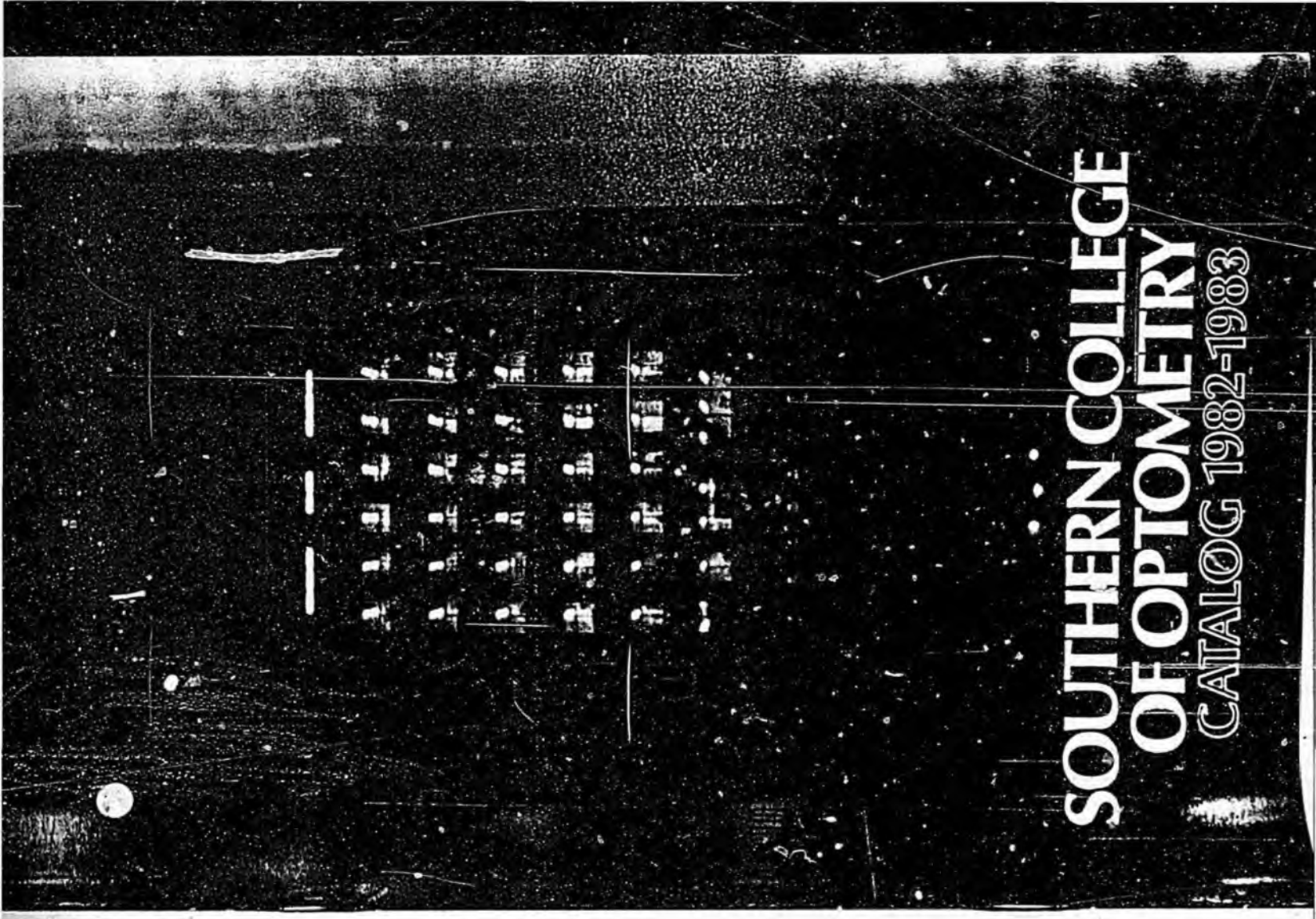
The bill authorizes the optometrist to use legend drugs for both diagnostic and treatment purposes. A majority of states authorize the use of legend drugs for diagnosis, but not for treatment. (See Oregon law attached).

The arguments in favor and in opposition of the bill are presented well in Dr. Rabeau's position paper. In a rural setting, particularly in Alaska where referrals to other professionals are difficult, the authorization to allow optometrists to expand their capabilities may carry more credence than in more populated states.

One method, proposed this session in Oregon, is to allow the use of drugs for treatment purposes by optometrists after they have received an endorsement by the Board of Examiners of Optometry and they are authorized to prescribe or use drugs or treatments that are approved jointly by the Board of Examiners in Optometry and by the Board of Medical Examiners.

The fiscal note from Commerce and Economic Development is $38,300 for FY 84.

The fiscal note from Department of Health and Social Services is zero.



SOUTHERN COLLEGE
OF OPTOMETRY
1245 MADISON AVENUE
MEMPHIS, TENNESSEE 38104

CORRESPONDENCE DIRECTORY

SOUTHERN COLLEGE OF OPTOMETRY
1245 Madison Avenue
Memphis, Tennessee 38104

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This edition of the Southern College of Optometry catalog is effective for the academic year 1982-83. Inasmuch as changes may be necessary from time to time, this catalog should not be construed as constituting a contract between the College and any person.

SOUTHERN COLLEGE OF OPTOMETRY

Memphis, Tennessee

1982-83 CATALOG

INFORMATION CURRENT AS OF JUNE, 1982

CURRICULUM

FIRST PROFESSIONAL YEAR			HOURS CREDIT	Clock Hours*
FALL QUARTER				
Biomedical	110	Human Anatomy & Physiology I: Structure & Function - 1 (5 HRS. LEC., 2 HRS. LAB)	6	70
Biomedical	111	Optics Applied To The Eye I (4 HRS. LEC., 2 HRS. LAB)	5	
Optometry	110	Introduction to Optometry (1 HRS. LEC., 3 HRS. LAB)	4	
Optometry	111	Preventive and Community Optometry Epidemiology & Research Methodology (4 HRS. LEC.)	4	
Clinic	110	Clinic Orientation (2 HRS. LAB.)	1*	
			Total 20	
WINTER QUARTER				
Biomedical	120	Human Anatomy & Physiology II: Structure & Function - 2 (5 HRS. LEC., 2 HRS. LAB)	6	70
Biomedical	121	Optics Applied To The Eye II (3 HRS. LEC., 2 HRS. LAB)	4	
Biomedical	122	Visual Perception: Psycho-Physiological Optics (4 HRS. LEC., 2 HRS. LAB)	5	
Optometry	120	Ophthalmic Diagnostic Principles I (3 HRS. LEC., 3 HRS. LAB)	4	
Optometry	121	Preventive & Community Optometry: Jurisprudence (2 HRS. LEC.)	2	
Clinic	110	Clinic Orientation (2 HRS. LAB)	*	
			Total 21	
SPRING QUARTER				
Biomedical	130	Human Anatomy & Physiology III: Structure & Function - 3 (5 HRS. LEC., 2 HRS. LAB)	6	70
Biomedical	131	Optics Applied To The Eye III (3 HRS. LEC., 2 HRS. LAB)	4	
Biomedical	133	Vegetative Physiology: Ocular Biochemistry (2 HRS. LEC., 2 HRS. LAB)	3	40
Optometry	130	Ophthalmic Diagnostic Principles II (4 HRS. LEC., 3 HRS. LAB)	5	
Optometry	131	History of Optometry (1 HR. LEC.)	1	
Clinic	110	Clinic Orientation (2 HRS. LAB)	*	
			Total 19	

*Note: One quarter hour credit is awarded upon completion of this course in the Spring Quarter

*Clock hours = hrs per week x 10 wk. quarter

SECOND PROFESSIONAL YEAR

				HOURS CREDIT	Clock Hours
FALL QUARTER					
Biomedical	210	Principles of Medicine I: General Pathology (5 HRS. LEC.)		5	50
Biomedical	211	Physiological Optics: Eye As An Optical System (3 HRS. LEC., 2 HRS. LAB)		4	
Biomedical	212	Neuroanatomy and Neurophysiology (3 HRS. LEC., 2 HRS. LAB)		4	50
Biomedical	213	Principles of Pharmacology & Therapeutics I (2 HRS. LEC.)		2	20
Optometry	210	Advanced Optometry I (3 HRS. LEC., 2 HRS. LAB)		4	
Clinic	210	Clinical Procedures (2 HRS. LAB)		1*	
				Total 20	
WINTER QUARTER					
Biomedical	220	Principles of Medicine II: Ophthalmic Pathology I (5 HRS. LEC., 2 HRS. LAB)		6	70
Biomedical	221	Physiological Optics II: Monocular Sensory (3 HRS. LEC., 2 HRS. LAB)		4	50
Biomedical	223	Principles of Pharmacology & Therapeutics II (4 HRS. LEC.)		4	40
Optometry	220	Advanced Optometry II (3 HRS. LEC., 2 HRS. LAB)		4	
Optometry	222	Ophthalmic Optics I (2 HRS. LEC.)		2	
Clinic	210	Clinical Procedures (2 HRS. LAB)		*	
				Total 20	
SPRING QUARTER					
Biomedical	230	Principles of Medicine III: Ophthalmic Pathology II (5 HRS. LEC., 2 HRS. LAB)		6	70
Biomedical	231	Physiological Optics III: Monocular Sensory & Binocular Vision (2 HRS. LEC., 2 HRS. LAB)		3	40
Biomedical	233	Principles of Pharmacology & Therapeutics III (4 HRS. LEC.)		4	40
Optometry	230	Advanced Optometry III (4 HRS. LEC., 2 HRS. LAB)		5	
Optometry	232	Ophthalmic Optics II (1 HR. LEC., 2 HRS. LAB)		2	
Clinic	210	Clinical Procedures (2 HRS. LAB)		*	
				Total 20	

*Note: One quarter hour credit is awarded upon completion of this course in the Spring Quarter.

THIRD PROFESSIONAL YEAR

				HOURS CREDIT	Clock Hours
FALL QUARTER					
Biomedical	310	Principles of Medicine IV: Pediatrics and Pediatric Optometry (2 HRS. LEC., 2 HRS. LAB)		3	40
Biomedical	311	Principles of Medicine V: Neurology (2 HRS. LEC.)		2	20
Biomedical	312	Principles of Medicine VI: Neuro-ophthalmic Disorders (3 HRS. LEC., 2 HRS. LAB)		4	50
Biomedical	313	Principles of Pharmacology & Therapeutics IV (2 HRS. LEC.)		2	20
Optometry	310	Contact Lens Practice: I (3 HRS. LEC., 2 HRS. LAB)		4	
Optometry	311	Orthoptics & Vision Therapy I (3 HRS. LEC., 2 HRS. LAB)		4	
Clinic	310	Clinical Practice I (1 HR. LEC., 8 HRS. LAB)		3	
				Total 22	
WINTER QUARTER					
Biomedical	320	Principles of Medicine VII: Gerontology & Geriatrics (3 HRS. LEC.)		3	
Biomedical	322	Principles of Medicine VIII: Dermatology (2 HRS. LEC.)		2	20
Biomedical	323	Principles of Pharmacology & Therapeutics V (3 HRS. LEC., 2 HRS. LAB)		4	50
Optometry	320	Contact Lens Practice II (3 HRS. LEC., 2 HRS. LAB)		4	
Optometry	321	Orthoptics & Vision Therapy II (3 HRS. LEC., 2 HRS. LAB)		4	
Clinic	320	Clinical Practice II (1 HR. LEC., 8 HRS. LAB)		3	
				Total 20	
SPRING QUARTER					
Biomedical	333	Principles of Pharmacology & Therapeutics VI (3 HRS. LEC., 2 HRS. LAB)		4	50
Optometry	331	Preventive & Community Optometry: Environmental Vision (3 HRS. LEC.)		3	
Optometry	332	Preventive & Community Optometry: Public Health (2 HRS. LEC.)		2	
Optometry	333	Limited Vision (Partial Sight) (3 HRS. LEC., 2 HRS. LAB)		4	
Optometry	334	Preventive & Community Optometry: Economics and Practice Management (3 HRS. LEC.)		3	
Clinic	330	Clinical Practice III (1 HR. LEC., 12 HRS. LAB)		4	
Clinic	331	Contact Lens Clinic (4 HRS. LAB)		1	
Clinic	332	Orthoptics and Vision Therapy Clinic (4 HRS. LAB)		1	
				Total 22	

FOURTH PROFESSIONAL YEAR

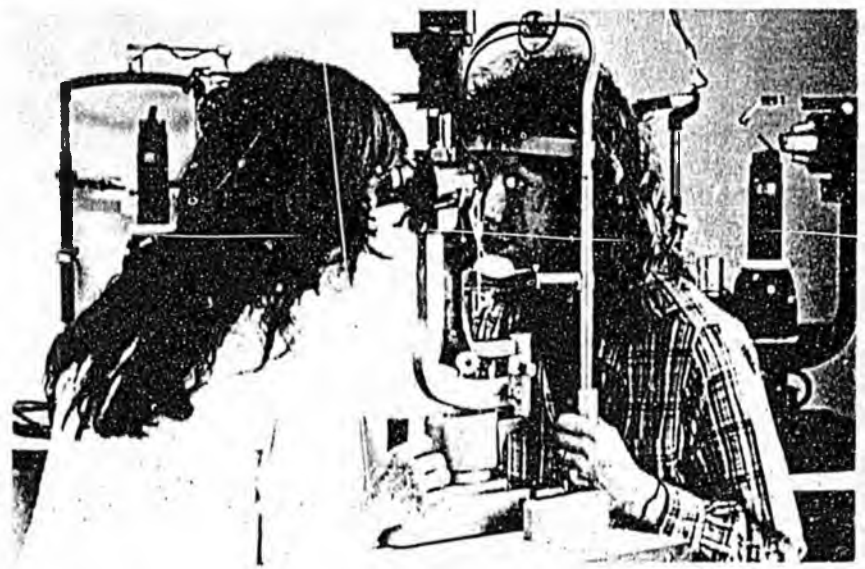
A twelve-week externship is required during the fourth year. Externship information appears under COURSE DESCRIPTIONS (Clinic Department) in this catalog.

			HOURS CREDIT
SUMMER QUARTER			
Optometry	400	Optometry Seminar	2
Optometry	401	Clinical Case Analysis I (2 HRS. LEC.)	2
Clinic	400	Clinical Practice IV (1 HR. LEC., 20 HRS. LAB)	6
Clinic	401	Contact Lens Clinic (4 HRS. LAB)	1
Clinic	402	Orthoptics and Vision Therapy Clinic (4 HRS. LAB)	1
		OR	Total 12
Clinic	405	Externship	12
FALL QUARTER			
Optometry	410	Optometry Seminar (2 HRS. LEC.)	2
Optometry	411	Clinical Case Analysis II (3 HRS. LEC.)	3
Clinic	410	General Clinic Practice V (1 HR. LEC., 16 HRS. LAB)	5
Clinic	411	Contact Lens Clinic (4 HRS. LAB)	1
Clinic	412	Orthoptics and Vision Therapy Clinic (4 HRS. LAB)	1
		OR	Total 12
Clinic	415	Externship	12
WINTER QUARTER			
Optometry	420	Optometry Seminar (2 HRS. LEC.)	2
Optometry	421	Clinical Case Analysis III (2 HRS. LEC.)	2
Clinic	420	General Clinic Practice VI (1 HR. LEC., 20 HRS. LAB)	6
Clinic	421	Contact Lens Clinic (4 HRS. LAB)	1
Clinic	422	Orthoptics and Vision Therapy Clinic (4 HRS. LAB)	1
		OR	Total 12
Clinic	425	Externship	12

• Total basic science clock hours = 730

SPRING QUARTER

Optometry	430	Optometry Seminar (2 HRS. LEC.)	
Optometry	431	Clinical Case Analysis IV (3 HRS. LEC.)	
Clinic	430	General Clinic Practice VII (1 HR. LEC., 24 HRS. LAB)	
		OR	Total 1
Clinic	435	Externship	1



...ved by the board and embodied in the board's certificate or order of revocation or suspension.

18.54.110 Suspension or revocation of license for unprofessional conduct—Judicial review. Any person whose license has been revoked or suspended may seek judicial review of the board's action or decision under the provisions of chapter 34.04 RCW as amended from time to time.

18.54.120 Reinstatement. Any person whose license has been revoked or suspended may apply to the board for reinstatement at any time; and the board may hold hearings on such petition, may impose such terms or conditions as are appropriate under the circumstances, and may order a reinstatement.

9.04 False advertising.

69.32 Narcotics.

18.54.150 Powers previously vested in director of licenses under RCW 18.53.100 now vested in optometry board.

70.96A Uniform alcoholism and intoxication treatment act.

West Virginia Optometry Law

30-8-1. EVIDENCE OF QUALIFICATION TO PRACTICE AND REGISTRATION REQUIRED.—Any person practicing or offering to practice optometry in this State shall be required to submit evidence that he is qualified so to practice, and shall be registered as hereinafter provided, and it shall be unlawful for any person to practice or offer to practice optometry in this State, except under the provisions of this article.

30-8-2. PRACTICE OF OPTOMETRY DEFINED.—Any one or any combination of the following practices shall constitute the practice of optometry:

(a) The examination of the human eye, with or without the use of drugs, prescribable for the human eye, which drugs may be used for diagnostic or therapeutic purposes for topical application to the anterior segment of the human eye only, and, by any method other than surgery, to diagnose, to treat or to refer for consultation or treatment any abnormal condition of the human eye or its appendages;

(b) The employment without the use of surgery of any instrument, device, method or diagnostic or therapeutic drug for topical application to the anterior segment of the human eye intended for the purpose of investigating, examining, treating, diagnosing, improving or correcting any visual defect or abnormal condition of the human eye or its appendages;

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

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

30-8-3. BOARD OF OPTOMETRY, DUTIES.

30-8-3a. REGISTRATION OF OPTOMETRIC CORPORATIONS.

30-8-3b. PRACTICE OF OPTOMETRY BY OPTOMETRIC CORPORATIONS.

30-8-4. REGISTRATION PREREQUISITE TO PRACTICE OF OPTOMETRY; EXCEPTIONS.—No person shall practice or offer to practice optometry in this State without first applying for and obtaining a certificate of registration for such purpose from the West Virginia Board of Optometry; but the following persons, firms and corporations are exempt from the operation of this article, except as hereinafter provided:

(a) Persons who have heretofore been registered as optometrists in this State, or who were engaged in the practice of optometry in this State before the passage of any law by this State regulating such practice, and who have heretofore received from the Board of examiners certificates of exemption from examination;

(b) Persons authorized under the laws of this State to practice medicine and surgery or osteopathy;

(c) Persons, firms and corporations who sell eye glasses or spectacles in a store, shop or other permanently established place of business on prescriptions from persons authorized under the laws of this State to practice either optometry or medicine and surgery;

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

30-8-5. QUALIFICATIONS OF APPLICANT FOR REGISTRATION, EXAMINATION.—An applicant for registration shall present satisfactory evidence that he is at least eighteen years of age, of good moral character and temperate habits, and has graduated from a high school or secondary school, or has completed an equivalent course of study approved by the West Virginia board of optometry, has satisfactorily completed all preoptometry or premedical college requirements and has graduated from a school or college of optometry approved by said board. No school or college of optometry shall be approved by the West Virginia board of optometry unless at first it has been accredited by a regional or professional accreditation organization which is recognized by the national commission on accreditation or the United States commission of education. Each applicant shall submit to and be examined in all phases of optometry as is provided by the school or college of optometry and shall include, but not be limited to, anatomy and physiology of the human eye, the use of instruments such as the ophthalmoscope, retinoscope, tonometer, slit lamp biomicroscope, the general laws of optics and refraction, general and ocular pharmacology, general and ocular pathology and other such subjects or instrumentation as the board of optometry may deem necessary.

The West Virginia board of optometry shall be responsible to determine the educational training received by the applicant from the schools and colleges of optometry, the educational qualifications of each applicant and the administering of the examination and certifications of each applicant commensurate with his education. No optometrist shall be registered or certified to practice optometry in the state of West Virginia in any area that is beyond the scope of his educational training as determined by the West Virginia board of optometry: Provided, That any optometrist presently registered in the state of West Virginia and who desires to employ the use of pharmaceutical agents must submit to the West Virginia board of optometry evidence of satisfactory completion of all necessary educational requirements as made mandatory by the West Virginia board of optometry: Provided further, That the West Virginia board of optometry shall provide for continuing educational requirements to be completed from time to time by all optometrists desiring to employ the use of pharmaceutical agents.

30-8-6. CERTIFICATE OF REGISTRATION OR EXEMPTION SHALL BE DISPLAYED; BILL OF PURCHASE. Every person practicing optometry shall display his certificate of registration or exemption in a conspicuous place in the principal office wherein he practices optometry, and, whenever required, shall exhibit such certificate to the board of examiners or its authorized representatives. And whenever practicing the profession of optometry outside of or away from said office or place of business, he shall deliver to each customer or person so fitted with glasses a bill of purchase which shall contain his signature, home post-office address, and the number of his certificate of registration or exemption, together with a specification of the lenses furnished.

30-8-7. ANNUAL RENEWAL OF REGISTRATION; RESTORATION OF EXPIRED CERTIFICATE. Every registered optometrist who desires to continue in active practice or service shall, annually, on or before the first day of August, of each year, renew his certificate of registration, and pay an annual renewal fee of twenty dollars. Every certificate of registration which has not been renewed during the month of August in any one year shall expire on the first day of September of that year. A registered optometrist whose certificate of registration has expired may have the same restored only upon payment of the required renewal fee. Any registered optometrist who retires from the practice of optometry for more than five years may renew his certificate of registration upon payment of all lapsed renewal fees.

30-8-8. REFUSAL TO ISSUE, SUSPENSION OR REVOCATION OF CERTIFICATE; FALSE AND DECEPTIVE ADVERTISING. The Board may either refuse to issue, or may refuse to renew, or may suspend or revoke any certificate of registration for any one, or any combination, of the following causes: Violation of a rule or regulation governing the ethical practice of optometry promulgated by the Board under the authority granted by this article; conviction of a felony, as shown by a certified copy of the record of the court wherein such conviction was had; the obtaining of, or the attempt to obtain, a certificate of registration, or practice in the profession of optometry, for money, or any other thing of value, by fraudulent misrepresentation; gross malpractice; continued practice by a person knowingly having an infectious disease; habitual drunkenness, or addiction to the use of morphine, cocaine, or other habit-forming drugs; advertising, practicing, or attempting to practice under a name other than one's own; advertising by means of knowingly false or deceptive statements. All advertising, whether by means of newspapers, or in any manner, whatsoever, of the following statements, or statements of similar import, that are "false and deceptive" within the meaning of this law, shall be prohibited. False and deceptive advertising shall include but not be limited to the following: (a) Advertising of complete glasses, that is to say, lenses and frames or mountings, at a stated price, either alone or in conjunction with professional services; (b) advertising "free examination of eyes", or "free consultation", or "free advice", or words of similar import and meaning; (c) advertising frames or mountings for glasses, by advertisement which does not accurately describe the same in all its component parts (all such advertisements shall state clearly, in type equal in size to the price figures given, that such price does not include cost of lenses, or professional services in examining of eyes), and, (d) advertising a particular sum or sums of money required as a "down" or cash payment, or any definite amount or amounts of future payments, or when the same shall be paid.

30-8-9. OFFENSES; PENALTIES; JURISDICTION OF JUSTICES. Each of the following shall constitute a misdemeanor punishable, upon conviction, for the first offense, by a fine of not less than one hundred nor more than two hundred dollars, and, upon conviction for a second or subsequent offense, by a fine not less than two hundred nor more than five hundred dollars, or by imprisonment for not less than thirty nor more than ninety days, or by both such fine and imprisonment, at the discretion of the court. The practice of, or an attempt to practice optometry, without a certificate of registration as a registered optometrist, except as hereinbefore provided; permitting any person in one's employ, supervision or control, to practice optometry, unless such a person has a certificate of registration as a registered optometrist when such certificate is required by this article; the obtaining of, or an attempt to obtain, a certificate of registration, or practice in the profession, or money, or anything of value, by fraudulent misrepresentation; the making of any willfully false oath or affirmation, whenever an oath or affirmation is required by this article; the violation of the provisions of section six of this article.

Justices of the peace shall have concurrent jurisdiction with circuit and criminal courts for the enforcement of this article.

30-8-10. UNLAWFUL PRACTICE OF OPTOMETRY; PENALTIES.—Any corporation or voluntary association shall not practice, or assume to practice, or in any manner to hold itself out to the public as being entitled to practice the profession of optometry, or advertise the title of optometrist in such a manner as to convey the impression to the public that it is entitled to practice optometry, or furnish optometric advice and services, or advertise that, either alone or together with or by or through any person, whether a duly registered and licensed optometrist or not, it has, owns, conducts or maintains an office or place for practice of optometry. Any duly registered and licensed optometrist shall not associate himself with any corporation or voluntary association for the practice of optometry, or in any manner practice such profession, on a salary or commission basis, for any such corporation or voluntary association. Any corporation or voluntary association violating any of the provisions of this section, or any officer, trustee, director, agent or employee of such corporation or voluntary association who, either directly or indirectly, engages in any of the acts, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not less than one hundred nor more than one thousand dollars. The fact that any such officer, trustee, director, agent or employee shall be a duly registered and licensed optometrist shall not be held to permit or allow any such corporation or voluntary association to do the acts prohibited herein, nor shall such fact be a defense upon the trial of any of the persons hereinbefore mentioned for a violation of this section. Any duly registered and licensed optometrist who shall violate the provisions of this section shall be guilty of a misdemeanor, and upon conviction thereof shall be fined not less than ten dollars nor more than twenty-five dollars, and each and every day such violation continues shall constitute a separate offense; and in addition to the foregoing penalties, such offending optometrist shall have his license to practice suspended for a period of one year, by the court in which such conviction is had. Provided that this section shall not apply to a partnership of two or more duly registered and licensed optometrists who practice under their own names.

It shall be unlawful for any registered optometrist to practice his profession as an employee, lessee, or sub-lessee of any commercial or mercantile establishment or to practice his profession in connection therewith, or to advertise either in person or through any commercial or merchantile establishment that he is a duly registered practitioner, and is practicing or will practice optometry as an employee, lessee, or sub-lessee of any such commercial or mercantile establishment or in connection therewith. But nothing herein shall be construed to prohibit or prevent the rendering of professional services to the officers and employees of any person, firm or corporation by an optometrist, whether or not the compensation for such services is paid by the officers and employees, or by the employer, or jointly by all or any of them. Any person violating this provision shall be guilty of a misdemeanor, and, upon conviction thereof shall be fined not less than fifty nor more than five hundred dollars, and each and every day such violation continues shall constitute a separate offense.

Wisconsin Optometry Law

Optometry

449.01 (1) Optometry. (a) (1) The practice of optometry is defined as follows: The employment of any means including topical ocular diagnostic pharmaceutical agents under S. 449.17, to determine the visual efficiency of human visual system, including refractive and functional abilities or preliminarily diagnose the presence of ocular disease or ocular manifestations of systematic disease and other departures from normal.

(2) The diagnosis and treatment of the refractive and functional ability of the visual system and enhancement of visual performance by prescribing, furnishing, fitting or employing ophthalmic lenses, con-

ALASKA COURSE SCHEDULE #750B2 OCULAR THERAPY FOR THE OPTOMETRIC PRACTITIONER

WEEKEND #	TIMES & DATES	LOCATION	COURSE CURRICULUM	FACULTY	HOURS LECTURE	HOURS CLINIC	COMMENTS
1	Fri.3/5/82 -9a.-4p. Sat.3/6/82 -9a.-4p. Sun.3/7/82 -9a.-4p. Mon.3/8/82 -9a.-4p.	ANCHORAGE ~~JUNEAU,~~ ALASKA	Principles of Pharmacology Autonomic Drugs Ocular Diagnostic Pharmaceuticals CPR and Emergency Care	Ph.D. Pharmacologist " " " " Alaska, American Heart Ass'n	6 6 6	6	AHA Cert. and/or Re-certification required
2	Fri.3/26/82-7p.-9p. Sat.3/27/82-9a.-4p. Sun.3/28/82-9a.-4p.	ANCHORAGE ~~PORTLAND,~~ ~~OREGON~~ ALASKA	OPA Examination The Pharmacology of Ocular Therapy (Part I) " " " " " (Part II)	PCO Proctor Ph.D. Pharmacologist " "	2 6 6		
3	Fri.4/23/82-9a.-4p. Sat.4/24/82-9a.-4p. Sun.4/25/82-9a.-4p.	ANCHORAGE ~~FAIRBANKS,~~ ALASKA	Systemic Diseases (and Ocular Manifestations) Applied Pharmacology Anterior Segment Eye Disease (Part I)	M.D. (Internist) Pharm.D. O.D.	6 6 6		
4	Fri.5/21/82-8a.-9a. " " " " 9a.-4p. Sat.5/22/82-8a.-9a. " " " " 9a.-4p. Sun.5/23/82-9a.-5p.	ANCHORAGE, ALASKA	Midterm Examination (Part I) Anterior Segment Eye Disease (Part II) Midterm Examination (Part II) Anterior Segment Eye Disease (Part III) Anterior Segment Clinic, Day #1	PCO Proctor O.D. PCO Proctor M.D. (Ophthalmologist) M.D. (Ophthal.) & O.D.	1 6 1 6	7	10-1 Ratio
5	Fri.6/25/82-9a.-4p. Sat.6/26/82-9a.-4p. Sun.6/27/72-8a.-5p.	ANCHORAGE ~~PORTLAND,~~ ~~OREGON~~ ALASKA	Glaucoma (Part I) " (Parts II & III) " Clinic	O.D., Ph.D.(Anatomist) M.D., (Ophthalmologist) O.D. Staff & M.D.(Ophth'l)	6 6	8	8-1 Ratio
6	Fri.9/10/82-9a.-4p. Sat.9/11/82-9a.-4p. Sun.9/12/82-8a.-5p.	ANCHORAGE, ALASKA	Diagnosis & Management of Advanced Eye Diseases Anterior Segment Eye Disease (Part IV) " " " " Clinic, Day #2	M.D. (Ophthalmologist) O.D. O.D. Staff	6 6	8	10-1 Ratio
7	Sun.10/24/82-9a.-12p	ANCHORAGE, etc. JUNEAU, ALASKA	FINAL EXAMINATION	State Board Proctor	3		
7	20 DAYS	4 SITES	TOTALS	21 { 4 Ph.D.'s, 4 M.D.'s, 3 O.D.'s }	91	29	

offered by *Pacific University*
Diane P. Yolton, Ph.D.
Jimmy Bartlett, O.D.
Roland Manthei, Ph.D.
March 27-28-29 UAA
April 24-25-26 UAA

PATHOPHYSIOLOGY AND PHARMACOLOGY: principles of pharmacology, clinical application of ocular pharmacology and ocular toxicology. Pathophysiology of ocular allergy, infection and inflammation. Pharmacologic considerations in ocular steriod therapy, and in glaucoma therapy.

offered by *Pennsylvania College*
Philip Gerbino, Pharm.D.
Mack Lipken, Jr., M.D.
May 1-2 UAA

APPLIED PHARMACOLOGY: administration of drugs, Rx writing, patient management.
SYSTEMIC DISEASE: systemic disease related to ocular disease. Allergic-immunology; cardiovascular-cerebrovascular; endocrine; hematological; infectious and inflammatory; metabolic-chromosomal; musculoskeletal; mucocutaneous-dermatological; neurological nutritional-gastrointestinal

offered by *Pennsylvania College*
Louis Catania, O.D.
Linda Casser, O.D.
May 22-23-24 UAA

ANTERIOR SEGMENT DISEASE: corneal dystrophies, degenerations, infections, inflammations, irritations, injuries. Differential diagnosis, systemic considerations, treatment/management of anterior uveitis. Eyelid/adnexa disorders. Disorders of the lacrimal system, conjunctiva, sclera, and episclera.

offered by *Pacific University*
Tom Lewis, O.D., Ph.D.
Ronald Reed, M.D.
....and clinical staff
June 11-12-13 UAA and clinics

GLAUCOMA: anatomy-pathophysiology review. Epidemiology-risk factors. Examination, differential diagnosis, clinical classification. Medical management, surgical considerations. Concepts and controversies in glaucoma care. Methods of examination and clinical procedures.

offered by *Pennsylvania College*
Theodore Buckner, M.D.
....and clinical staff
September 10-11-12 clinics

ANTERIOR SEGMENT DISEASE CLINIC: examination protocols, techniques in dilitation and irrigation, gland expressing, epilation, cyst drainage, scrapings, cultures, cytology. Foreign body removal. Management of lacerations and corneal abrasions. Techniques for diagnosing systemic disease; exophthalmometry, ophthalmodynamometry. Clinical procedures

REGISTRATION FORM

Advance registration of $100 is required and due by February 24, 1982. Please complete the form below and return with payment to: Alaska Optometric Association, 3401 Denali Street, Suite 204, Anchorage, Alaska 99503

Tuition: $1,550

Payments and Due Dates

$100	February 24, 1982
400	March 17, 1982
400	April 17, 1982
400	May 17, 1982
250	September 1, 1982

NAME _____

ADDRESS _____

City _____ State/Zip _____

I will need the following required textbooks:

_____ Goodman and Gilman, The Pharmacological Basis of Therapeutics $45.00

_____ Fraunfelder & Roy, Current Ocular Therapy $43.00

_____ Deborah Pavon-Langston, Manual of Ocular Diagnosis & Therapy $15.00

FACULTY

Jimmy Bartlett, O.D.
Associate Professor, Director of Continuing Education University of Alabama in Birmingham School of Optometry/ The Medical Center

Theodore Buckner, M.D.
Board Certified Ophthalmologist, Wills Eye Hospital, Philadelphia, Attending Surgeon, Shore Memorial Hospital, Somers Point, New Jersey

Linda C. Casser, O.D.
Assistant Professor, Pennsylvania College of Optometry, Chief, Primary Care Module No. 4, The Eye Institute, Pennsylvania College of Optometry, Philadelphia

Louis J. Catania, O.D.
Director, Center for Continuing and Post-Graduate Education Pennsylvania College of Optometry, Philadelphia; Past Director, Primary Care Optometry Residency Program of the Joseph C. Wilson Health Care Center Medical Group, Rochester, New York

Philip Gerbino, Pharm.D.
Associate Professor of Clinical Pharmacy, Philadelphia College of Pharmacy and Science; Former Director of Drug Information Center of Cornell University

Thomas L. Lewis, O.D., Ph.D.
Doctorate in Anatomy, Jefferson Medical College; Dean of Academic Affairs and Associate Professor, Pennsylvania College of Optometry

Mack Lipkin, Jr., M.D., F.A.C.P.
Graduate of Harvard Medical School; Board Certified in Internal Medicine; Assistant Professor of Medicine, University of Rochester School of Medicine, Rochester, New York

Roland W. Manthei, Ph.D.
Doctorate in Pharmacology, University of Chicago; Professor of Pharmacology, Jefferson Medical College, Philadelphia

Ronald R. Reed, M.D.
Board Certified from Wills Eye Hospital; Adjunct Assistant Clinical Professor, University of Rochester, School of Medicine Strang Memorial Hospital, Department of Ophthalmology

Diane Yolton, Ph.D.
Assistant Professor of Anatomy and Pathology, Pacific University College of Optometry.

Clinical Faculty will include experienced clinicians including optometrists and ophthalmologists from various universities and V.A. medical centers in the United States.

Sponsored by Alaska Optometric Association

in cooperation with....

PACIFIC UNIVERSITY COLLEGE OF OPTOMETRY,
PENNSYLVANIA COLLEGE OF OPTOMETRY, and
UNIVERSITY OF ALASKA ANCHORAGE

Pathophysiology & Pharmacology
D. Yolton, Ph.D. - J. Bartlett, O.D. - R. Manthei, Ph.D.
March 27-28-29 April 24-25-26 UAA

Applied Pharmacology & Systemic Disease
P. Gerbino, Pharm.D. - M. Lipkin, M.D.
May 1-2 UAA

CPR & Emergency Care
American Red Cross Instructors
May 3 UAA

Anterior Segment Disease: cornea, uvea, lids conjunctiva, lacrimal system
L. Catania, O.D. - L. Casser, O.D.
May 22-23-24 UAA

Glaucoma
T. Lewis, O.D., Ph.D. - R. Reed, M.D. - clinical staff
June 11-12-13 UAA and selected clinical facilities

Anterior Segment: Clinical Procedures
T. Buckner, M.D. - L. Catania, O.D. - clinical staff
September 10-11-12 Selected Clinical Facilities

Final Examination
October 16 University of Alaska Campuses

Announcing

DIAGNOSIS, MANAGEMENT, AND TREATMENT OF OCULAR DISEASE

.... an in-depth postgraduate course including 120 hours of instruction with emphasis on diagnosis, treatment, and ocular therapeutics; and, recognition of ocular manifestations of systemic disease....

Oregon Health Sciences Center - School of Dentistry

Curriculum Leading to the Degree Doctor of Dental Medicine (DMD) 1978-9

(Typed from microfiche)

FIRST YEAR

Fall Interval

			Clock Hours Lec	Conf	Lab	Clinic	Total	Credit Hours
An	411-2	General Histology	16		32		48	-
An	411-2	Gross Anatomy	29		40		60	-
BCh	411	Biochemistry	40				40	4.0
BeS	411	Omnibus	17				17	1.7
CJT	411	Prevention of Dental Diseases	12		17		29	2.1
DA	411-12	Dental Anatomy Lect	12				12	-
DA	411-12	Dental Anatomy Lab			24		24	-
DM	410-20	Dental Materials	4		9		13	-
FP	411	Fixed Prosthodontics Technic			36		36	1.2
Mb	411	Microbiology	12		12		24	1.7
OD	411	Oral Examination Technic	14		9		23	1.7
Phy	411	Physiology	31	4	5		40	3.5

Winter Interval

			Clock Hours Lec	Conf	Lab	Clinic	Total	Credit Hours
An	411-2	General Histology	3		6		9	3.8
An	411-2	Gross Anatomy	8		16		24	5.6
An	412	Head and Neck Anatomy	22		32		54	3.8
BCh	412-3	Biochemistry	31				31	-
DA	411-2	Dental Anatomy Lect	4				4	1.6
DA	411-2	Dental Anatomy Lab			8		8	1.6
DM	410-20	Dental Materials	4		9		13	-
FP	412	Fixed Prosthodontic Technic			63		63	2.1
Per	412	Periodontics Technic	5		21		26	1.5
Phy	412	Physiology	34	4	4		42	3.8

Spring Interval

			Clock Hours Lec	Conf	Lab	Clinic	Total	Credit Hours
An	413	Neuroanatomy	12		24		36	2.4
An	413	Oral Histology	12		24		36	2.4
BCh	412-3	Biochemistry	17				17	4.8
CJT	413	Biology of Inflammation	16				16	1.6
DM	410-20	Dental Materials	3		9		12	-
FP	413	Fixed Prosthodontics Technic			36		36	1.2
Op	413	Operative Technic Lecture	22				22	2.2
Op	413	Operative Technic Lab			66		66	2.2
Per	613	Periodontics Clinic				15	15	0.5
Phy	413	Physiology	35	4	3		42	3.8
		First Year Total						62.8

SECOND YEAR

Fall Interval

			Clock Hours Lec	Conf	Lab	Clinic	Total	Credit Hours
BeS	421	Personal Adjustment		10			10	1.0
DM	410-20	Dental Materials	3				3	-
FP	421	Fixed Prosthodontics Technic			72		72	2.4
Mb	421	Immunology	25				25	2.5
Op	421	Operative Technic Lecture	11				11	1.1
Op	421	Operative Technic Lab			66		66	2.2
Per	421	Periodontology	12				12	1.2
Per	620	Periodontics Clinic				33	33	-

			Clock Hours Lec	Conf	Lab	Clinic	Total	Credit Hours
PH	421-2	Dentistry & The Health Care System	11				11	-
Phc	421-2	Pharmacodynamics	53		15		68	-
Pth	421-2	Disease Processes	14	31			45	-
RP	421	Removable Prostho-dontics Technic	11		33		44	2.2
Winter Interval								
BeS	422	History of Dentistry	10				10	1.0
CJT	422	Caries	21		7		28	2.5
DM	410-20	Dental Materials	3				3	-
FP	422	Fixed Prosthodontics Technic			33		33	1.1
Mb	422	Pathogenic & Oral Microbiology	26		11		37	2.9
Med	422	Medical Emergency Procedures	8		4		12	1.0
OD	420-30	Oral Diagnisis & Treatment	6				6	-
Op	422	Operative Technic	11				11	1.1
Op	422	Operative Technic Laboratory			33		33	1.1
OS	422-3	Control of Pain & Anxiety	20		6		26	2.6
OS	422	Introduction to Oral Surgery	11				11	1.1
Pedo	422	Child Development	22				22	2.2
Per	620	Periodontics Clinic				15	15	-
PH	421-2	Dentistry & the Health Care System	11				11	2.2
Phc	421-2	Pharmacodynamics	7				7	6.5
Pth	421-2	Disease Processes	4				4	3.5
Pth	422	Inflammatory Disease	18				18	1.8
Ro	422	Oral Radiology	11				11	1.1
RP	422	Removable Prostho-dontics Technic	8		24		32	1.6
Spring Interval								
DM	410-20	Dental Materials	5				5	3.1
Endo	423	Endodontology	11		24		35	2.2
FP	423	Fixed Prosthodon-tics Technic			69		69	2.3
Nu	423	Nutrition	14			1	15	-
Op	623	Operatives Clinic				33	33	0
Ord	423	Orthodontics	9				9	0.9
Ord	423	Orthodontics Technic			27		27	0.9
OS	423	Oral Surgery			12		12	0.6
Pedo	423	Child Development	11				11	1.1
Pedo	423	Pedodontic Technic				44	44	1.1
Per	620	Periodontics Clinic				15	15	2.1
Pth	423	Pathology of Systems	34	24			58	4.6
Ro	423	Oral Radiology Laboratory			15		15	0.5
RP	423	Removable Prostho-dontics Technic		4	33		37	1.5
						Second Year Total		68.2

THIRD YEAR

			Clock Hours Lec	Conf	Lab	Clinic	Total	Credit Hours
Fall Interval								
CJT	431	Oral Pathology - Oral Radiology	20	10			30	3.0
DM	431-2	Dental Materials	22				22	-
Endo	431-2	Endodontology	6				6	-
Endo	630-40	Endodontology Clinic				11	11	-
FP	431-2	Principles of Fixed Prosthodontics	6				6	-
FP	631	Fixed Prosthodon-tics Clinic				33	33	1.1
OD	420-30	Oral Diagnosis & Treatment	7				7	1.3

			Clock Hours Lec	Conf	Lab	Clinic	Total	Credit Hours
Op	631	Operatives Clinic				66	66	2.2
Ord	431	Facial Growth	12				12	1.2
OS	431	Oral Surgery	12				12	1.2
Pedo	631	Pedodontics Clinic				33	33	1.1
Per	431	Periodontology Lecture	12				12	1.2
Per	631	Periodontology Clinic				33	33	1.1
Ro	630	Oral Radiology Clinic				10	10	-
RP	431	Removable Prostho-dontics Technic	9		27		36	1.8
RP	631	Removable Prostho-dontics Clinic				66	66	2.2

Winter Interval

DM	431-2	Dental Materials	13				13	3.5
Endo	431-2	Endodontology	6				6	1.2
Endo	630-40	Endodontology Clinic				11	11	-
FP	431-2	Principles of Fixed Prosthodontics	6				6	1.2
FP	632	Fixed Prostho-dontics Clinic				30	30	1.0
OD	432-3	Clinical Conference		2			2	-
Op	632	Operatives Clinic				60	60	2.0
Ord	432	Orthodontics	11				11	1.1
OS	432	Oral Surgery	11				11	1.1
Pedo	632	Pedodontics Clinic				30	30	1.0
Per	632	Periodontology Clinic				30	30	1.0
Pth	432	Pathology	22		22		44	3.3
Ro	630	Oral Radiology Clinic				10	10	-
RP	432-3	Principles of Remov-able Prosthodontics	11				11	-
RP	632	Removable Prostho-dontics Clinic				60	60	2.0

Spring Interval

Endo	630-40	Endodontology Clinic				11	11	-
FP	633	Fixed Prostho-dontics Clinic				33	33	1.1
Med	433	Principles of Medicine	12				12	1.2
OD	432-3	Clinical Conference		22			22	2.2
OD	630	Oral Diagnosis Clinic				33	33	1.0
Op	433	Principles of Clinical Operatives	12				12	1.2
Op	633	Operative Clinic				66	66	2.2
OS	433	Oral Surgery and Hospital Dentistry	12				12	1.2
OS	630	Oral Surgery Clinic				22	22	1.2
Pedo	633	Pedodontics Clinic				33	33	1.1
Per	633	Periodontology Clinic				33	33	1.1
PP	433	Dental Jurisprudence	12				12	1.2
Pth	433	Comprehensive Exam	12	22			34	2.2
Ro	630	Oral Radiology Clinic				10	10	1.0
RP	432-3	Principles of Remov-able Prosthodontics	12				12	2.3
RP	633	Removable Prostho-dontics Clinic				66	66	2.2
		Third Year Total						58.2

FOURTH Year

Fall Interval

DM	441	Dental Materials	12				12	1.2

			Clock Hours Lec	Conf	Lab	Clinic	Total	Credit Hours
Endo	630-40	Endodontology Clinic				12	12	-
FP	641	Fixed Prosthodontics Clinic				77	77	2.2
Med	441	Principles of Medicine	12				12	1.2
Med	440	Hospital Clinic				6	6	-
OD	441	Oral Diagnosis & Treatment Planning	11				11	1.1
Op	641	Operatives Clinic				154	154	4.4
Pedo	441	Pedodontics Conference		15			15	0.6
Pedo	641	Pedodontics Clinic				44	44	1.1
Per	641	Periodontology Clinic				5	5	0.2
PP	441	Professional Viewpoints	22				22	2.2
Ro	640	Oral Radiology				7	7	-
RP	641	Removable Prosthodontics Clinic				66	66	2.2

Winter Interval

Endo	630-40	Endodontology Clinic				10	10	1.9
FP	442	Principles of Fixed Prosthodontics	11				11	1.1
FP	642	Fixed Prosthodontics Clinic				66	66	2.0
Med	442	Principles of Medicine	11				11	1.1
Med	440	Hospital Clinic				6	6	-
Op	642	Operatives Clinic				143	143	4.0
Pedo	642	Pedodontics Clinic				30	30	1.0
Per	642	Periodontology Clinic				5	5	0.2
DP	442	Dental Psychology	11				11	1.1
Ro	640	Oral Radiology				7	7	-
RP	442	Principles of Removable Prosthodontics	11				11	1.1
RP	642	Removable Prosthodontics				60	60	2.0

Spring Interval

FP	643	Fixed Prosthodontics Clinic				99	99	3.3
Med	440	Hospital Clinic				6	6	0.9
OD	640	Oral Diagnosis Clinic				66	66	2.0
Op	643	Operatives Clinic				154	154	4.4
Ord	443	Orthodontics Conference		11			11	1.1
OS	640	Oral Surgery Clinic				32	32	1.0
Pedo	643	Pedodontics Clinic				33	33	1.1
Per	643	Periodontology Clinic				16	16	0.3
PH	440	Community Dentistry				30	30	1.0
PH	443	Gerodontology	11				11	1.1
Ro		Oral Radiology Clinic				7	7	1.1
RP	643	Removable Prosthodontics Clinic				66	66	2.2
		Fourth Year Total						52.4

Total basic science clock hours = 938

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 arenas (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.

Dr. Kalina is professor and chairman, Department of Ophthalmology, University of Washington School of Medicine, Seattle. Dr. Van Dyk is professor, Department of Ophthalmology, Louisiana State University School of Medicine, New Orleans. Dr. Weinstein is professor and chairman, Department of Ophthalmology, West Virginia University School of Medicine, Morgantown.

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 and as a supplement to lectures. The microfiche illustrations, newly added in the third edition (1978), had been found useful by students in 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

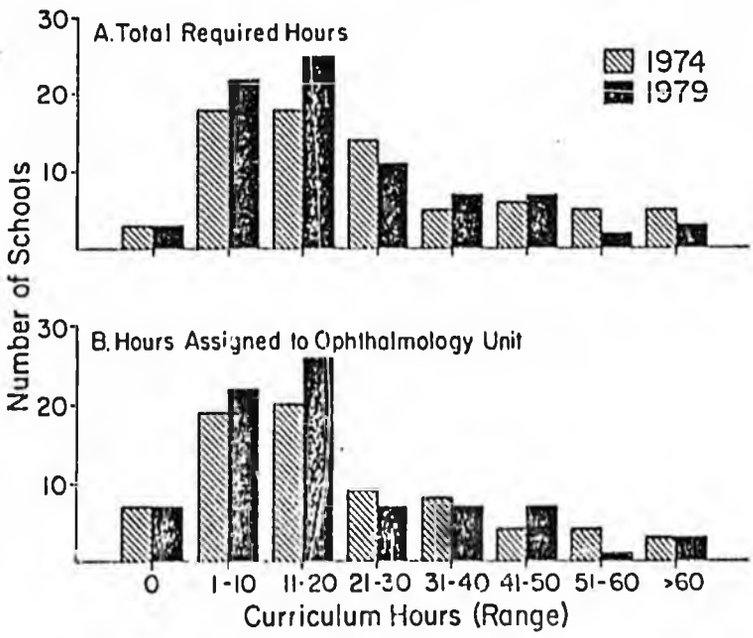


FIGURE 1
Minimum requirements for ophthalmology in U.S. medical schools.

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

1. Cogan, D. G. Association of University Professors of Ophthalmology. *Arch. Ophthalmol.*, 74:740, 1965.
2. Winograd, 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.

TO: HESS Committee Members DATE: May 10, 1983
FROM: Heidi H. Borson
RE: HB 225, CSHB 225 Versions 1 and 2

COMPARATIVE ANALYSIS

CSHB 225 Version #2	HB 225
Sec. 1 An optometrist with an endorsed license may use and prescribe legend drugs, and may use nonprescription drugs under this chapter.	Sec. 1 An optometrist with an endorsed license may use and prescribe legend drugs.
Includes the following:	
Sec. 2 Adds one person to the of examiners in optometry.	No alteration to present board statutes.
Sec. 3 Stipulates that the added member will be a licensed physician in Alaska; requires that the public member on the board have no direct or indirect interest in the practice of optometry, opticianry or medicine.	Not included.
Sec. 4 Under powers and duties of the board of examiners in optometry: 3) States that the board, with the guidance of the state medical board, shall develop a list of specific prescription, nonprescription, diagnostic and therapeutic drugs and their dosages that may be used by authorized optometrists. 4) Mandates the provision of continuing education for optometrists who want to use drugs.	Not addressed in HB 225.
Sec. 5 With regards to registration: b) Adds that an optometrist may not be certified to practice optometry beyond the scope of his/her training; stated that the board of examiners in optometry is determine an optometrist's qualifications.	No alteration to present statutes.
Sec. 6 Adds another ground for disciplinary action by the board: 10) Using the prefix 'Dr.' or 'Doctor' before the license holder's name without using the word 'optometrist' in connection with the title.	Not addressed.

Comparison continued:

CSHB 225 - Version #2	HB 225
Sec. 7 Regarding the use or prescription of drugs: Subsections a,b,c,d,e refer to 'drugs'.	Sec. 2 Regarding the use or prescription of drugs: Subsections a,b,c,d,e refer to 'legend drugs'.

In addition:

Definitions for 'optometry', 'practicing optometry', and 'legend drugs' are the same in HB 225 and CSHB 225 - Version #2.

Both bills also include Section 08.64.360 regarding penalties for practicing without a license or in violation the applicable statutes.

CSHB 225 - Version #2 and CSHB 225 - Version #1 differ in one respect only, that being that CSHB 225 - Version #1 adds Section 08.72.278 regarding approved drugs. This section names drugs which may be used in addition to the list of drugs to be developed by the board of examiners of optometry and the state medical board.

STATE OF ALASKA
THE LEGISLATURE

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M February 17, 1984

SUBJECT: Optometry
(HB 225)

TO: Representative Mae Tischer
Chairman, House Health, Education,
and Social Services Committee

FROM: Russ Josephson
Legislative Counsel

You have requested a comparison of the introduced version of HB 225 and the committee substitute for your committee dated February 3, 1984. Perhaps it will be easiest to compare the two bills if I begin with a brief sectional analysis of each bill.

HB 225

Section 1 Amends the provision of law governing the practice of medicine by persons other than physicians by adding a new paragraph allowing optometrists to use certain drugs under the provisions of the remainder of the bill.

Section 2 Provides for identification and approval of (1) training programs for the use of drugs and (2) continuing education programs. Also provides for license endorsements certifying completion of required training for drug use, regulations concerning the use or prescription of legend drugs, the loss of license endorsements for violations of those regulations, and the furnishing of the names of holders of license endorsements to the board of pharmacy.

Section 3 Amends the definition of "optometry" reflect the provisions of the bill for the use of drugs.

Section 4 Amends the definition of "practicing optometry" as in Section 3.

Section 5 Adds a definition of "legend drugs".

Section 6 Adds optometrists to those excepted from the provisions of law penalizing the practice of medicine by persons who are not physicians.

CSHB 225 (HESS)

Section 1 Provides an additional ground for the imposition of disciplinary sanctions that the board of examiners in optometry may impose under AS 08.72.240: use, dispensing, or prescription of a drug in violation of the new provision regulating drug use by optometrists (Section 2). In addition, provides a modification of the provision that requires referrals to appropriate health care practitioners.

Section 2 Adds a new section to the statutes, providing for the use of legend drugs, excluding controlled substances and other types of drugs. Lists the categories of topical legend drugs that may be used by an optometrist who has obtained a license endorsement from the board of examiners in optometry. Lists the requirements for a license endorsement, including the required training before and after receiving an endorsement.

Section 3 Contains a new definition, "legend drugs". Also amends the definitions of "optometry" and "practicing optometry" to reflect the provisions of the bill concerning the use of drugs. The definition of "legend drugs" is identical to that in the introduced version of the bill. The amendments of "optometry" and "practicing optometry" differ from those in the introduced version of HB 225 in that they have added a phrase to exclude the use of surgery in diagnosis and treatment. The definitions in the introduced version of the bill do not mention surgery.

As you can see, the two bills accomplish basically the same thing. The major differences are as follows:

HB 225 contains (in Sections 1 and 6) amendments regarding the practice of medicine and providing the necessary exemptions for optometrists using drugs. CSHB 225 (HESS) does not contain these provisions, but it should.

Both bills provide for license endorsements and for the training required before and after receiving an endorsement. HB 225 provides for regulations to handle those requirements; CSHB 225 (HESS) provide more detail in the statute.

CSHB 225 (HESS) provides a new ground for discipline by the board of examiners in optometry; violation of the provisions concerning drugs. It also amends another ground for discipline, failure to refer a patient to the appropriate health care practitioner. Neither of these provisions was in the introduced version of the bill. HB 225 did provide for regulations concerning the use or prescription of legend drugs, and it provided for the suspension or revocation of the license endorsement for violation of the regulations.

CSHB 225 (HESS) is more specific than HB 225 in its detailing of the types of drugs that may be used by optometrists.

The definitions in CSHB 225 (HESS) contain provisions concerning the prohibition of surgery in diagnosis and treatment by optometrists. Similar language does not appear in HB 225.

HB 225 provided for the names of endorsement holders to be submitted to the board of pharmacy. CSHB 225 (HESS) does not contain this provision.

I trust these sectional analyses and this comparison will be useful. If I may be of further service, please call.

RJ:ojb
J3/111

MSG 84-00005682 PRTY 1 01/21/84 13:09:15 ORIG: SOL$ IN= 0007 OUT= 0022
FROM: SOLDOTNA/ TO: JUNEAU T/C
TARGET: LJHV SUBJ: F. STATS H.HESS OPTOMETRY 1/21

****

LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

****

SATURDAY, 1/21/84 :DATE
SOLDOTNA, :SITE/LOCATION
H. HESS, REP.TISCHER "HB-225, :SPONSOR/SUBJECT
OPTOMETRY AND PRESCRIPTIONS"

NAME/REPRESENTING	ADDRESS/PHONE	TESTIFY	OBSERVE
1. ROBERT O'CONNELL OPTOMETRY	BOX 3470 SOLDOTNA 99669		X
2. PETER CANNAVA MD	BOX 1629 SOLDOTNA 99669	X	
3. JOHN DEMSKE OD	RT.2 BOX 368 SOLDOTNA AK. 99669	X	
4.			

_____STATS_____
2 ___TESTIFY/ED 10:30 AM T/C STARTED
1 ___OBSERVE/ED 12:50_____T/C ENDED
3 ___TOTAL

MSG 84-00005784 PRTY 1 01/21/84 15:27:47 ORIG: LF20 IN= 0003 OUT= 0013
FROM: LYNDG/TBX TO: JNU T/C
TARGET: LJHV SUBJ: FINAL STATS - HSE HESS 1/21

****

LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

****

JANUARY 21, 1984____:DATE
FAIRBANKS_____:SITE/LOCATION
HSE HESS/REP TISCHER HB225_____:SPONSOR/SUBJECT
(OPTOMETRIST & PRESCRIPTIONS)

TESTIFIED/PARTICIPATED:

1. JIM GRAVES, OPTOMETRIST, FBX CLINIC OPTOMETRIC CENTER, 1867 AIRPORT WAY, FBX #452-1761 EXT279

OBSERVED:

_____STATS_____
1_____TESTIFY/ED *****T/C STARTED _____
_____OBSERVE/ED *****T/C ENDED:_____
1_____TOTAL

=====EOM

MSG 84-00005800 PRTY 1 01/21/84 16:15:40 ORIG: LM01 IN= 0006 OUT= 0080
FROM: MATSU TO: PRIMARY MODERATOR & JUNEAU T/C
TARGET: LJHV SUBJ: SIGN IN - MAT-SU ONLY

****

LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

****

1/21/84 :DATE
MAT-SU :SITE/LOCATION
H. HESS COMMITTEE :SPONSOR/SUBJECT
-1- TESTIFY/ED ********T/C STARTED 10:45AMADT
-0- OBSERVE/ED ********T/C ENDED 1:00AMADT
-1- TOTAL

NAME/REPRESENTING	ADDRESS/PHONE	TESTIFY	OBSERVE
1. DR. DENISE L THANEPOHN,	P O BOX 871700, WASILLA 99687 376-5266		

MSG 84-00005766 PRTY 1 01/21/84 14:57:45 ORIG: LM08 IN= 0015 OUT= 0071
FROM: RING IN ANCHORAGE TO: KEN IN JUNEAU
TARGET: LJHV SUBJ: OMTOMETRISTS AND PRESCRIPTIONS HB225 (H)

****

LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

****

DATE: JANUARY 21, 1984
SITE: ANCHORAGE
SPONSOR/SUBJECT: (H) HESS OPTOMETRISTS AND PRESCRIPTIONS HB225

...5..TESTIFIED ******T/C STARTED: 10:45AM
...2..OBSERVED ******T/C ENDED: 12:50PM
...7..TOTAL

TESTIFIED
****

1. JAMES H. PATTERSON MD 3500 LATOUCHE ST. ANCH. AK. 99508 562-2969
2. STEVEN DAUBSON OP 8301 BRIARWOOD SUITE 203 ANCH., AK. 99502 349-6932
3. T. SENTER MD 718 K ST. ANCHORAGE, AK. 99501 272-2571
4. CHARLES R. RUSH/BD. OF PLANNING 1345 W. 11TH ANCH., AK. 99501
5. JON NYBOER MD 3300 PORVIDENCE DR. SUITE 302 ANCH. AK. 99508

OBSERVED
****

1. DENNIS BUNKERHOFF OP 1345 W. 5TH AVE. ANCH., AK. 99501 272-2557
2. T. MC LAUGHLIN OP 9750 VAN GUARD ANCH., AK. 99503

****

MSG 84-00005679 PRTY 1 01/21/84 13:04:16 ORIG: LB00 IN= 0006 OUT= 0020
FROM: WALLY IN BETHEL TO: JNUTC
TARGET: LJHV SUBJ: FINAL STATS

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LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET/FINAL STATS

****

DATE: 1-21-84
LIO SITE: BETHEL
SPONSOR/SUBJECT: HOUSE HESS/HB225

NAME/REPRESENTING	ADDRESS/PHONE NUMBER
OBSERVED ONLY	
1. DR. JIM TAYLOR, REPRESENTING HIMSELF	PO BOX 1018, BETHEL 543-3446 (HM) 543-2251 (WK)

****

TIME T/C STARTED: 10:30 AM
T/C ENDED : 12:50 PM
LOCAL MODERATOR : WALLY

TESTIFIED: 0
UNABLE TO: 0
OBSERVED : 1

TOTAL : 1

****

Peninsula Eye Clinic
Peter E. Cannava, M.D., A.P.C.
OPHTHALMOLOGY
P.O. BOX 1629
SOLDOTNA, ALASKA 99669
TELEPHONE 262-4462

January 24, 1984

Representative Mae Tischer
Pouche V
Juneau, Alaska 99811

Dear Representative Tischer,

I felt as though the teleconference which you chaired on HB 225 went very well and I wish to congratulate you on your smoothly run hearing. You raised two points which I felt were exceedingly important and although I touched on the responses I do feel as though they deserve ampliflication.

You were frustrated at the inability of the public to differentiate between optometrists and opthalmologists as they can differentiate between gynecologists and peditricians! We agree with your problem and as a result have started to educate the public as to the vast difference in education between an O.D. vs M.D.! Our cause, however, is frustrated by the trend by O.D.'s who portray themselves to the public as the provider of total eye care! Witness, for example, the name of some of the optometry offices in Anchorage: 'Anchorage Eye and Contact Lens Centre', or Opthalmic Associates'. These titles more than suggest that total medical and surgical eye care is offered at these establishments. With such misleading introduction, you can easily see why our patient education campaign is going slowly!

Your referral to this bill as a "turf" battle is a reasonable conclusion. If it viewed in that sense then imagine the "bag of worm's" that the legislature is getting into if it legislates this group of providers into an entirely new professionbased on a post-graduate 100 hour crash course! How will the legislature handle the myraid of other Alaskans who wish to legislate themselves into a new profession! Will it grant the "born again Professionals" new enriched status based on a 100 hour course or will it refer them back to the appropriate professional school for the time honored educational background?

Your question concerning cost of an office visit is also very important in that you will find the cost of a visit to an O D. is traditionally equal to or more often higher than a comparable visit to an M.D.! If the public were truely informed as you would have them be, would they seek out a optometric office visit when they could buy an M.D. for the same price? This situation poses a dilemma for the O.D.'s and helps to explain their duplicity in advertising their services.

Please let me know if I can answer any more questions for your committee and please notify me of additional hearings you may schedule.

Sincerely,

Peter E Cannava, MD

Peter E. Cannava, M.D.

P.S. Please disperse a copy of this letter to your committee members. Thanks!

Mae, if I remember correctly Dr. Cannava gave testimony at the optometric hearings I promised to send

STATE OF ALASKA
THE LEGISLATURE

POUCH Y STATE CAPITOL
JUNEAU ALASKA 99811
907 465-3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M

February 17, 1984

SUBJECT: Optometry
(HB 225)

TO: Representative Mae Tischer
Chairman, House Health, Education,
and Social Services Committee

FROM: Russ Josephson
Legislative Counsel

You have requested a comparison of the introduced version of HB 225 and the committee substitute for your committee dated February 3, 1984. Perhaps it will be easiest to compare the two bills if I begin with a brief sectional analysis of each bill.

HB 225

Section 1 Amends the provision of law governing the practice of medicine by persons other than physicians by adding a new paragraph allowing optometrists to use certain drugs under the provisions of the remainder of the bill.

Section 2 Provides for identification and approval of (1) training programs for the use of drugs and (2) continuing education programs. Also provides for license endorsements certifying completion of required training for drug use, regulations concerning the use or prescription of legend drugs, the loss of license endorsements for violations of those regulations, and the furnishing of the names of holders of license endorsements to the board of pharmacy.

Section 3 Amends the definition of "optometry" reflect the provisions of the bill for the use of drugs.

Section 4 Amends the definition of "practicing optometry" as in Section 3.

Section 5 Adds a definition of "legend drugs".

Section 6 Adds optometrists to those excepted from the provisions of law penalizing the practice of medicine by persons who are not physicians.

CSHB 225 (HESS)

Section 1 Provides an additional ground for the imposition of disciplinary sanctions that the board of examiners in optometry may impose under AS 08.72.240: use, dispensing, or prescription of a drug in violation of the new provision regulating drug use by optometrists (Section 2). In addition, provides a modification of the provision that requires referrals to appropriate health care practitioners.

Section 2 Adds a new section to the statutes, providing for the use of legend drugs, excluding controlled substances and other types of drugs. Lists the categories of topical legend drugs that may be used by an optometrist who has obtained a license endorsement from the board of examiners in optometry. Lists the requirements for a license endorsement, including the required training before and after receiving an endorsement.

Section 3 Contains a new definition, "legend drugs". Also amends the definitions of "optometry" and "practicing optometry" to reflect the provisions of the bill concerning the use of drugs. The definition of "legend drugs" is identical to that in the introduced version of the bill. The amendments of "optometry" and "practicing optometry" differ from those in the introduced version of HB 225 in that they have added a phrase to exclude the use of surgery in diagnosis and treatment. The definitions in the introduced version of the bill do not mention surgery.

As you can see, the two bills accomplish basically the same thing. The major differences are as follows:

HB 225 contains (in Sections 1 and 6) amendments regarding the practice of medicine and providing the necessary exemptions for optometrists using drugs. CSHB 225 (HESS) does not contain these provisions, but it should.

Both bills provide for license endorsements and for the training required before and after receiving an endorsement. HB 225 provides for regulations to handle those requirements; CSHB 225 (HESS) provide more detail in the statute.

CSHB 225 (HESS) provides a new ground for discipline by the board of examiners in optometry; violation of the provisions concerning drugs. It also amends another ground for discipline, failure to refer a patient to the appropriate health care practitioner. Neither of these provisions was in the introduced version of the bill. HB 225 did provide for regulations concerning the use or prescription of legend drugs, and it provided for the suspension or revocation of the license endorsement for violation of the regulations.

CSHB 225 (HESS) is more specific than HB 225 in its detailing of the types of drugs that may be used by optometrists.

The definitions in CSHB 225 (HESS) contain provisions concerning the prohibition of surgery in diagnosis and treatment by optometrists. Similar language does not appear in HB 225.

HB 225 provided for the names of endorsement holders to be submitted to the board of pharmacy. CSHB 225 (HESS) does not contain this provision.

I trust these sectional analyses and this comparison will be useful. If I may be of further service, please call.

RJ:ojb
J3/111

The ALASKA OPTOMETRIC ASSOCIATION

AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

PRESIDENT

Alaska's doctors of optometry (O.D.) are preparing to introduce legislation that will allow qualified Alaskan ODs to use prescription drugs in the treatment of infections, allergic inflammations and minor injuries of the eyes and lids not requiring the services of a specialist Many such conditions are treated by general practitioners, who have minimal training in this area. However the optometrist, who is considerably better qualified by training, experience and instrumentation than a general practitioner, must refer his patient to an MD (usually an ophthalmologist), at additional expense to the patient. We have estimated, based on the experience of West Virginia, that the elimination of extra visits would save Alaskans $235,000. in the first 3 years, not counting travel and lost time.

A majority of Alaska's ODs have recently completed a 120 hour course of postgraduate education and training in ocular therapy. While 120 hours (and an equal amount of home study) is extensive for working practitioners, it should be considered only against a background of 4000 hours of professional training, much of it in the background medical sciences The combination provides a medical background comparable to dentistry and podiatry. Dentists and podiatrists, like physicians, have unrestricted drug prescribing authority, though in practice they limit themselves to drugs appropriate to their field.

Drug legislation in more restricted form was originally introduced in 1978, when it passed the House. However ophthalmologists, who oppose the bill, have been able to tie it up in one committee or another since that time, despite a two thirds favorable majority in each house. If passage is further delayed, the skills gained or sharpened in this training will begin to deteriorate and problems of "grandfathering" may arise. The bill provides that prescribing authority will be limited to those ODs who have been trained and certified in primary care therapeutics.

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

HES
Monday
Jan 16, 1984

Commissioner Reynolds:

Questions:
Finance
State Board Ed. study
HB-251

Budget:
Full Funding
+ 30 Mil more
Increase Enrollment C.I.P.
Increase Categoricals
Community Schools
+ 2% Dept. activities = ½ Mil
98% $6.00 Mill. (Inc Debt Serv)
Pass thru to Local Schools

need more explain.
will Produce
a Found. Formula

? Model Curriculum - Mandatory or voluntary participation?

Media Concern

Primary Concerns:
Board: Policy Leadership
Dept asked to develop Model Elementary & Secondary Curriculum

Improve quality of Administrators
Principals Academy
Assessment Center (for Principals)

Dick Luthen -
Alyson Algey - Budget

HOUSE HEALTH, EDUCATION & SOCIAL SERVICES
STANDING COMMITTEE
January 21, 1984
10:00 a.m.

Members Present: Rep. Tischer, Chairman
Rep. M.W. Miller, Vice-Chair
Rep. Martin
Rep. Uehling
Rep. Goll
Rep. Koponen
Rep. Davis

COMMITTEE CALENDAR

HB 225 "An Act relating to the practice of optometry and authorizing the use of prescription drugs by optometrists."

HB 347 "An Act relating to the licensing of practitioners of naturopathic medicine; and providing for an effective date."

WITNESS REGISTER

Dr. James Demsky
Soldotna, Alaska
Position Statement: In support of HB 225.

Dr. Peter Cannava
Soldotna, Alaska
Position Statement: In favor of HB 225.

Charles Rush
Anchorage, Alaska
Position Statement: Stated concerns if HB 225 was passed.

Jan Nyboer
Anchorage, Alaska
Position Statement: Strongly opposed HB 225.

Steven Dobson
Anchorage, Alaska
Position Statement: In support of HB 225.

Mr. Center
President
Anchorage Medical Society
Anchorage, Alaska
Position Statement: Stated AMS unanimously opposed HB 225.

James Patterson

Anchorage, Alaska
Position Statement: Opposed HB 225.

Dr. Jim Graves
Anchorage, Alaska
Position Statement: In favor of HB 225.

Denise ...
Mat Su, Alaska
Position Statement: In favor of HB 225.

Shirley...
Fairbanks, Alaska
Position Statement: In support of HB 347.

Harry Treager
Director
Division of Occupational Licensing
Pouch D
Juneau, Alaska
Position Statement: Was present to answer questions on HB 225 and 437.

Stuart Ball
Juneau, Alaska
Position Statement: Against HB 225.

Diane McDermott
Anchorage, Alaska
Position Statement: Supports HB 347.

Julia Reinhar
Anchorage, Alaska
Position Statement: In support of HB 347.

Debra Lucas
Mat-Su, Alaska
Position Statement: Supports HB 347.

Efrin Resume
Fairbanks, Alaska
Position Statement: In support of HB 347.

Steven Cox
Anchorage, Alaska
Position Statement: Supports HB 347.

David...
Anchorage, Alaska
Position Statement: In support of HB 347.

Karen Red Stone
Anchorage, Alaska
Position Statement: In support of HB 347.

Molly Mauline
Mat-Su, Alaska
Position Statement: In support of HB 347.

Scott Jamison
Juneau, Alaska
Position Statement: In support of HB 347.

Joanne Selmar
Anchorage, Alaska
Position Statement: In support of HB 347.

David McGuire
Anchorage, Alaska
Position Statement: Stated concerns on HB 347.

Mark Rierdan
Mat-Su, Alaska
Position Statement: Supports HB 347.

John Ghaddio
Fairbanks, Alaska
Position Statement: Supports HB 347.

Dr. J. Bonner
Anchorage, Alaska
Position Statement: Opposed HB 347.

Virginia Pettyjohn
Anchorage, Alaska
Position Statement: In support of HB 347.

Dr. Patton Pettyjohn
Anchorage, Alaska
Position Statement: In support of HB 347.

Dr. Jasper
Anchorage, Alaska
Position Statement: In support of HB 347.

Georgia ...
Mat-Su, Alaska
Position Statement: Supports HB 347.

Sandra Jay
Anchorage, Alaska
Position Statement: Supports HB 347.

Sherry ...
Anchorage, Alaska
Position Statement: In support of HB 347.

Jean ...
Anchorage, Alaska

Position Statement: In support of HB 347.

Ruby Pettyjohn
Mat-Su, Alaska
Position Statement: In support of HB 347.

Karen Jasper
Anchorage, Alaska
Position Statement: In support of HB 347.

Captain E.P. Pettyjohn
Alaska Airlines
Position Statement: In support of HB 347.

Connie Walker
Anchorage, Alaska
Position Statement: Supports HB 347.

Paul Pettyjohn
Mat-Su, Alaska
Position Statement: Supports HB 347.

Bill ...
Anchorage, Alaska
Position Statement: In support of HB 347.

Tom Pettyjohn
Mat-Su, Alaska
Position Statement: Encourages the passage of HB 347.

Cindy Ziegler
Anchorage, Alaska
Position Statement: Supports HB 347.

Cathy ...
Anchorage, Alaska
Position Statement: Urged passage of HB 347.

PREVIOUS ACTION

HB 225	2/23/83 - First Reading.
	Committee Referrals - HESS and Rules Committees.
	See HESS minutes of April 27, May 16, 17, 18 and 19, 1983.
HB 347	4/12/83 - First Reading.
	Committee Referrals - HESS, Labor & Commerce, Finance and Rules Committees.

See HESS minutes of May 20 and 21, 1983.

ACTION NARRATIVE

TAPE#5, Side 1
Recording
Number 0001

Chairman Tischer: I express my sincerest apology for the delay of 45 minutes of at least beginning this meeting as I said before the meeting should be in Anchorage, however, the members were not able to leave Juneau because of inclement weather, the airplanes weren't flying so we are conducting this hearing from the site here in Juneau.

Chairman Tischer: I'd like to now welcome those who have come to all sites either to observe or testify, there are several members of the public here and I right now don't have their names. I'll call off the names that are listed here on all sites and if there are any others I wish that you would pass the names on to me before we start the hearing process. Those that I have listed to testify from the other parts of the state; John Demsky and Dr. Peter Cannava from Soldotna, in Anchorage; Charles Rush, Jan Nyboer, Steven Dobson, Mr. Center and James Patterson, there is also an observer I understand in Anchorage, Dr. Jim Graves. In addition, we have a witness in Mat Su, Denise ... and please correct me if I'm mis-pronouncing these names, and Dr. Jim Taylor who is an observer at this time from Bethel and who may wish to make comments. In Juneau; we have Harry Treager and Stuart Ball, with that list than I extend an invitation for Mr. James Demsky in Soldotna, if you would like to come forward we would appreciate hearing from you.

Number 0024

James Demsky: My name is John Demsky and I'm an optometrist and practicing in Alaska for 6 years, five of those years with the Yukon-Kuskokwim Health Corporation and recently I've opened a private practice in Soldotna. I gave a lengthy testimony for the hearing in April, I believe and I don't want to repeat myself too much. I'm also a member of the Board of Optometry and I would like to make a few comments as to the Board's position; first of all we do not

intend to have any grandfather, the certification used drugs would be by examination. We plan on increasing the hours of continuing education prior with the percentage related pharmacology and pathology. The advantages that we see are;

1) prevented health care

2) much cost to the consumer

3) provide higher level of care

Number 0041

There is 38 states that can use drugs now, 35 of them diagnostic and 3 with therapeutic, one of the states just passed their therapeutic....last year. North Carolina in 1977 and West Virginia in 1976. There are no drug related complaints against West Virginia optometrists since that time and there have been only two formal complaints against North Carolina's optometrists and there's also been a national study done by the National Association of Insurance Commissioners from July of '75 through December of '78 and that period of time there were 47 claims against the optometrists and 354 claims against ophthalmologist and there is not any significant difference between drugs and non-drug states of optometrists. I believe that since I've said most of my other testimony previously thats all I wish to say today. Thanks.

Number 0055

Chairman Tischer: Thank you very much, Mr. Demsky. Would you be open for questions from the committee? Mr. Demsky: Certainly.

Chairman Tischer: Rep. Martin wishes to ask you a question Mr. Demsky.

Number 0058

Rep. Martin: Yes sir, I'm interested in the continuing education program, I know that if not last summer or the summer before the optometrist profession had an extensive education course during the summer involving many hours. Can you give us an update perhaps as to how many optometrists today would qualify for certification of diagnostic drugs with the latest minimum standards that the profession is putting upon itself?

Mr. Demsky: I could not answer accurately the diagnostic drugs because our pursuit is for therapeutic drugs, I do know from the course that was offered a year ago which had primary emphasis on therapeutic drugs that the majority of MD's from the state passed that took that course and passed the final exam. That course would fulfill all the requirements for using therapeutics and just about all the states, of course the major requirement is being able to pass the exam given by the Board, so all applicants would have to take ours and additional exam for diagnostic. Since your question was about diagnostic, I would just say just guessing that about 75-80% in the state already have the requirements for diagnostic drugs.

Rep. Martin: Thank you for clarifying that difference between therapeutic and diagnostic; we haven't had this bill for awhile and I forgot the difference. I think thats it for right now, Chairman. Thank you.

Number 0080

Chairman Tischer: Let the record show that Rep. Miller of North Pole is now present; and Rep. Davis would like to ask a question.

Rep. Davis: Just a quick question; Dr. Demsky do you have any comments on the bill that is still in the committee?

Dr. Demsky: Are you referring to the Committee Substitute? Rep. Davis: Yes, thats correct CS for HB 225.

Chairman Tischer: I'd like to clarify this for the committee's benefit and for those that are listening, we are hearing the original HB 225 and the reason that we are doing that is because there are three Committee Substitutes all prepared by Sen. Josephson and the sites out there do not have copies of that, so if you are referring to any particular version you must first of all state the version number and the section and line that you are identifying, if you would please, committee members and those who have copies of other bills out on the field you would have to refer to which bill or which version you are complimenting or criticizing and which section. To solve the confusion, the Chair is identifying the

original House Bill only.

Number 0097

Rep. Davis: I'm just curious on what his testimony is on the original bill or if he has an alternative one that he supports, I'd like to know that.

Mr. Demsky: Yes, the original bill was shot down rather excessively for its lack of ... I would say and there are several alternative bills that I would certainly consider, I do not have a copy of the Committee Substitutes in front of me, but I do know that one of the Committee Substitutes included a position on the optometry board and a list of prescription and non-prescription drugs with the advice and guidance of the state Medical Board. In regard to that Committee Substitute I don't see any advantage of having a position on our board, I would be in favor of having a list of different classifications of drugs that we could use, but not a list perse of each individual drugs. That is the only Committee Substitute that I am aware of, also the initial bill does not have any statements about the exam itself or the continuing education that is required and it does not list the drugs. According to the initial bill there are not any limitations whatsoever, according to the bills that we have considered as an alternative the drugs would be limited to topical ophthalmological drugs only with emergency use for systemic drugs in the office only.

Number 0126

Chairman Tischer: Thank you John. I'm looking at a version number 1 and it really doesn't matter which version. I think which version you are referring to is that particular version, which is version 1. It does set out the scope of practice, it does set out the section in section, the list of people who should be sitting on a board, one of which would be a physician and let me just read that to you and see if this meets the qualifications that you wish.

The board will consist of (6) members instead of (5), there should be a change in the original statute, appointed by the Governor the members must serve staggered term years, there will be (4) members and 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 in-direct practicing optometry; one board member shall be a licensed physician in the state. That one provision is provided for in the Committee Substitute and in addition it has another section that is called approved drugs and this is how it reads:

The licensee holding a certificated issued under AS. 08.72.277. The employer prescribe an addition to the drugs approved under another statute, legend drug as follows; and then they identify the actual drugs, subsection topical anesthetics anti-effective which lists the types of drugs underneath it, anti-glaucoma agents and so forth down the list, there are probably 35 different drugs that are listed. You're composing that these drugs not be listed that identify only in categories, is that what you are suggesting?

Number 0156

Dr. Demsky: That is correct.

Chairman Tischer: And how would you ask those drugs to be listed in categories, what categories would you suggest?

Dr. Demsky: I believe the ones that you have listed there, the anesthetic, optometric and anti-glaucomas.

Chairman Tischer: Thank you very much, do you have any comments for us to hear?

Dr. Demsky: I don't believe so.

Number 0163

Chairman Tischer: The next witness that I'd like to call would be Charles Rush from Anchorage.

Charles Rush: Good Morning, I'm sorry that I'm not well prepared on this, this is the first time that I've seen the bill, however, I am on the Board of Pharmacy and I serve as the Secretary and we addressed this bill or a similar one a couple of years or maybe last year and essentially I just want to be sure that that letter was still in the possession of the Legislature and would be considered.

I think essentially, what we said in that letter was that this was a real concern to us, that in pharmacy we have and always had sort of a traditional problem and its a very minor one with dentists who have restricted prescriptive authority in the date prescribed for the mouth, and we have the same type of problem with the veterinarians who are limited to animal, and this sometimes is a problem if they get out of their speciality.

Now we really ran into problem when we got the nurse practitioner and the physician's assistants who were given the authority to prescribe and when they came to us with this we did not see it would be a problem and we said that we thought we could monitor all the NP's and PA's. When it happened all of a sudden we were faced with every NP and every PA that had a different regiment that they could write for, as set up by their collaborating physician. This we soon found that pharmacist could not do, we were not able to keep track of the certain items that each nurse practitioner or PA was allowed to prescribe, so at that time we went to the medical board and the nursing board and we said that there was no way that we could monitor, that we felt that this had to be changed and the responsibility for the PA and nurse practitioner had to be the responsibility of the collaborating physician. Naturally all care was going to be exercised in throwing their prescriptions, but if they got outside of their field than they were allowed to prescribe and that is something the collaborating physician would have to check on and would have to handle. I feel that this optometrist would be a similar category and it would be extremely hard for the pharmacist to first of all would have to identify their prescription so that the pharmacists knew that this was an optometrist and he had limited prescribing authority and then at that time it would have to be very plain what that prescribing authority was. I think thats our main concern, the other thing that we did not address here I would presume and I would hope that you are not planning on having any DEA numbers involved with the optometrist and they would not prescribe for controlled

substance. Has that been considered?

Number 0212

Chairman Tischer: If you are asking the committee that question, is that what you are doing?

Mr. Rush: Yes, I am. I just read through this real quickly, I don't see where its addressed here, the use of prescription or legend drugs.

Chairman Tischer: There is nothing in this proposed piece of legislation that addresses controlled substances as far as I can see.

Mr. Rush: Controlled substances are legend drugs, however, normally they are classified separately, I believe if it were addressed it would save, possibly it should be in the statute, that DEA drugs, controlled substances would not be prescribed and that they would not have DEA number.

Chairman Tischer: Thank you, thats a good suggestion. How do you feel about categorical listing in this proposed piece of legislation, Mr. Rush?

Mr. Rush: I feel that its difficult I don't know, I think its going to be very hard for pharmacist to draw the line or know where the line is drawn at, if thats what you are doing. Maybe it should be like industry, they are limited to diseases of the mouth, maybe the only limitation should be limited to the eye, I don't know, maybe thats too broad a category.

Chairman Tischer: Mr. Rush, if I may, the bill addresses that by virtue of the definitions that are contained within the bill and what the licensing process should be. I have a question, am I given to understand that at the present time the pharmacists are the police force of the prescription industry if you will on all fields of medicine or is that just a policy?

Number 0241

Mr. Rush: I think this is maybe the way it really works, a pharmacist is certainly jointly liable if he fills a prescription for say for instance a dentist, who is prescribing something that is not related to the mouth. In that particular case the

pharmacist I feel is probably under a real obligation, not to fill that prescription.

As far as a doctor of medicine is concerned there is no limitation, there's certainly a limitation if you do something wrong, if its an overdose or something they should catch, but as far as a veterinarian writing a prescription for a human, now the pharmacist fills that, he certainly has some liability.

I think the same thing is true with dentistry and I think that under this, the optometrist, and I don't think we like the word "policeman" but essentially is, yes, you are saying to us, do not fill prescriptions except for the eyes and the eyelids than they are going to give us a specific list. And so, when the prescription comes in it is his determination, it could result in a law suit if he strays away from that.

Number 0261

Chairman Tischer: I think what you are saying to the committee, Mr. Rush, is that the pharmacy industry and profession feels a moral obligation to police that prescription portion of dispensing drugs to the best of their ability. What I would like to know is that if you are mandated by the law to do that and rather than the moral obligation part of it?

Mr. Rush: Well, I certainly think that we are mandated by law, yes, its in the dental statutes that they can only prescribe for diseases of the mouth, under the nurse practitioner they can only prescribe the items or the legend drugs that their collaborating physician allows them to write for. So I think, definitely that means the pharmacists fills the prescription outside of that scope, certainly, its against the law, so I don't think its a moral, I think it is law.

Chairman Tischer: Mr. Rush, I am going to ask for a legal opinion from the Attorney General's office on that account, so that the committee has a clear understanding of whether or not its a policy issue more than it is a statute. What I'm looking at here is a provision within one of the substitutes and it says; "the board shall furnish to the

Board of Pharmacy the names of all holders of endorsements issued under this section", you mean its a policy of one board to supply the pharmaceutical board list of all the holders or allowed to prescribe drugs? But it does not say anything that you are liable to police their actions and I think we need an opinion on that.

Chairman Tischer: Rep. Martin has a question.

Number 0288

Rep. Martin: Thank you Madam Chairman, Good Morning Charles, as you said we have been on this thing for 4 or 5 years now, same thing, no progress. The same questions are being asked and I believe there are answers if we don't try to nit pick this bill to death one way or the other, there's always going to be any if or but. But I feel that the categorizing drugs is probably the best way to go through this as you know in your profession there's always new drugs on the market for new things and its awful hard to keep up with, and thats up to the professional group. Ones to regulation and the ones to educational program, we know in the last two years the optometrist have done a superb job in upgrading everyone's education, making sure they had minimum hours of training for x use to what drugs or what procedures, and rather than tidy all these things in the law itself that we should let the regulation and the education be the guide line of what they are allowed to do. If we get involved in saying that we want drugs only for the eyes we know that anything that enters the body is going to go through the whole body no matter what point of interest, and than we get into the nit picking technologies on that too. What I'm looking for is to allow a professional group and we have to have faith in those professional groups to give the best that they have to offer to the patients. And I feel that in this state we have a lot of top rated optometrists that go out into the remote areas and if they have the expertise they should be allowed to use them and work upon the patients that they suddenly run into that needs it.

Number 0313

Mr. Rush: I don't know if I definitely disagree with what you said there, Terry. I

think our concern on the Board of Pharmacy is that we not put our pharmacist in the position where it is extremely difficult for them to know whether they are allowed where its legal to fill a prescription or not and I think that maybe something should be continued if you are considering that they are going to give us a list, like the list that we got of the nurse practitioner and of the PA's. That has had a few problems, they add new people all the time to the list and then there are people who are taken from the list that are no longer licensed and this gets into a continual need for updating and especially we have in our nurse practitioners and the PA's regulations a part that says if a collaborating physician no longer collaborates with the nurse practitioner, the Pharmacy Board will be let known in 24 hours. Because, if this happens, the collaborating physician has some problem with the nurse practitioner or the PA, than its essential that we get that information quickly so that we can notify the pharmacist and they don't fill the prescription.

Number 0332

Rep. Martin: Thank you, I whole wholeheartedly agree with your problem and personally think the pharmacists have done a number one job around the state in trying to control misuse of drugs whether it comes to doctors or where you are almost forced to at times to accept that prescription when you know darn well that a problem will speculate anyway. And I very much appreciate pharmacists I've known who have conscientiously notified the various departments if they can't get the doctor to rightly consider the prescriptions. I personally appreciate the concerns that you are expressing, I think its a very valid report and maybe the optometrist can work up an easier procedure for the pharmacist, because they want to protect themselves too. They don't want their image tarnished by any weak members.

Number 0345

Chairman Tischer: Thank you.

Chairman Tischer: I'd like to now go to Juneau, we have a Stuart Ball who would like to testify, and for those who are listening or preparing to testify I appreciate very

much if you would as you come to the table announce your name and your affiliation if any.

Number 0354

Stuart Ball: My name is Dr. Stuart Ball, an ophthalmologist, and would initially say that I am opposed to this bill. Let me go through my qualifications through college; pre-medical education, medical school - 4 years, did straight medicine, internship and 3 years of ophthalmology training for the year of specialized training in New York City and glaucoma. I'm opposed to this bill, because it proposes to give the privilege of practicing medical care of the optometrists, it is put forth by some who sincerely, but mistakenly believe that optometrists have the proper training. Fact is, this is not so. It is only recently that any ... attention has been turned to the medical care and diagnosis and treatment of condition of the eye in optometry school.

The majority of practicing optometrist have only accuracy look at this and even recently trained optometrist have certainly not had enough. The lectures they have had in optometry schools do not qualify them to practice as physicians. I maintain that is wrong minded to propose by legislative fiat to give to any professional group the rights and privileges that should have first been earned, to give the optometrist the right to practice and than ask them to return for the education they need, seems to me be both ridiculous and frightening. The fact is, few had the ... education and none had the clinical training to practice and diagnose the treatment of medical conditions of the eye without the supervision of a qualified physician. I implore you the legislature to consider the seriousness of this bill, we are talking here about people, sight and the health of their eyes. National public opinion polls, and I'm sure you'll agree, rank loss of sight, second only to cancer as their greatest fear. You have the responsibility to protect the public, if passed this bill under consideration would only serve the complicated already confusing situation. Most of the public is unaware of the difference between an optometrist and ophthalmologist and the great differences in their capabilities and training. Passages

of this bill would imply to the public both that optometrists have the ability to diagnose and manage eye conditions and a complete understanding of the use of these drugs and the management of their possible complications. None of these conditions are true. Optometrist have claimed they can safely use the medication proposed but during my glaucoma fellowship I personally witnessed three surgical emergencies brought on solely by the use of these drugs and many more which the quick and accurate diagnosis and emergency medical treatment was vital to preserving the sight.

Number 0401

I shudder to think that the bill was passed and the public was further confused about who is the proper provider primary eye care, what needless pain and suffering and loss of sight might be caused. In summary, I feel this bill proposes to give an unearned privilege without corresponding requisite responsibility. It is unearned, because optometrists have had even none or inadequate clinical training, and they propose in this bill to determine among themselves who is competent among them to use the drugs. That frightens me, it should frighten you and would certainly frighten an informed public, also this bill gives the right to "to diagnose" to people who qualify at best only to detect and do so without requiring referral to a qualified physician for diagnosis and care. I think there's room for compromise though, certainly compromise substitute bill as being submitted to both the House and Senate for proposing to give educationally, qualified and tested optometrists the use of a limited list of drugs to assist in their detection of abnormalities of the eye, but it also recognizes their limitations to "to diagnose" as distinct from detect abnormalities of the eye and requires the referred to a qualified physician.

Number 0423

I feel this is the most appropriate to the realities of the situation and the welfare of all concerned and if I could just answer one comment that was made by the optometrist who spoke first. About the realities and the insurance; he mentioned insurance rates from '75 and '78 which were published I think by the National Association Insurance

Adjusters. I want to note that those dates were before those states had drug bills for diagnostic drugs, but were not therapeutic drugs and from '79 to '80; the insurance rates for optometrists went up 38% because of the claims against them, and since then they have gone up dramatically more, but I don't know the percentage.

Number 0435

Chairman Tischer: Thank you very much, Dr. Ball, are there questions from the committee? Rep. Davis?

Rep. Davis: Thank you Madam Chairman. Thank you for your testimony, I'm curious to know if you seen this CS for HB 225 that has been referred to as the compromise bill or is it one of Sen. Josephson's?

Chairman Tischer: Which version?

Rep. Davis: I think the only version that I've seen is Sen. Josephson's.

Chairman Tischer: You will note that some of us have several versions from Sen. Josephson's and at the top of the right hand corner for those who are privy to having a copy, its version number 1, 2 and 3, and each one is different. While you are looking for that, well, I'll let you ask that question first.

Chairman Tischer: I was looking at version number 1 to begin with.

Rep. Davis: The last version is the version the committee was looking at, version number 3.

Chairman Tischer: The real watered down one, is that what you think?

Number 0452

Dr. Ball: The last version is the one thats actually in the other body right now is the one you feel is the compromised one, the one you can live with? Is that what you're saying?

Number 0457

Chairman Tischer: Its going to be real confusing for all those listeners and observers who are testifying to carry on a conversation without documents in front of them, so I caution to the committee to make

sure that when you are identifying anything please refer to a section or a line and identify what document you are looking at. So that even though people who don't have the document in front of them will know what you are talking about.

Chairman Tischer: Rep. Davis, do you have your answer?

Rep. Davis: Yes, thank you Madam Chairman.

Chairman Tischer: Are there any questions from the committee for Dr. Ball?

Chairman Tischer: I have a question Dr. Ball; version number one of Sen. Josephson's bill; identifies a list of approved drugs and they are categorized and under the categories are subsections that list various drugs that could be used by a licensee holding a certificate. In other words the licensed optometrists that is controlled by the optometry board and so forth, would you please look at that list and make comments on it please.

Number 0476

Dr. Ball: Yes, I've been looking at the list and topical anesthetics which I think they can, certainly those who have been properly trained and tested on their recent use and effectives, I think is outside their realm and implies that they have a sufficient clinical understanding and knowledge to diagnose conditions. And I think they can detect when there is an abnormality, but I think it puts too big of a burden on them who have only gone back to learn.

Number 0486

Chairman Tischer: If you were sitting down on an examination for an optometrist who maintain that they had the skill and the education to utilize having effective drugs and demonstrate to you through testing and examination that they had those qualifications, what would you say?

Number 0491

Dr. Ball: If I can set an exam and they passed it, I would still feel there other people, paramedical people who can demonstrate for efficiency and certain limited areas; like intensive care nurses have certain limited specified capabilities

and certain situations, but that even then is still always under the supervision of a physician to re-evaluate and to monitor what they do, and I feel in these situations, where the health of the eye preservation of sight is always a factor. And the other categories is even more important, any glaucoma agents, any inflammatory agents, any virals, the situation comes even more important. I think that in any of these situations, they would first have to demonstrate for efficiency, but always under the guidance of a physician.

Number 0496

Chairman Tischer: I would like to have you first answer my question, if you put the exam to the optometrist and they passed the exam sufficiently to meet your desires and your needs, proving or disapproving one or the other, that they have the ability to do anything; what you are saying to me is that you would still not allow them to do it unless you supervise them, is that correct?

Dr. Ball: Yes.

Chairman Tischer: Thank you doctor. I would also like to have for those who are in the field, if you stay at the sites if you have any questions of the other witnesses through the Chair, I would appreciate you either submitting them, so we can ask them if you are not going to stay or that you direct them yourself. I think this would be a good time to have an exchange of dialog, so if you have a specific question through the Chair to another witness that would clarify for the committee and inform them I would appreciate you doing that. The next witness that we would call is in the Mat Su Valley; Dr. Denise ..., and please correct my pronunciation, if you would please.

Number 0499

My name is Denise ... and I'm an optometrist in private practice here in Mat-Su Valley and I've been here for about two years. I'm testifying in favor of diagnostic and therapeutic drug use by optometrists. You have already heard much on this, so I'll be brief. Dr. Ball seems to feel that none of the optometrists have the proper ... clinical training. I, however, was an optometrist working in Thialand for a year after I graduated and I used both diagnostic

and therapeutic drugs there and I felt that my optometric education adequately prepared me for any type optometric care. The nearest ophthalmologist to me in Thialand was about 8 hours away and I referred all my surgical patients to him, but I felt qualified to do basic diagnostic treatment myself. To be able to provide that same scope of care here in Alaska, I think would be extremely useful, not only to the optometrist but also obviously to the patient. Here in the valley, we don't have an ophthalmologist here all the time, our offices open late on Fridays and also open on Saturdays, and the General Practitioner here in town are open during those particular hours. So if you have a patient that comes with some kind of contact lens over wear or small abrasion and you want to give them some kind of antibiotic just to ....you cannot do that, so you either have to send that patient to the Palmer Emergency Room which is going to cost them a lot of money and time or send them to Anchorage, which is a real hardship on people, especially your older patients who don't like to drive that distance. So, basically,

I see it as an increased inconvenience for the patient, a lot of decrease in cost for patient and especially for people who practice not in Anchorage are a real advantage to the people that you serve.

Chairman Tischer: Does that conclude your testimony?

Denise ...: Yes, it does.

Chairman Tischer: Any questions from the committee?

Chairman Tischer: I have a question for you doctor, there is a proposed list of drugs in version number one of Committee Substitute and identify those in categories, although I did not read the entire list. How do you feel about the legislation proposing listing specific drugs versus categorical drugs or none?

Denise ...: Well I'd be in favor of categorical, however, listing them seems a little bit restrictive just because new

drugs come on the market every so often if you have a certain list and your list will be outdated and you'll have a problem if can you prescribe it and you need to change the bill and that sort of thing.

Chairman Tischer: I also have another question, Doctor, in the proposed legislation. Do you have a copy of the original bill?

Denise ...: Yes, the original bill,

Chairman Tischer: Thank you. Are there any provisions in House Bill 225, original version that you feel needs to be expanded or declarified for the protection of the optometrist as well as to prove your worth, if you will?

Denise: Basically, it seems that everything is really complete, again you have to refer to our legislative committee and again I'm not a part of that, I'm somewhat uninformed as to the various versions.

Chairman Tischer: Thank you. I have another question, will you hold on, I have to look it up. How do you feel about a provision that would require that upon the advice and guidance of state medical board that developing a specific list of prescriptions and non-prescription, diagnostic and therapeutic drugs and their dosages be used in practice of optometry?

Denise: I don't particularly like that for the reason being that with advising consent it means that if you try to get a group of people together to advise and consent to anything, its a very difficult thing to do, you have to get a meeting, you have to get optometrist and ophthalmologist together and you have to get something accomplished. Three things which are all very difficult to do.

Chairman Tischer: The language reads; with advice and guidance, it does not require approval of the medical board, but just the advice and guidance, in my interpretation it means that there be a collaborative effort to ...(end of tape).

Tape 5, Side 2
Recording
Number 0001

Chairman Tischer continues: ... The approval of the Medical Board be secured but that the Board of Optometry and the Board of Medicine collaborate for the best interest of the client.

Denise: ...I don't really see a big problem with that.

Chairman Tischer: Thank you very much. We'll call the next witness; James Patterson, and please indicate yourself and who you are.

James Patterson: My name is Jim Patterson, I'm an ophthalmologist who has been in private practice in Anchorage for the past 12 years; I am testifying as a concerned individual. I'm opposed to HB 225 because I feel that the present level of education and background of practicing Alaskan optometrist in no way qualifies them for using drugs for diagnosis and or treatment or to perform surgery. There are several articles and literature which dramatically demonstrate the educational differences between ophthalmologist and optometrist. One of the better articles by Don Pearson and it appeared in the transaction of the American Academy of Ophthalmology and ...; these articles indicate the present day optometrists, these are the individuals who are practicing in Alaska are sorely lacking in medical and clinic expertise. Another article by Dr. Campbell, he states an accurate and appropriate referral for treatment of eye problem in the effectively performed on the basis of a good history and externally examination...(noise in background). As high as 95% of all eye disorders can be protected and determined in this fashion, all of these procedures can be performed without the use of any diagnostic drugs. I would like to address the categorization of drugs listed in the proposed bill and point out one specific example: Cocaine, in the broad sense of the word is a ... drug, drugs when applied the front surface of the eye can be absorbed systematically within a minute of 7 to 8 seconds, it has a topical effect of numbing the front surface, it was one of the first

agents to use to perform eye surgery, it also dilates the pupils.

Number 0033

This drug included for use by optometrists in present form of legislation, this drug presently requires DEA numbers and approval for physician to prescribe this agent. In summary, if optometrists want to function as ophthalmologist, let us protect the people of the State of Alaska and require them to go back to school through the existing program and gain the necessary clinical and practical experience needed in this field of medicine. For these reasons, I urge you to defeat this proposed legislation in its present form. Thank you.

Number 0042

Chairman Tischer: Thank you, Dr. Patterson, are there questions from the committee? I see none. I have a question, Dr. Patterson, rather a comment, this present legislation that is before the committee is the original House Bill and for the benefit of those who do not have the document before them, I would like to read Sections 2 and 3, actually they are practically the same. One is the "optometry" is the examination of, the other section is; the "practicing optometry" and I would like to read that and have you comment Doctor, if you would please:

"Practicing optometry" is an examination 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 diagnosis and treatment, including the use of drugs, of inflammations, infections and injuries of the eyes and eyelids; or the prescription or application 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.

Number 0060

Chairman Tischer: I heard in your testimony something referring to surgery which this

proposed legislation does not address, but in addition to that, would you comment on that definition and give us some guidance?

Number 0063 Dr. Patterson: I would think that a surgical procedure would be the removal of a foreign body from the surface of the eye or perhaps even the removal of a partially penetrating foreign body. If an individual given an agent which has sufficient power to numb the front surface of the eyes and such a procedure can be performed I would expect that such an individual might be tempted to remove the foreign body after having removed several foreign bodies, perhaps they might be so inclined to remove a growth on the surface of the eye, since they have the agents to perform such. Surgery is not specifically excluded in the bill and I would see problems with possibly extending into the surgical area. I have trouble redefining optometry as a practice in which eye disease is diagnosed as also specific therapeutic and diagnostic procedures are performed.

Number 0078 Chairman Tischer: But there is no identification in that definition at all that deals with disease or any inference even close inference as far as I can see and surgery, Doctor, I wanted to know what you're interpreting that section of the bill correctly.

Number 0081 Dr. Patterson: I'm saying that, yes, I realize that surgery is not specifically addressed in that bill, I think that deficiency, I also am against saying optometrists diagnose and treat diseases of the eye.

Number 0085 Chairman Tischer: Thank you, Doctor, are there any questions from the committee? If not, we will go on to the next witness and that will be Steven Dobson from Anchorage.

Number 0092 Steven Dobson: This is Steven Dobson, I'm an optometrist practicing in Anchorage, I was born and raised in Alaska and attended the local Community College and University and Undergraduate. I received my Doctor of Optometry Degree from Southern California College of Optometry, I also completed a one-year residency at the Veterans Medical

Center in Los Angeles; and first of all I am very grateful for the Alaska Student Loan Program and also the WICHE program that helped finance this study. I decided to return to Alaska to practice optometry at the level of which I've been trained, I guess thats why I'm testifying here before the committee today about the issues that have been brought up by prior testimonies.

I would like to clear one area of confusion, thats the area of professional judgment; if the law requires that I treat any or all eye diseases, I have a difficult time going to my office each morning, needless to say, I utilize the professional judgment every day on every patient, and even with the drug law I still would be referring many of my patients for that secondary and ... eye care, a need whether medical or surgical.

Currently, one of the most significant role models we can use to guide this legislation is that of a West Virginia, they had a therapeutic drug law now since 1976 and I don't have the latest which talks about the success of this bill in terms of decreasing patient care cost and all of the optometric care. I do have a letter in front of me that was written three years ago; they used a total of 72 different drugs for the human eye, they treated some 47,000 individual patients, the distance of these patients would have otherwise traveled to geographical locations. Other than those treated by optometrist were treatment by ophthalmologist or appropriate medical specialist, combined a total of 620,000 average miles, 52 pathological conditions were diagnosed and treated by the West Virginia optometrist and there are 135 West Virginia optometrist that have this traditional privileges for optometric license in that state. Its also noted that there has been no reports to the Board of any adverse reaction to the diagnosis and treatment rendered to patients involved in any West Virginia certified optometrist.

Number 0136

I also have another very brief letter that was written two weeks ago from the Director of Nebraska Department of Social Services and she was responding to Sen. Don Wesley who is in the Nebraska State Legislature and

the comments were as follows:

The department anticipates a decrease in expenditures for these services for the following reasons: (Now Nebraska is also introducing a therapeutic legislation), and her first statement was; the plans will now have to go through the optometrist to an ophthalmologist for this minor treatment, therefore, the department would have to pay for one office visit and instead of two office visits. The medicaid and liable fees for optometry visits are generally less than liable fees paid to ophthalmology.

Number two: This legislation will have a very positive effect on the availability of service to the clients as there are a few ophthalmologists in outside and out state Nebraska.

We have very similar situations here in Alaska, and another issue that has been brought up in prior hearings is that for some reason the bill ends up in the Finance Committee and obviously this must be a stall tactic. The comment made here was the administrative cost of this bill would be minimal, estimated at less than $500. and so I hope that this bill will not be tied up in the Finance Committee again, its absolutely non-productive.

Number 0157

Steven Dobson: Again some restrictions I think may be appropriate on this drug bill and one was brought up earlier by Mr. Rush and that is; controlled substances should be eliminated and therefore, would not require any DEA numbers, also classifications of drugs I think are appropriate. Restricting these specific drugs would be inappropriate because certain patients as you know have sensitivities to certain drugs and also drugs do change. That would require legislative hearings to allow the use of new drugs that do come on the market. In reference to Dr. Patterson's comment that 95% of all eye conditions were diagnosed without drugs, my question is why do most all ophthalmologists dilate the vast majority of their patients for routine eye exams.

Secondly: Foreign body removal, I work on

Saturdays and also have evening appointments in my office and patients who are working in a garage and get dust or piece of rust in the eye and make stick on the cornea, any of these are easily rinsed out with a saline irrigation. We require even a Q-tip or something to superficially take this away and again these patients are referred to the emergency room, especially after hours. And again, a day doesn't go by that a contact lens patient doesn't show up in the office with an over wear or a condition that would require that they have an antibiotic and our decision is to refer them to a general physician who has less expertise and does not have the equipment or again send them to the eye specialist, the ophthalmologist for treatment. And in my conclusion, I urge the support of a diagnostic and therapeutic bill. I will answer any questions at this time.

Number 0188

Chairman Tischer: Thank you Steve, are there any questions from the committee? Rep. Martin.

Rep. Martin: Madam Chairman, I don't have any question except to confirm a couple of things with Dr. Dobson. We have a West Virginia Board of Optometry of 1981 report and someone has conscientiously updated it to department numbers to the various categories of drugs and the number of patients and so on. But what I like about the West Virginia report and also the Nebraska report is that they show in those areas they have similar problems to what we have in Alaska and that is a geographical problem and economic problem, a problem of availability of services needed by the people and its in my mind that the optometrist, because of the way they develop their professional group in this state of reaching people, going out into the rural areas and provide a major access to providing services that people need on small emergency basis.

Number 0201

And to me, we would be very negligent and not do our duty as legislators not to consider these factors and making it possible for people in the remote areas to receive the best medical available. Some day, some age when the ophthalmologists are

willing to travel to the bush, are willing to go out there and make themselves available to the people, than we may be able to reconsider 10 to 20 years down the road. If a person gets a splinter in their eye due to an accident or a hunter is out there and he or she knows they can see an optometrist near by; than we should help them...best, professional expertise to that individual.

Number 0213

Chairman Tischer: Thank you Rep. Martin, I'd like to ask Mr. Dobson and Mr. Patterson who is sitting here with us a couple of questions; Mr. Dobson if I were to come to you with a piece of dust in my eye, how much would charge me?

Dr. Dobson: I wouldn't charge you anything. The average patient ...brings up the issue of the economics and situation. A lot of patients come in for a routine eye examination at the same time they will mention their eyes have been tearing or redness and may have a minor infection in addition to a visual problem, and to treat that at the same time, the additional fees would be nominal. We have not set a fee schedule for that, we don't have those privileges.

Chairman Tischer: No, I'm talking just about, if I came into your office unannounced and you had time, wouldn't you charge me for an office call? Not just because I'm a representative, but because I live Spenard and am walking up to your place and I need some help.

Number 0230

Dr. Dobson: It would probably determine a number of factors; a standard office call would probably be $25.00, but again.

Chairman Tischer: Thats what I wanted to know, what your standard office call was.

Dr. Dobson: Prior patients, we see them for other care, we see them quite often for contact lens, irritation, various questions they have and again we don't charge every time they come into the office, but I would think that an office visit would be appropriate and that fee again would probably depend on type of service.

Chairman Tischer: Thank you and Dr. Patterson, if I came to you with the same problem, how much would you charge me for an office call?

Number 0240

Dr. Patterson: I would have to agree with Dr. Dobson, if you came in, there probably will be no charge. The routine office is run anywhere in my office from $26 to $45 depending upon what services provided. No one is turned away from my office and the fees are negotiated all the way down to nothing, this is what I interpret as the patient's financial status.

Chairman Tischer: Thank you, Dr. Patterson.

Chairman Tischer: Dr. Ball is sitting here with us also, I think he would like to make a comment before we go on to the next witness.

Dr. Ball: Well, I wanted to comment to the third question of the remoteness, which is also an issue, the remoteness of the people in the bush or in little cities or on islands to good medical care for eye problems. I want to say first all, ophthalmologist do travel to some of these remote areas and I in fact have been and we do go to Sitka, Tenakee, Wrangell and Petersburg and Pelican and places like this to give optical care. Secondly: I just joined Dr. Page so we are able to travel to these places more frequently, and to give you the exact frequency I can't right now since we are in the determination stages on how frequent we can do it with other person covering practice in Juneau, and certainly its not there all the time, but there is no optometrist in Pelican either. They were doing it in rotation basis as well. But I think just to use expediency as justification for less then adequate medical care is not I think valid.

Number 0269

Chairman Tischer: Thank you, I have something to clear up with the committee members, I mistakenly saw the name Josephson on the revisions that we have on file as being Sen. Josephson, that happens to be drafter of the revisor, I apologize for my mistake.

Rep. M.W. Miller: Madam Chairman thats correct, but Sen. Josephson is also the original sponsor of the Senate side with this piece of legislation.

Chairman Tischer: Rep. Martin?

Number 0276

Rep. Martin: Thank you. I'm glad to hear what Dr. Ball said, this is my feeling that because the competition in the field and because we had no ophthalmologist in Southeast for a long time. The only resource that people had with eye trouble besides needing a prescription like I do, the only resource they had as to optometrist for help, there was a lot of good optometrist...I know ophthalmologist they can really help you. I'll make a point, I'll call Dr. So and So in Seattle and I'm very pleased to see that we have specialist here in Juneau and Southeast, and I know the professional people here will establish, optometrist will establish a good relationship once they have mutual touch with each other. And that an optometrist will say, hey, I know of an ophthalmologist in Southeast who is really good, you don't have to travel to Juneau or Anchorage anymore, that's the whole idea; where we allow each profession ... in the long run allow the public to know if your professional people work in hand and glove with each other. I don't believe in there needs to be competition.

Number 0293

Chairman Tischer: Rep. Davis.

Rep. Davis: One comment and one question; last year there was a testimony on this piece of legislation and one optometrist made the comment that when he was traveling in the villages, that the health aides had a lot less training, and they could a lot more things with the eye than they could, by law. Which is sort of an interesting observation, and the other question; what percentage of care in your office is treatment of people with over use of contact lenses?

Dr. Dobson: First of all a comment on the policy about the public health service, I am not a member of the public health service.

I serve as an advisement for the health

service, mainly for pediatric ophthalmology problem, I have also done contract work in the villages doing eye screening and ... for the public health service. My understanding and having talks with specifically with the present Director, Dr. Holly Corshion, that all drugs are dispensed under the umbrella and with the full protection of the license of the ophthalmologist and the Public Health Service. The optometrist were working directly for the Public Health Service, function under this umbrella the Health Aides also work under this umbrella, if this policy has been changed I'm not aware of it. The second question as to what percentage of the individuals in my practice are over wearing contact lenses? I see anywhere from 85 to 120 people a week, on the average probably during that week if there would be 1 or 2 contact lens over wearing syndromes. Most of these are minor, heal quite readily, perhaps I don't even need a topical antibiotic to treat them.

Number 0327

Rep. Davis: Yes, thank you Dr. Patterson, I realize that those health aides in the village would be the under the umbrella with somewhat else, but I just meant on sight they have perhaps greater capability of treatment of the eye than the optometrist, its just a comment that someone made. Thank you for the information.

Number 0331

Dr. Patterson: I think the excessibility to additional advice, and consultation is an important factor there. I think thats why the system has worked so well, either through the radio network or through telephone, either with the regional hospital like in Bethel or even contact with the main hospital here in Anchorage. System has worked for ...its an every effective system.

I think that this is the kind of set up that might be looked at very carefully and maybe some of the good points be incorporated in the situation here in private practice here in Alaska.

Chairman Tischer: Dr. Patterson, it comes to mind a question as to all through the process of hearings on this bill and other bills that are proposed pieces of legislation that deal with other term

medical profession and so forth, the legislature is seeing a real tremendous turf battle here. Thats what I have come to realize, its a frustration on the part of the legislators to accommodate the needs of our constituents and the folks in the rural areas. We find it difficult to manage this turf battle, if you will, and I guess a couple of questions; why the heck don't the professions get a little closer together in resolving some of these types of things in the best interest of the general public? And two; why is it that the general public, I'm asking this specifically of the ophthalmologists, why in the world doesn't the public understand what the difference is between an optometrist and ophthalmologist? It seems to me as if though the profession would be the primary folks that would be interested in making sure thats a clarification to the public.

Number 0363

Dr. Patterson: Without the answer to those questions I don't claim to have a particular insight. I myself, an ophthalmologist, presently because of two excellent optometrist that I had the pleasure of serving within the United States Navy. I deal with my fellow ophthalmologists on a personal individual basis, I deal with fellow optometrists on a personal individual basis, realizing that there are some individuals who are highly skilled, some that are not so highly skilled and than some I disagree remarkedly with. I do not interpret this legislation as the turf bill, granted 5 years ago I did. Realistically thinking and trying to study this, this bill will in no way affect my practice, financially, emotionally or any other way.

So I dismiss it as a turf battle, I have no qualms speaking as an individual allowing optometrist to use certain medications that are listed out as prescribed and those that are given preparation for "diagnostic purposes". I have very marked reservations in creating another class of medical providers using prescription type drugs. I've persisted in coming to these hearings and making my presence known as much as I can because of my own personal beliefs on this latter as ...

Number 0392

Chairman Tischer: Thank you Dr. Patterson and could you address the problem that was mentioned here earlier, the general public doesn't really know the difference between ophthalmologist and optometrist?

Everybody knows the difference between a gynecologist and a pediatrician, but apparently very few people know what the difference is between an optometrist and ophthalmologist, so could you tell us how better you could improve that understanding to the public.

Number 0399

Dr. Patterson: I think the way we can improve is through educational programs. During the last 7 to 8 years, ophthalmologist has been behind the times in their political loxy, its taken us 3 to 5 years to catch up. We have national organizations, our present academy is doing TV spots, they are putting editorials in the newspapers in trying to educate the public. Its been my impression that people are smarter than a lot of us would generally like to give them credit for, I get a fair number of my people referred from optometrist, I also get a fair number of my people referred from themselves, because they are smart enough to realize that they have a major ophthalmological problem as opposed to an optometric problem. One other point, if this were such a burning consumer issue, I'm surprised that our legislative hearing this morning isn't just absolutely packed with consumers. I wonder why there are none present.

Number 0419

Chairman Tischer: Thank you doctor, thats why I think its a turf battle. Are there any questions from the committee? If not we'll go on to the next witness and, Rep. Davis?

Rep. Davis: That was one of my concerns too, last year, it didn't seen to be a big out cry by the consumer with this piece of legislation, but I can understand the general public not necessarily knowing the difference between professions. Some don't even know the difference between a democrat and a republican.

Number 0430

Chairman Tischer: Thank you Mr. Davis, Mr.

Harry Treager please, he is here in Juneau and we ask him to come forward to the table.

Harry Treager: Madam Chairman, my name is Harry Treager, I'm the Director of Division of Occupation Licensing for Department of Commerce. I don't not have a formal presentation to you, I can only tell you that as the administrative support for the Board of Pharmacy and for the State Medical Board, their positions are unchanged from last year, they opposed the legislation. I do not have any of the technical answers for you, as far as your questions in regards to the registration factor, if an optometrist is given prescriptive authority and do they answer to the Board of Pharmacy or do they both answer to the Board of Dispensing Opticians or Optometry, the answer would be, the Board of Pharmacy make the report to the Board of Optometry and the Board of Optometry would have the licensing jurisdiction. Other than that, unless there's some questions from the committee.

Number 0448

Chairman Tischer: Thank you Mr. Treager, is there any legal obligation on the part of the pharmacist to be the watch dog of dispensing drugs from the prescription end of it?

Harry Treager: Madam Chairman, In response to your question, I would have to say yes, because if a pharmacist licensed by the Board of Pharmacy is in violation of their statute which is filling prescriptions or over dosing by prescribing health care professionals, than they are responsible to the Board of Pharmacy, so they would be in jeopardy.

Chairman Tischer: A little more clarity on that, what if an optometrist prescribed a drug that was not in one of those categories like over dosing or the frequency of renewal and so forth, but was simply a request by an optometrist who fills the prescription for a client and the client went to the pharmacy and presented the prescription request, is the pharmacist responsible for what kind of drug that optometrist can dispense?

Harry Treager: Yes ma'am, we had one case as Mr. Rush the Secretary of the Pharmacy

Board pointed out.

Chairman Tischer: No, I'm talking specifically about optometry right now.

Number 0466

Harry Treager: Yes, I'm giving you a correlation between the two, if the pharmacist felt that the drug should not be prescribed he would contact a member of the Pharmacy Board. So, the answer to your question is yes, they could refuse to fill a prescription.

Chairman Tischer: And if they did by accident fill a prescription, lets just say accidentally, maybe they didn't look at the list, for whatever reason they dispensed that drug, and someone else knew that drug should not be dispensed on behalf of the optometrist, wouldn't the pharmacist be legally liable?

Harry Treager: Madam Chairman: In response to your hypothetical question, I have to give you a hypothetical answer. So far, all evidence points out that the licensed pharmacists in the State of Alaska are pretty conscientious and they have not to my knowledge or to the investigating agency knowledge fills any unauthorized prescriptions as you pointed out, as scenario.

Number 0483

Chairman Tischer: I'm not questioning the responsibility or the ethics in terms of dedication to their profession at all, I just want to know whether or not by whatever quirk of an imagination, a pharmacist prescribed a drug that they weren't legally privileged to do and the prescription was filled by the pharmacist to the client, if the pharmacist is going to be legally liable or is it the optometrist who is initially and primarily liable for asking for that drug to be dispensed? That is really my question and it has nothing to do with ethics or their dedication to their profession.

Number 0493

Harry Treager: Madam Chairman, I understood your question, but its hard for me to answer both the optometrist and pharmacist would be held liable to their respective boards.

Chairman Tischer: That's more clearer, thank you. Rep. Martin?

Rep. Martin: Perhaps a statement, in relationship to your question about the concern about the pharmacy board, Number one: Over the years I've been involved in medicine there has been a number one agency that really monitors whether by law or their professional standards what medical professions are doing in the misuse or use ...medical services... so there is going to be a potential abuse, they are going to be the first one to stop it. Also, I think we do have a ...in the FDA and the Medicaid Program, Medicare Program that monitors the prescriptions that go out and here again those doctors in the past who have been guilty of over use or abuses that came to the pharmacy and I don't think they'll hesitate to make sure the optometrist are responsible agencies once it is given to them. So it is not written in law, we do have this agency that above all has been controlling the misuse of drugs.

Number 0499

Chairman Tischer: They are to be complimented. Do you have any more comments Mr. Treager?

Mr. Treager: No Madam Chairman.

Chairman Tischer: Thank you very much, if you will stick around, maybe there's somebody else who might have a question.

Chairman Tischer: We have several more witnesses before we break for lunch, so I'd like to with the committee's permission to go ahead since they were patient with us to wait on the beginning of this hearing. We have a doctor Peter Cannava in Soldotna. Is Dr. Cannava available?

Dr. Cannava: Yes, my name is Peter Cannava and I'm an ophthalmologist in Soldotna here and I'd like to address a few points and I'd like to answer some questions which I felt were left unanswered. One point I think is important, is that there is no human cry from the people of the state for this bill to pass and there's several good reasons for it. One of which is that the people desire

stricter drug control laws, not liberalization of the existing drug laws.

The state already spends a lot of money on enforcing drug laws and tracking down drug problems, we don't really don't in any way and the people don't I gather from their attitude desire any more liberalization over it.

Number two: The cost of medicine is high and the people of the state and the country would do anything to try and hold the cost of the way it is or at least reduce it. And this bill is going to increase the cost, for several reasons; one of this is repetition of service and the second reason is, its going to increase the cost of medicine, its for the mis-diagnosis with the implications which will ensue after that.

The third reason; it will increase the cost of medicine in the treatment of disease and injury because there will possibly ...too long without the appropriate treatment being started. The last reason why I feel that it will increase the cost is that this was ... there's very little difference in charge between an optometrist and ophthalmologist for an office visit for similar service and I think if the people can buy an ophthalmologist visit for $25 and an optometrist for $25 there is little reason to suspect they will select the ophthalmological visit that is the same amount, because the money is buying a lot more. There were some questions raised which I don't think were answered, so I would like to mention to Rep. Davis that well it is true that the health aides in the village and even the EMT on ambulance have ... (noise on tape) responsibilities in certain instances than do the optometrists.

I think it should be realized these paramedical people are controlled by physicians and any time they act they do phone in for permission from physician and are very willing to do this.

Optometrists are very reluctant to be under the supervision of the physicians or hospital and as you can see from the wording

on the bill they resent and are very much oppose to having to answer to physicians, and I think thats an important difference because the health aide issue and the EMT issue is raised so frequently. Rep. Tischer said why isn't the public more attuned to the difference between OD and the MD? And I don't think you run around finding medical doctors advertising that they do things that the optometrists does. But the reverse is very true, there use to be a clear difference between the OD and the MD, because our services were advertised differently. The past few years you will notice that the optometrists are advertising that they perform services which traditionally were performed before by physicians and I think is certainly muddying the water.

The last issue you mentioned turf battle; I think you can interpret somewhat a turf battle and it wouldn't be hard to make the analogy of our feeling with those of lawyers for example; if optometrist said, well we had 100 hours of court law, we want to go to court with our clients and practice law, or if an accountant says, we had 100 hours of court law, we want to go to court and represent our clients, how would the lawyers feel if such were to occur? That's all I have to say. Thank you.

Chairman Tischer: Thank you very much, Rep. Davis has a question.

Rep. Davis: Yes, I just have a quick question, I appreciate your comments. My question is; is there some kind of an agreement, lets say an optometrist has someone in his office and its Saturday and he's in a village, is there some kind of an umbrella coverage where he could than, if is possible that he could then contact...and say look and I have this situation in my office or whatever. Is that a practice that is common or is that even permissible by law?

Dr. Cannava: That's a good question, I think the Bethel situation functions very nicely, we hear the Bethel optometrist do ... (end of tape).

Tape 5, Side 2, 2 of 2
Recording
Number 0002

Chairman Tischer: Thank you very much, would you clarify one more thing for the committee, I thought I heard you say in the beginning you favored the legislation, I would like your position made quite clear to us.

Dr Cannava: I favor the legislation, I'm opposed to the legislation, did I hear you correctly?

Chairman Tischer: We are getting a three time around echo here and I presume your getting the same thing, I'm not sure, maybe someone's microphone is broken or something, now I understand you to say that you do oppose the bill, is that correct doctor?

Dr Cannava: Correct.

Chairman Tischer: Thank you very much for your testimony, we have a Jan Nyboer from Anchorage to testify.

Number 0011

Moderator from Anchorage says there is an echo on the line.

Number 0020

Dr.. Jan Nyboer: This is Dr. Jan Nyboer speaking, I'm a forty-one year old ophthalmologist, certified and I have been practicing in Anchorage area for the last 8 years. I might just briefly mention you my background; aside from my degree from college, I have received a Masters Degree in Physiology and Pharmacology, I have aside from the 4 years of medical school have received additional year in internship training at a 4 year residency training in ophthalmology at the Mayo Clinic.

One thing that pressed me about our speciality is that I like optometry, ophthalmology is a branch medicine and I feel optometry since it is not a branch of medicine can just further confuse this matter. Our background has done in training has been closely integrated with clinical experience in knowledge and pursue this knowledge that we are able to gain knowledge which really bring us to day really defending our position as ophthalmologist. We are proud of our profession and realize

what we can do in terms of the public service.

The medical point that I'm opposing is the use of drugs by the optometrists is this; the eye can not be treated apart from the rest of the body, statement by Dr. Patterson earlier mentioned 95% of all the eye problems can be diagnosed and treated by pen light or undilated pupil carefully history .... Yes, we do dilate people's eye in our office but we are interested in giving that last 5%. Now before, ...for a general exam, perhaps you could be surprised what we could tell you about your eyes, and again I mention that we are concerned more than just the eye.

A similar local complaint could indicate that something else is wrong and perhaps I would be able to tell you that you have early signs of diabetes, hypertension, early signs of multiple sclerosis, brain cancer and brain tumors, maybe thyroid ... disorders, or even a surgical problem. Its hard for me to even imagine what my background knowledge without having this intensive integrated clinical experience in the past, even began to guess whats going on with these situations and for this reason, sometimes I have to consult other physicians and colleagues to get further answers.

Number 0054

In short, when I'm looking through the eye, looking at the back of this its not that we are just ...(noise on tape) computer print out of what we see there, its an analytical procedure considering all the possibilities drawn and all the general medical knowledge in training and clinical experience. In terms of the drugs being applied to the eye, it is well known that it enters in the blood stream quickly and ...the problems of some of these drugs have the potential to stop the heart, stop breathing, cause seizures and could even blindness... and what physician is going to want to cope with these types of questions. Now some of the optometrists in Alaska who want the privilege of using diagnostic and therapeutic drugs for their clients and I say some because they are not all in agreement that they want this. It has being denied in the past by all previous Alaskan

Legislators, but it is re-attempted every year. And with this privilege, comes responsibility, but how can one be really responsible without the knowledge, even general physicians here in town and emergency room physicians are aware of their limited knowledge and the potential hazards to the patients.

They are intimidated by a good percentage of these cases they have and so they do call us for consultation immediately, eye sight is too precious and too perishable to laws, however well, their intentions may be that could result in permanent loss or impaired vision. So if I can by my position here against this bill can say that by opposing this bill, I feel that I have won, because I'm a long term thinker and not a short term immediate gratification thinker.

Now, considerations further on this, dilations for treatment of course have certain dangers and we don't need to get into that, how does the optometrist really know what he is treating without that indepth knowledge, when does he decide to refer the case, what if he never does refer the case.

Number 0085

I can tell you from my experience at Mayo Clinic, we saw interesting cases from all over the country, I can go through several horror stories regarding delayed referrals and situations like this and who pays double or suffers...(noise on tape). So, the optometrists have the right to use free enterprise, but there are some things I feel they don't have, basic college degree, medical training, clinical experience, they are not educated primarily by ... they do not have hospital privileges, many of them do not have a follow through program, after the patients referral for which they can learn from the past patients and many of them do not have rapport with other ... for advise. There are some things that I feel the optometrist should not have; I feel they should not receive support in the national campaign to get something for nothing, they want the MD's image without 24 years of schooling. They want to re-educate the public by PR rather than further educating themselves, they want their patient's trust

without taking the responsibility. I am not in favor of any compromise bill, I may sound abrasive, maybe we are dealing with a ego problem or a financial marking problem looking for legal license, but please don't give it to them. Thank you.

Number 0107

Chairman Tischer: Thank you Dr. Nyboer, I would just like to make a comment from some of the comments which you were making. As little similarity to the bill before us in terms of the expansion that you talked about; one of which is the hospital privilege and so forth. I would not want anyone to be misled by the some of the testimony that you have given, although you were justifying the Doctorate that you hold in order to practice medicine. I do have a question; the frequency in which the other states allowed prescription drugs to be dispensed and prescribed by optometrists, can we have approximately 35-38 states who's citizens are now jeopardized if you will, according to the ophthalmologists' position in terms of their eye health. Do you think that is a menace mistake, that 38 states have already made and how do you compare that with those that have not so far, thats about 2/3 of the entire 50 states.

Number 0123

Dr. Nyboer: Well, you know, two wrongs do not make a right, I feel that I can't really in terms of the numbers I'm not prepared to ... those numbers, only to say that, someone would like to give me some testimony from ophthalmologist and basically check the fruit on the tree and talk to the people that are in the middle of the system and namely the ophthalmologist and feel how happy they are with the situation. I really don't know.

Chairman Tischer: Thank you doctor. I think the main concern of this committee is to make sure that there are provisions for the general public for their protection of health and welfare, and also, on the other hand to make sure that there isn't a corner on the market, if you will, on any specific thing. Not just dealing with the paramedical profession. This committee is concerned and will deliberate on those issues as best as we know how and the advise from the professionals and legal

professionals that we are able to garner. We have one more person to testify, unless there are others out there, Mr. Center from Anchorage and is that person still available?

Number 0142

Mr. Center: My name is Thomas Center, M.D., I'm a board certified dermatologist who has been in practice in both Anchorage and Fairbanks, and am going on my third year. I also am informally an emergency room physician, approximately 7,000 hours I've serve in various emergency rooms across the country. I have not practiced that sort of medicine since coming to Alaska. I'm here this afternoon for two reasons; one as an individual physician, and the second; is in my capacity as President elect of the Anchorage Medical Society, the later capacity I would like to inform members of the committee that the Anchorage Medical Society unanimously indorses the resolution firmly opposing this bill. As an individual physician I just have a couple of comments to make and than I will be done.

Number 0156

The first that I have is; I wonder what need there is for this proposed bill, as being pointed out by a couple of the other speakers this morning there are no consumers present in this room and I would be curious to see how many consumer patients are in the other rooms around the state. Secondly: Again to repeat that comment made earlier by both Dr. Patterson and Dr. Nyboer, the 95% of eye complaints can be handled essentially with very little hands on medicine and no drugs, I think is a very good one to keep in mind. However, back in my experience as an emergency room physician, most problems that I saw when I was in the emergency room were referred on to an ophthalmologist, because I felt even with two months of clerk-ship as a medical student and then as a resident in dermatology, I did take a month of ophthalmology because I felt that there was enough correlation between the eye and the skin and that I should broaden my knowledge in that area. Even with those two months I felt I still felt uncomfortable, particularly I worried about the last 5% that Dr. Nyboer so eloquently talked about.

Number 0171

The second concern that I have; is really

related to the first, in addition to the need I wonder about the possible harm that could be brought upon the patients of Alaska by giving a group of people who not really have the training or background to handle some more sophisticated drugs that I can see possibly could be included in this generic list thats been offered. Let me give you a couple specific examples; and again I am not an ophthalmologist. I wonder about someone as an optometrist being allowed to prescribe a drug such as demoral, this is a drug which is a ... blocker, what little I know about the drug and is used in ophthalmology, is that its marvelous, it helps to control glaucoma, however, like any good drug it has side effects.

From my emergency room background, I know that such a drug in that class precipitate a case of asthma, and what would the optometrist do if he were to prescribe this drug if he were in the bush somewhere, (loud noise on tape), even more alarming to me would be an ... reaction, a person could get from topical neosporin, if put in someone's eye rapidly absorb in the system where the patient could suffer from complete cardiac arrest and die. I would like to ask the members of the committee, would you like to have that resting on your conscience, I'm done, thank you.

Number 0189

Chairman Tischer: Thank you Dr. Center, any questions from the committee members? I'll repeat a question that I had for the previous witness. Whats your feeling on the measure of success if you will, by the push if you will, the optometrist throughout the country successfully presenting arguments and obviously new legislation was initiated and about 38 other states regarding the dispensing of prescription drugs. Whats your opinion about that?

Number 0195

Dr. Center: Again, this is my personal opinion, I think that the optometrists in those states must have good lobbyists and I don't think that their legislatures in those states are good as ours, furthermore, thats one of the reasons I came to Alaska, because I felt that the lawmakers were a little more inlightened and would protect the public with far greater expense than the 38 states

where the optometrists are allowed to prescribe drugs.

Chairman Tischer: Thank you very much doctor. Dr. Ball has a comment.

Number 0202

Dr. Ball: I would like to make a comment to your questions, specifically to clarify in those 38 states that have given the optometrists the right to prescribe drugs, it is only three states that optometrists have the right to prescribe drugs, the other 35 states have the use of diagnostic drugs in their office.

Chairman Tischer: Thank you for that clarification, Dr. Ball. Are there any other witnesses out in the field that wish to come forward and testify before we take a recess for our next bill.

Number 0210

Dr. Jim Graves: Hello, this is Jim Graves, optometrist from Fairbanks, Alaska, Fairbanks Medical and Surgical Clinic. I'm back in this year to state my position on this legislation, I went to Pacific University College of Optometry with a grant from the State of Alaska, and this was sponsored in part by WICHE, as with Dr. Dobson. When I went to Pacific University and was also involved in elective for sensor ships, such as, at the Yukon-Kuskokwim Health Corporation and Seattle Indian Health Board, I studied both diagnostic and therapeutic pharmaceutical agents, and much of that study was done in a clinical study. Since my schooling I've come back to Alaska my home to practice, being a resident in Alaska for 15 1/2 years, I wanted to establish an optometric practice in Alaska even though I knew relative to what I learned in school, and being ... to optometry to practice I would still be able to practice limited optometry.

I feel that those who will benefit most by the passage of this legislation would be the patients themselves. When applicable, they'll have the same appropriate services as provided by ophthalmologists, by optometrists without extra expenditures.

I'm not concerning myself right now with the difference between fee amounts, but the fact

is whenever you have to go to a second doctor its going to cost you a second fee. I would also like to mention the importance in the extra time off that a person must take off to go to an ophthalmologist for a second evaluation.

Also, I would like to ask Dr. Patterson before he changed his position on the use of diagnostic drugs, Dr. Nyboer and Dr. Center, what about the other 5%, the extra 5 out of every 100 persons, that may have a serious problem with their eyes that could potentially be blinding. If optometrist are limited to such that they have just those clinical evaluatory tests to make without the use of drugs, would they than, as you mentioned have 5 out of every 100 that could potentially go blind, whenever they could go to that primary health specialist? Thats all, thank you.

Number 0252

Chairman Tischer: Thank you. Are there questions from the committee members? I have a question or comment, and it deals with your educational background, specifically you mentioned in regards to study of dispensing drugs and so forth. I need to have some clarification on that as far as individual's concern, when you go to school and are studying to become an optometrist, how does your education and requirements compare do that of an ophthalmologist in dealing with prescription drugs in dispensing and administering that, please, if you have that information.

Number 0258

Dr. Graves: Ma'am I feel that could be best addressed by a committee member relative to this legislation.

Chairman Tischer: I'm not sure what you mean by that.

Dr. Graves: Thats a committee member meaning an optometrist who is on the committee to follow this legislation through.

Chairman Tischer: You are talking about optometrist committee, you are not talking about the legislative committee, is that correct?

Dr. Graves: Yes ma'am.

Chairman Tischer: Do you have someone in mind?

Dr. Graves: Well, I think Dr. John Demsky is one, Dr. Steven Dobson would be another one.

Chairman Tischer: Thank you, are either one of those gentlemen present yet and if so, would either one of them come forward and try to answer my question?

Number 0270

This is the moderator in Anchorage, Mr. Dobson is no longer present at the Anchorage center.

Chairman Tischer: Is Dr. Demsky in Soldotna available?

Dr. Dobson: Yes I am.

Chairman Tischer: I will restate my question as best as I know how. I'd like to know from somebody when an optometrist or one who is wishing to become one takes their training and scholastic education on drugs and prescription drugs and such as that.

How does that prepare with an ophthalmologist's training, is it optional in terms of what is studied and is there amount of time that must be is mandated for comple[illegible] and certification of your educa[illegible] What is it that is different from optometrist and an ophthalmologist? Co[illegible] you tell me that?

Number 0283

Dr. Dobson: I can try. I graduated over 10 years ago and at that time there was only (1) state that allowed any optometrist to use drugs, so my pharmacology training ends in formal optometry school is very limited.

I had a (2) hour course in most of the training I received and since than its been post-graduate or just about all of it. Now all optometry schools have a minimum of 110 hours of ocular and systemic general pharmacology and courses they also have labs for using those drugs. Ophthalmologists receive their diagnostic training in medical school and they received much more intensive training and clinical use of therapeutic

drugs, most optometrists schools work jointly with other medical schools or with pre-sensorships, inter-ships such as Dr. Graves and Dr. Dobson mentioned, or their therapeutic use of medicine. Did I answer your question?

Number 0299

Chairman Tischer: Yes, you did in part, what it sounds as though, sounds like there is going to be any measure of relaxing, you would have to have examination to decide whether or not an individual qualified and knowledgeable versus their training and their clinical experience in dispensing drugs and application, thereof, am I joined the proper conclusions?

Number 0304

Dr. Dobson: Yes, I would not want any grandfather and if this bill is passed, as a board member we intend to examine everyone who wants to use drugs.

Chairman Tischer: Thank you, Dr. Ball, do you have any comments on that? Could you help us out with that a little bit?

Number 0309

Dr. Ball: Yes, initially I'm a little confused that somebody who admittedly had so little training initially and than only in post-graduate courses later is going to be the person deciding who has adequate training to dispense drugs under the present proposed bill. And to answer your question; as was pointed out just before, in the past optometry schools have not covered pharmacology or only in just a little cursory lectures at present they do require two semesters of pharmacology, as do medical schools require two semesters of pharmacology, but the big difference is after that, thats in second year of medical school for the next 6 years theres the practice of pharmacology in human subjects, it marks the difference between an ophthalmologist and optometrist.

Chairman Tischer: Thank you for your help Dr. Ball. Are there any other witnesses out in the area that would like to testify?

Number 0332

Dr. Demsky: I would like to further clarify that, in regards to Dr. Ball's comment about our limited knowledge, we certainly intend to use all of the resources available for

writing the exam and for giving the exam, as the other three states do, who now use therapeutics. Our national board is in the process of writing a written national exam for pharmacology and pathology for those states who have the use of therapeutics.

Chairman Tischer: Thank you, as that exam is being written, what assistance from the medical profession are you aware of in creating that examination?

Dr. Demsky: I believe there are specialists and authorities, especially in ophthalmology who will be assisting in the writing of the exam, however, since I'm not associated with that board, I cannot answer that, not 100% accurately.

Chairman Tischer: Thank you, would you be able to assist this committee by giving contact that we might secure information that is desirable for committee members regarding that national test? Is there a contact, is there a board, office telephone number or address that you might request that information?

Dr. Demsky: I believe there is, I don't have that with me, but I could send it to your attention, if thats alright with you.

Chairman Tischer: I would appreciate that very much if you could, are there any other witnesses that could wish to testify.

Moderator: Rep. Tischer, this is Anchorage and Dr. Patterson would like to make additional comment at this time.

Number 0348

Dr. Patterson: Rep. Tischer, in one of the references that I alluded to in my original testimony is by Dr. Pearson, specifically looks at the curriculum with the number of hours of study in pharmacology and comparing optometry to ophthalmology, this study was published in '77,

I have included it in my packets that I've sent before, I will do so after this testimony, but Dr. Pearson ... lives 126 hours of pharmacology being standard or average in the optometric schooling contrast to rather marketedly to 200 hours in the

ophthalmological training with additional 3 years of clinical experience with 148 hours of ocular pharmacology. Pathological training; study of pathology, specifically 60 hours optometrist compared to better than 200 hours, so approximately 3 to 1 would be a conservative estimate, difference in hours devoted to study, and like I said earlier, I would be sending you this with the letter, Thank you.

Chairman Tischer: Thank you, Dr. Patterson. What I'm attempting to do here is to secure enough information so that the second bill might be drafted, if that is the wish of the committee, to make sure that guidelines that are provided for in the legislation so that all areas are protected, but all areas are equally addressed and thats the reason for my questions and request for information. It is not the wishes of the Chair that this measure goes unaddressed, on the other hand we are very cognizant of the dangers involved in exercising legislative powers over an area that none of us have the expertise to do, we are hopefully going to garner as much information from the professionals as possible so that we can make an intelligent judgment as to what decisive action can be taken in fairness to all.

I just want to insure those that are still listening that I'm not interested in ram roding this legislation through with eyes closed, on the other hand I'm not interested in preserving a turf that may very well be expanded carefully and with consideration for the benefit of the general public as a whole. So, thank you very much for those of you who have put the time in testifying and again, my apologies for the lateness of the beginning of this hearing, with that we are going to recess for 20 minutes so that committee members can grab a sandwich and be back at 1:15 p.m., to continue the hearing on the next House Bill. Thank you very much. Recess.

Tape #6, Side 1, 1 of 2
Recording
Number 0002

Dr. Jay Bonner: ...well I first can't answer your number of the ones that have been misdiagnosed, the majority of patients that

I am seeing now are referred by another physician because they see my expertise in the field of phrenologist because they either didn't know they had ... problem or they were questioning what type of problem they had. The majority of these are legitimate questions, many of them don't have questions that are being asked; example, they refer a patient to, since we are talking about adrenal problem, does this patient have ... disease. I think that the question that they are asking you is legitimate many times, this is a rare disease many times they don't have it, the question they pose is; legitimate and so that...(loud noise in background). The naturopath owe them one patient that I can think of it not directly referred to me, the patient from the naturopathic physician came on their own. So I just want to be more specific.

Number 0014

Chairman Tischer: Thank you doctor, that answers my question very nicely. I appreciate your comment. Lets see, I think we have, we need to go to Mat-Su now.

Number 0017

(anonymous) ...and I'm a mother of four children and I would first like to make a statement, that I and my husband are in favor of the House Bill 347 for the licensing of naturopathic physicians, and I feel it is our constitutional moral right to chose the kind of doctor and treatment that we feel that is best for ourselves and our family. Naturopathic treatment has helped me in Alaska, Oregon and Utah, when other types of treatment could not.

I feel that highly trained and skilled naturopaths in our state would be an advantage to us in our community, and also to ensure that naturopathic medicine will be practiced responsibly and professionally, so I would urge you to support this bill.

I would also like to say that I've had one child in naturopathic clinic in Oregon and I had two children at home with naturopaths, I had one in the hospital and I have always had very professional care and felt very comfortable and I would also have another child coming and I would definitely want to have it at home and have that choice over

the hospital. I feel that its helped many women who had children at home for the naturopath and they never had complications or problems, and when they had, the naturopath was able to take care of them responsibly and I also like to state that you mentioned before that the reason we didn't have a Board of Naturopath before was there wasn't enough people, there was only 3 or 4 practicing in Alaska.

If this wasn't passed than what would ensure that in the meantime we would be able to practice according to the ...of our conscience ...that there was not a board to regulate this and I would just like to urge you to pass the bill and put my support and my family's support on this bill. Thank you.

Number 0036

Chairman Tischer: Thank you, I have a question, as a mother of 6 children who were born 5 different births, I have twins, you and I can have a private conversation here if you would. One of the doctors in her earlier testimony, I don't know exactly who it was, had indicated that there are times that during childbirth as you and I both know, there is usually surgical procedure to arrest the stretching of the vagina for the child to pass through, sometimes that tear reaches a long way. Have you had that experience in your natural childbirth, whether it be with a naturopath or midwifery? How was that handled, did the naturopath do the surgical stitching or what happened?

Number 0046

...Yes, my first child was 8-lbs, 14-oz and I did not have a surgical for the baby to come through and there is a procedure by messaging and by helping the baby to come through that this is not necessary. I had all four of my children without any risk or care without any surgical tear and I just had a baby that was 9-lbs., 10-oz. also.

Chairman Tischer: Boy, you beat me about 3 oz., there. Thank you, I would like to go to Fairbanks and than we have one witness here in Juneau.

Number 0054

Shirley... in Fairbanks: I would like to speak for Sheila Baker who could not wait,

she had to be back at work, so this is her written statement that I will be reading:

As the former owner of a health food store many people who are not helped by standard medical procedures were helped immensely by a naturopathic doctor in Anchorage. I myself have been, and feel very strongly about being denied my rights to use the type of medical care I want. A woman I know had a tumor on her uterus and the medical doctor wanted to remove the tumor which would result in the abortion of the baby she was carrying, she asked me what to do, and I said, if I were she I would go to the naturopathic doctor in Anchorage, which she did. Not only did the naturopathic doctor dissolve the tumor with treatment, but the woman gave birth to a beautiful, healthy son. And on my own, I strongly support House Bill 347 for my ... for naturopath and I think that one of the important things that we looked at today so far is that keeping these people and other alternatives, health practitioners in the closet will not help people get healthy. All we'll do is help people practice fearfully and without more information in the public and its very important that we let more people know that alternative help is available without leaving the state, and that we make here quality alternative help available to anyone who desires it. Thank you.

Number 006? Chairman Tischer: Thank you very much, and now from Juneau we have Mr. Treager.

Number 0064 Harry Treager: Madam Chairman, my name is Harry Treager and I'm the Director of the Division of Occupational Licensing for Department of Commerce. I am just here to answer any questions the committee might have. I think that possibly I could offer some assistance with a difference of license and ...license activity, without the state license sanction. Its been my experience from the Attorney General's Office that without a license doesn't mean that the practice can't continue.

The license moreless legitimizes the profession, but any profession would carry over to another already licensed profession is where the problem starts to exist. And I

think from hearing some of the testimony this afternoon. (problems on microphone, Anchorage couldn't hear the testifier).

Harry Treager: Again, Rep. Tischer, its the licensing or unlicensing function, its because one occupation or profession is not licensed does not prohibit that occupation from proceeding, its when they carry over areas of those already licensed; such as naturopathic healing to medicine, thats where the problems become complicated. Our position is that we are not restricting anyone from seeking what ever care or treatment they desire. Its just that cross over situation that complicates the issue, and I think one of the things we would have no problem with licensing naturopaths, I think our problem is with defining the scope of practice.

Chairman Tischer: So, its really a turf that we are protecting in a licensed area and a non-license area, isn't that correct?

Its kind of like truckers that in some places they are required to be licensed to do certain things and travel certain places and where somebody else gets into their area there is a complaint, because they are infringing on, I think its the same thing as professions. Am I reading this correctly, Mr. Treager?

Number 0095

Mr. Treager: Madam Chairman, I don't think I'm qualified to on the turf protection issue, you could also say turf protection and try to become licensed also. It sounds to me more like a legal question, but I just encourage the committee to give something in the scope of practice that you would want me or for the state to follow.

Number 0100

Chairman Tischer: Thank you, Rep. Uehling has a question.

Rep. Uehling: One of the questions that I had, do we have an idea to exactly how many naturopaths we have in the state right now and what we are talking about as far as numbers?

Mr. Treager: Rep. Uehling, the last knowledge I had was two; Dr. Pettyjohn in

Anchorage and Dr. Jamison here in Juneau.

Rep. Uehling: A follow-up question, what you're saying is we have a couple of people, it sounds as if have other people to testify, but there is no licensing structure, there is a licensing structure now?

Chairman Tischer: There is no licensing structure, Rep. Uehling, for naturopathic medicine and I add to Mr. Treager's comments that even as of late last year there was testimony and you will see it in your minutes that there were two practicing naturopaths known, there was another naturopathic practitioner that wasn't practicing that medicine because there was no licensing procedure. There are also several chiropractors that are trained as naturopathic physicians, but are practicing under the licensure of chiropractic.

Rep. Uehling: Than I will also follow a question on that, so in other words if we were to license them, what is that potential number that we will actually have, obviously there is a lot of report there from the stand point of people testifying, but what is the potential number that we are going to license?

Chairman Tischer: There has been a request for that information and all that I have been able to determine is that, there are more that would attempt to be licensed if there was a provision for that so that they could legally practice and there has been a request to establish a board for naturopathic medicine and it has been suggested that perhaps we might make a provision within this legislation, that when the numbers reach, lets say (6) that is an automatic trigger to establish a board for examination of licensing. But until that time, although there has been objection by a number of witnesses, that the Department of Commerce and Economic Development be the overseer until that time occurs, but the objection comes from the fact that there is no expertise in that department literally do the licensing and examining, because they don't have the background.

So it would have to be some input from some place or some content within this legislation to establish guidelines by which the department could establish their examination criteria and thats what the original bill attempted to do, to give that guideline and seek that input. Tt is definitely addressed and we might want find ...so that it provides the guidelines for the department of temporarily at least, to do exactly that. I'm sure that the profession itself probably would be instrumental itself in assisting in that and I sure would be glad to and as well as consultation with the medical profession in order to make sure that the general public's protection is at hand.

Number 0140

Chairman Tischer: If there are no further questions from Mr. Treager, than I'd like to go back to Anchorage again and take the next two witnesses.

Diane McDermott: Hello, I'm here to speak in favor of House Bill 347, my husband wrote this editorial and it explains our feelings on this matter. (loud noise on tape) ... my wife and I were informed by our pediatrician that our son would have to be kept on three very strong drugs and a series of allergy shots for several years. (loud noise on tape).

Number 0168

Chairman Tischer: Thank you very much Diane, I wasn't able to hear you as clearly as I'd like to have and I'm going to ask the committee members if they heard. Otherwise we could perhaps ask LIO to transmit your testimony written so we could make it part of the record, just for clarity, if you could do that Diane, we would be very appreciative. Thank you and I would like to have the next witness in Anchorage.

Number 0173

Moderator in Anchorage: Rep. Tischer we have Julia Reinhart from Anchorage next.

Julia Reinhart: I have had a relatively short experience ...very pleased to say that I've experienced. First of all, there's been some questioning of the training that naturopaths receive. In many cases a patient does not even know what to ask the regular physician as far as their training

is concerned, we don't know what to ask a doctor, do you know how to do this medication, all kinds of ways given, will you show me? Do you see what I'm saying, we don't even know what to ask the regular doctor in his training. What it comes down to is the patient's responsibility to establish individual trust in whoever is treating him. There are incompetent physicians, even with all their ...regulations, boards and so forth, licensing or requirements that they have to meet. So I think first of all, I want to continue to be able to go to naturopath,

I'm sorry that there are so many licensing requirements in effects of life, but if this bill is required for my naturopath to continue practicing, I am in favor of it. If someone is concerned about the care that they are receiving whether from a naturopath or from their regular doctor it is up to them to ask questions and establish the trust in their care giver. Thank you.

Number 0195

Chairman Tischer: Thank you very much, Julia. Are there questions of the committee? Hearing none, I'd like to go to Mat-Su and take another of their witnesses please.

Debra Lucas: I'm a patient of Dr. Pettyjohn. When I came up here almost two years ago I was 8 1/2 months pregnant, when I was down in Texas my doctor told me I would have to have a Caesarean. When I got here I couldn't find an OB doctor to take me, so I was referred to Dr. Pettyjohn from my brother-inlaw and he told me that there was no complications why I couldn't have my child naturally and have it at home. I had my son at home and I was in labor for 21 1/2 hours, my son did rip me with his shoulders, Dr. Pettyjohn took care of me and I've been going to him ever since. I'm 6 1/2 months pregnant now and I wouldn't go to an OB doctor if it was the last thing to do, that would be the only way I'd go. I am for this bill and I think it needs to be passed and I agree with everybody that is for this, I think it does need to be passed. It is our opportunity to have the choice of who we want to go to and who we don't want to go to. Thank you.

Number 0213

Chairman Tischer: Thank you Debra, if I may ask you a personal question, can you and if you care to answer tell me why you weren't acceptable as a patient to an OB doctor, under what conditions did you seek one?

Number 0217

Moderator in Mat-Su: Madam Chairman, your coming in very badly and we could not understand your question.

Chairman Tischer: Thank you, I'll try again, please identify if I'm coming through better; Debra, could you tell me if you would please, if you care to answer, why was that you weren't accepted by an OB physician and by what criteria did you try to select one when you first came here?

Debra: Yes, I was referred to three different doctors and I won't give their names, but none of them wanted to take me because I was so far along and didn't want to take the risk. When I left Texas I had my medical records with me, blood tests and everything so that if anything did happen to me or if I had to go through the emergency room I had all my paper work with me.

Number 0231

Chairman Tischer: Are you saying that because of your risk that they didn't want to attend to the birth of your child, is that what you are saying?

Debra: I don't understand that question, please repeat it.

Chairman Tischer: I'm trying to figure out as a mother of (6) how in the heck did a doctor turn you down if you went to them for assistance in the attempt to have your child, if they turned you down and wouldn't accept you as their patient.

Debra: I was told that I was too far along for them to accept me and I don't feel that was right if they are an OB doctor they should be able to take anybody no matter what risk they have.

Number 0242

Chairman Tischer: Thank you very much for your candid remark, Debra. I would like to go to Fairbanks for the next witness.

Efrin Resume: This is Fairbanks and I am Efrin Resume and I have a few points to bring up: One is that I was raised in New York State and at that time the chiropractor profession was not licensed, as a matter of fact it was one of the last states not to be licensed. Now I was raised and my family on chiropractic care and naturopathic care and so we were very involved in what was going on there. At last (the AMA in New York State by the way was very strong), they realized that some licensing was necessary and what they tried to do in my opinion was have chiropractic license with the greatest limit possible and so chiropractors were licensed there even though it did take them a very long time. It seems to me that licensing is the only way that doctors in this state can answer their own questions as to the professionality and still of the naturopath.

The other area I would like to address; that since I've been in Alaska for the last 15 years, I have lived a great amount of time in the bush, as a matter of fact 11 years ago and a couple of days, I delivered my own daughter in a cabin on the Yukon River and I have not had any specific training in any of these areas that we are talking about. But I did try to get as much advise as I could and I have talked to many of the people living in the bush in the Interior of Alaska and I have not found yet one person who was not very interested in naturopathic medicine and was not followed and tried to get advise in those areas.

So I think that there is a great need for when one was in the bush one might have a radio and one may be able to get a plane called in or have a plane, but basically the many situations even in a village, prevented medicine is crucial. This isn't enough time in many circumstances to get to the doctor, so many young people come into Alaska and wanting to be away from the city vendors have had a great need to learn and to get by as far as keeping their health and keeping the health of their families safe where they do not need surgery or do not need to get to a hospital. Naturopathic medicine is that alternative, that helps people learn more about their bodies and do care for

themselves where they will avoid having to have the use of a hospital. So I am very much in support of HB 347. Thank you.

Number 0284

Chairman Tischer: Thank you, are there questions of the committee. Hearing none, I'd like to announce that because there's at least 15 or 16 folks at the Anchorage site still waiting to testify and I am going to take 3 at a time from Anchorage, than alternate to Fairbanks and back to Anchorage or the Mat-Su so that we will give equal time to every one before they decide to leave.

Number 0293

Steven Cox: My name is Steven Cox and I reside here in Anchorage, and I would like to state a few facts; my opinion for passing HB 347, it is my belief that people in the United States are ...(loud noise in background) ... for the American Medical Association and through this we had very little choice as far as what type of medical care or health care we need to have. (loud noise on tape). I feel it is very beneficial and has come a long way ... but I also believe that our nation also needs more emphasis placed on life saving medicine which naturopathic practitioners provide. (loud noise on tape)

Number 0336

Chairman Tischer: Thank you very much and could we have the next witness from Anchorage, please.

Number 0337

David ...: My name is David ... I am speaking for myself and also for my wife, I've been a patient of Dr. Pettyjohn since when he first began his practice in Anchorage and I have never had any cause to regret that my family has been under his care, what I'm basically saying is that I'm very much in favor of this.

Three doctors here have said they have no objection to alternative health practitioners practicing, but they don't want to see any kind of licensing which to my mind is they are going to give us our choice, but they are going to deny the practitioners the right to provide us what we want and thereby, make us incompetent in what is now perceived as a crime, practice of medicine without a license. They are

denying the practitioners the right to provide them with care that they would give us, there seems to be a growing body of evidence that a lot of the practices, methods and really the entire focus of the "traditional medical community" are inappropriate or based on assumptions which have not been proven or just plain don't work. So I think that we really come down to a question of attitude and approach, prevention versus treatment of symptoms helping the body to heal itself versus intervention with drugs, which often have many unpleasant side effects and also often inappropriate and unnecessary surgical procedures.

I feel that naturopaths need to be licensed, I would hope that would be just the beginning, I would like to see a licensing procedure established for mid-wifes. I'd like to point out in Holland the OB courses are taught by the teachers of the national mid-wives' school, the mid-wife in Holland teach the doctors how to do their jobs, because it is perceived in that the country that the mid-wives know more about what they are doing. My own child was born with the services of a mid-wife and I was present there, there were no complications of any kind for which I would say that we were blessed, but the attitude of the mid-wife that dealt with us and the attitude of all the mid-wives that I talked to is one of constant vigilance to possible trouble and they have fairly strict series of guide lines so that if you don't fit within the practice of their requirement they won't do the delivery, they will send you to the doctor or to the hospital. They know what their limitations are and everything that I've seen says they are eager to operate within their limitations. I would say this an attitude that characterizes all the alternatives of practitioners which I dealt with and I recommend that this bill be passed into law.

Number 0401

Chairman Tischer: Thank you very much David, and more witness from Anchorage, hold on just a minute, Rep. Koponen has a question.

Rep. Koponen: Thank you Madam Chair, the

question I have is in regards to mid-wives, do you happen to know how many mid-wives there are in the different categories?

David: I don't understand what you mean by categories.

Rep. Koponen: Well there are nurse mid-wives or plain mid-wives or nurse practitioners who are mid-wives or in other words if there are people who aren't MD's who do attend childbirth and I'm just wondering if you have any notion how many types of mid-wives there are, or how many gentlemen, mid-wives. I heard a number of mid-wives in practice and I was wondering how they were in practice.

Number 0416

David: Well, mid-wives that we dealt with was a nurse mid-wife, her education was in England and she immigrated to the Unites States and she went through a re-accredited program with a college on the east coast, I believe Boston. I've known mid-wives that fall into all three categories, I would say that they are all characterized by the same kind of attitude toward what it is they are doing, they are dedicated people who are trying to see the best done with the least amount of intervention possible, more by allowing nature to do the job, than to force issue.

Number 0428

Rep. Koponen: Do they have difficulty in practicing that you know of?

David: Yes, there is a great deal of difficulty in practicing, I've known several mid-wives who were given good service to their clientele who have been harassed by medical community, have met with open hostility in attempting to make referral.

I've heard of comments from the medical communities if they chose to go the mid-wife that you are stuck with it, we aren't going to help you. And I know thats a ... for me to say, but I have witnessed such a thing to happen.

Rep. Koponen: In light of that, which do you think is the more immediate problem, licensure of mid-wives or licensure of naturopaths?

David: Frankly, I would seem them as equal necessities, there's an immense growing number of community people who are teaching the natural methods of health and the naturopaths and the mid-wives have received ... in the same basic category of health care, it comes down to the question of specialization as you find in the more conditional medical community.

Rep. Tischer: Thank you very much, we have one more witness from Anchorage.

Number 0454

Karen Red Stone: I'm here to testify for this bill, I've looked around at these three doctors that gave their testimony and I must admit admit that I was rather upset by the last, I wished that I had taken enough notes that I would be able to counter some of the claims that she made, and I feel sorry that the women who have gone through .., as she has gone would deny the naturopaths who have also the same amount of college and medical schooling. The doctors I saw here in town were willing to use drugs the first couple of months to help me with the ...to prevent premature labor, none of them wanted to check into the background of why I was so ill for a couple of months except to tell me that it was in my head. And I'm sorry, but I couldn't buy that, I did see a naturopath, I worked with him for 9 months, became pregnant, I was 15 pounds underweight at that time, the first 3 months of pregnancy, I found myself hospitalized both previous pregnancies, this time I did not, I gained 15 pounds, brought my weight up for normal pregnancy and continued on. In the spring I had dilation that occurred at 20 weeks and continued dilating up until I delivered my daughter, who was born 4 days before her due date. She was the only baby that I had that I could carry full term and I must remind you that I lost two besides the two that were premature, both came from going with the medical community.

I have a daughter who is 5 1/2 years, who tends to have nosebleeds, I have medicine for her that says prescribed by naturopath, if she takes two pills every two minutes for about five minutes, her nosebleed will stop, however, the school nurse at her school refuses to give my daughter her medicine,

she would rather let her bleed for 30 minutes, and this woman could not get it stopped and I went to the school to pick up my daughter, I found the blood on the the front of her clothes and the waste paper basket half full of tissues that were bloody. Now that is the kind of standard medical care that these doctors are trying to keep us in line with, and I don't want any part of it, and I would also like to point out, that naturopaths in their naturopathic college have existed before the AMA was started.

After the AMA was started there was so many doctors that were so against the naturopathic route, that the AMA ... and politics managed to close these colleges down, I would suggest that before people condemn the education of naturopaths, they should check in to their education. I would also like to say that naturopaths do use laboratories, they use pathologists, my doctor sent my daughter to the pathologist and he ran laboratory tests on her to make sure that she didn't have a breathing disorder and that would be the cause of her nosebleeds. I know that my mother doesn't necessarily believe in naturopaths and is a little upset because I don't take my children to "the regular doctor", but I would like to point out that my mother is consistently on prescription drugs and must run a bill that is at least $60 a month and has been for the last 10 years and I see her getting no better. I see her staying the same and as far as I'm concerned I don't want my choice taken from me.

I think this licensing is what is needed and I think its good, as far as superficial laceration would be merely a minor cut, I see no reason for these people to be terrible upset that an 8 inch gash is going to taken as a superficial laceration that seems to be taken things a bit too far. I don't know what else I could say, I've been to these teleconferences before, I have gotten a hold of legislators before and I received letters, and I'm just a little tired that we are spending all this time talking about whether or not it should be or not be. If this bill passes it would certainly help us with our medical

insurance, we pay $700 a year insurance and it doesn't cover naturopath and since I don't see a medical doctor and none of my family does, we pay for that extra out of our pocket. If this bill was passed we could get the insurance to cover the naturopathic which would in turn cut down the money that we spend every year, I think thats all I have to say, thank you.

Number 0499

Chairman Tischer: Thank you very much Karen, any questions from the committee? Rep. Koponen?

Rep. Koponen: I'm not entirely certain that licensure makes much different than what the insurance company is willing to sell you on the policy. I know that the policies that we handle cover a great number of medical practices, but not others, it doesn't cover examination and it lists a whole list of things.

Chairman Tischer: Thank you Rep. Koponen, we will now go to the witness in Mat-Su.

Molly Mauline: I am for bill number 347, I have not had a lot of experience with naturopaths, mainly because my family has been blessed with good health and also I don't have much need for any type of doctors, except when I had my babies. But I do believe that we as Alaskans deserve the choice to chose what kind of health care we would like for our family, if maybe that in the future I would need more services of the medical community and I would like to be able to choose, I would like to try the natural method first ...(end of tape)

Tape 6, Side 2, 2 of 2
Recording
Number 0001

Chairman Tischer: In messages which have come in on this particular bill last year, during the last session and I compiled all those and if those that didn't receive them were unware, I provided the message from the public to them and there is a large group of folks out there that not only support this, but wish it to be moved along and we would like to do that. But once it hits the floor for debate and vote, if we don't have your legislature in our pocket, so to speak, for their yes vote, the bill could be voted

down, not only that, but once it passes through the committees, but especially in the other body, and the legislation becomes watered down or practically made in effective. Than you would see perhaps a movement of that particular legislation to the floor of the Senate, and passage may take place and a valueless bill would have become a statute.

What we need is the cooperation of the entire body on both sides of the isle in order to pass this piece of legislation. We have not yet been able to confirm that support, not because of their constituency support, but because of other valid or invalid reasons, whatever, the case may be, so the tough issue here is we need to get the support of the other legislators in order to get their yes vote on both sides of the house, both the Senate and the House.

Along with that we have one more hoop to jump through and that is the legislation has to be signed by the Governor, and as you know the latitude of the Governor is to sign, not sign or veto and many times, especially veto comes under constitutional issues or others issues that are sent down as an opinion by the Attorney General, and the legislacure has to take heed of that. In order for us to move along, in our best interests and yours to garner the support and cooperation from all three areas in order to pass this legislation and I sincerely hope that we can do that before the end of this session, it is my wish to do so. So I appreciate your comments, they are very well taken, thank you. Could we go on to Juneau, we have Dr. Jamison, would you please come forward.

Number 0035

Scott Jamison: I'm a doctor of naturopathic medicine, I am a graduate of the National College of Naturopathic Medicine in Portland, Oregon, currently living and practicing in Juneau, Alaska, and I wish to speak today in favor of the licensing of the naturopathic profession. In previous testimony, I spoken to different points of concern on HB 347, I've spoken to the establishment of a Licensing Board of Naturopathic Examiners, which I would like to see, but at the same time I understand

the financial limitation of such an act, I've spoken to the scope of practice which has come into question and a number of items that have already been in my testimony.

What I would like to say today is simply that our profession has been around for over 150 years and we have been recognized as being valuable in the field of preventive health care and natural health care for that length of time. And that our profession deserves to be recognized legislatively, many of our therapies are simple as common sense itself, as earlier testimony by a woman who stated naturopathic profession goes all the way back to ..., and further.

In addition to these traditional health practices that we learned over the years we have the valuable information of scientific community giving us bio-chemical and molecular information on the functioning of the body, biophysiology, pathology and so on. And naturopathic profession than is a combination of traditionally proven treatment and the latest scientific information in the field, rather than talk any longer, I would simply make myself open to questions from members of the committee. So at this point if there are any questions, I'll be glad to answer them.

Number 0065

Chairman Tischer: Thank you Dr. Jamison, Rep. Davis?

Rep. Davis: I have a question or perhaps a comment, Dr. Jamison, if you could at some later date take a look at the bill, you had some concerns on it, perhaps you could provide that to the committee, last year we were looking at a proposed bill and also a committee substitute so perhaps you could make some comments on that, go through the bill and see what concerns you have and give us your testimony.

Dr. Jamison: I'll be glad to do that.

Number 0075

Rep. M.W. Miller: Dr. Jamison, on April 22, 1983, you testified against this same bill, what has made you change, now that you support, because it is the exact same bill, what has made you change?

Dr. Jamison: The guiding force in making me change my mind on this bill is the committee substitute offered by Dr. Fritz who is no longer a member of the HESS Committee, but apparently his committee substitute is still here.

Rep. M.W. Miller: Are you testifying because you like the committee substitute, we are not discussing the committee substitute we are discussing the original bill, HB 347.

Number 0087

Dr. Jamison: At this point in time I feel that the House Bill currently is the best thing we have going for us, there have been concerns expressed to me, that I have addressed in previous testimony, and as regards to naturopathic professions there are still very few naturopaths practicing in the state and in terms of presenting a united front I want to go along with my profession. Although there are concerns that I would like to see addressed in the bill, I've already mentioned the establishment of the Board of Naturopathic Examiners. In previous testimony I've spoken to our scope of practice. Towards the end of the bill there is a grandfather clause which would was added on to the original bill four years ago when it was first submitted. Neither Dr. Pettyjohn nor myself particularly feel a need for that clause, although it was added and if the committee feels that is not necessary or that is not advantageous, I would personally not be upset if it weren't deleted in the bill.

Chairman Tischer: In other words, Dr. Jamison, the grandfather clause in the existing piece of proposed legislation would allow practicing physicians presently practicing to continue practice and to receive a license without the examination and what you are saying is that there would be no reason for you or any other practicing naturopath to refuse to take or not wanting to take the examination that you would prefer to be able to take that examination, to prove your worth and expertise in order to be licensed under the limitations of the present legislation, or whatever it comes out as. Is that correct?

Number 0112

Dr. Jamison: Thats correct.

Chairman Tischer: Thank you, are there any other questions from the committee?

Number 0114

Moderator in Anchorage: There is some concern in Anchorage that the committee members and witnesses in Juneau are not using their microphones, we hear the exchanges in the committee room in Juneau and there is quite a bit of interest here in what is being said there. We would ask that the people in Juneau to remember that there are listeners here in the North. The next witness is Joanne Selmar.

Number 0121

Joanne Selmar: I want very much to support House Bill 347, I have been a patient of Dr. Pettyjohn for at least 4 years and he has helped me in so many ways in clearing up my digestive problems that I hadn't been able to get help prior to 6 years before that. And through him and following his guidance and advise I now can have a balanced metabolism. And I think very much that he would continue to help people who want to be with him. Thank you.

Chairman Tischer: Thank you very much Ms. Selmar. Could we have one more witness from Anchorage before we go to Mat-Su.

Number 0132

Dr. McGuire: I'm an orthopedic surgeon practicing in Anchorage and I'm a member of the Alaska State Medical Association. I'm speaking from two view points; one from that of a concerned citizen and physician and one of that as a representative from State Medical Society. I'd like to thank you the opportunity to appear before you.

First I would like to point out what we perceive to be certain issues of fact and that is that we have not found this legislation, but it appears that it has been mandated by the Attorney General and that it has been asked for by naturopaths. It is not our position that we would deny to any patient the opportunity to seek whatever medical care they would deem appropriate, however, if the state has licensing care, we are concerned that it be done in a fashion that all who would seek this care have the assurance that they understand what care it

is and what things are included in that scope of practice.

Theoretic stands I would invite your attention on page 5 of the bill and some of these points may be reiterated in the sense that they have been previously mentioned.

There is a concern on our part as to what constitutes superficial lacerations and abrasions, what in fact are benign superficial abrasions and how will this be defined, and further if they are removed is there a standard of care as to their ultimate diagnosis? And I would point out to you that certain lesions which indeed appear very superficial if they are not subjected to appropriate pathological diagnosis may in fact not be that, but may be something far more malignant and I think those are important considerations.

Furthermore, we are concerned about the consultation available in the removal of certain foreign bodies, sometimes what appears to be a simple problem and in fact is not a simple problem and can lead to other serious consequences if not managed to appropriately. For example, foreign body in the ear if not managed appropriately can become impacted, in fact and cause significant difficulties with hearing, etc.

Again we would reiterate if anyone who wants to seek medical care on their own or any fashion, we are certainly not opposed to, we are concerned again that they understand that the understanding is wide spread. What for example, will be the treatment of complications should they occur in the course of ordinary obstetrical problems? Are these individuals in fact trained for neonatal resuscitation and if not should that be something that could be considered.

Certainly any normal childbirth suffers the potential of becoming complicated at any time if the infant in question is having difficulty. What are the procedures that will be followed or to insure the most optimal of outcome?

Number 0172

In paragraph B of that same sentence, we go down subsection 4, in which it would appear

from reading of this, that certain drugs will be allowed to be used by naturopaths, our concern is, as regards to local anesthetics, will these be applied topically or will they be injected or will they be applied to the mucous membranes? There are legitimate concerns I think as to that, for example, if local anesthetics are used in injectable fashion they can be rather severe in immediate and ... reactions to them. Are there provisions for these to be managed and should they be spelled out or should there be some appropriate referral? Once again the difficulty with plants and animals concentrate etc. has been mentioned, certainly many of the drugs we use right now are ... of plants and animal origin, and if such can be very potent medicine, should these be defined further and are they defined further?

Number 0185

Finally, what remedies are available for patients for poor results for pain, will these doctors be subject to the same malpractice problems that the rest of the medicine is subject to or will there be pure review? If so, how will it be accomplished? Who in fact will determine whether or not the individuals have training as outlined in the proposed bill. And finally, what will be the position in regards to the present existing malpractice view panel as to naturopaths, should they be licensed? Once again, I would like to reiterate that the cross for this bill has certainly not come from the medical doctors as a group nor to my knowledge individually, but rather has come from the Attorney General who ruled that these individuals must come under the laws of relating to the medical practice and finally, I think from the individuals themselves. Thank you for the opportunity to present this information, I'll be happy to answer any questions if I can.

Number 0198

Chairman Tischer: Thank you Dr. McGuire, I have before me, this is in regard to the Attorney General remarks that you made. I am aware of the fact that there is one naturopath, Dr. Pettyjohn who has been ordered by the Attorney General to cease and assist in practicing.

I have before me, March 29, 1979, Attorney

General's opinion handed down by Attorney General Gross, on page 2 it reads; given the medical boards posture with respect to naturopathy it is highly unlikely that the state would undertake any action to prosecute or otherwise discipline an individual naturopath for the unlawful practice of medicine. In essence than, the naturopathy within the State of Alaska is an unlicensed activity, and it goes on say in the second paragraph:

It is my understanding from the conversation with your administrative assistant Carlos Mercer, by the way this opinion was directed to Mike Colletta who happened to be at that time, Chairman of Rules in the House, it says; it is my understanding from my conversation with the administrative assistant that you are currently contemplating legislation to regulate the practice of naturopathy in the state. In formulating this legislation, two fundamental issues arise:

1. Does the practice of naturopathy constitute a practice which poses a risk to the health and safety of Alaskans? Such that it should be regulated and,

2. In what manner can the state best control entrance into the occupation and support and enforce standards of practice among licensed practitioners.

Chairman Tischer: Now the two points I think you have addressed properly in terms of questioning the pure review and my question to you in that regard is; would you favor establishing a pure review board, such as the medical profession has the dentistry and so forth, would you favor that there be a professional of state board of naturopaths consisting of a number of profession involved in health care? In order to do this pure review in number 2, I would like to have your reactions on that, on the original Attorney General's opinion.

Number 0230

Dr. McGuire: I'm not sure I'm in the position to speak on the original Attorney General's opinion, certainly I'm not an expert on the law. I would as to the risk and safety of the patient, I think that is a

legitimate concern, and inspite of some contentions on some orders that the Board of Medical establishment is interested only in the well being. I think it is a legitimate concern that we've attempted to present.

Whether or not, the establishment of a pure review board is the best solution to this problem. I don't know I would find myself in sympathy with Mr. Smith's testimony earlier that we find ourselves increasingly saddled with regulations and restrictions and assumingly unending appearance of board and licensing, etc. I wonder whether or not, such a system might be more complicated than productive. I don't have a solution to that problem, as I said earlier, we didn't propose this bill, we are trying to present what we think are legitimate concerns in that regard. I realize I haven't answered your question precisely not because I'm not trying to, but because I can't.

Number 0247

Chairman Tischer: I appreciate that doctor, I'd like to pursue this Board of Examiners or whatever we are going to wind up calling and ask the question in dealing with the established medical profession. What guidelines are you committed to practice and would you prefer that it could be less limited and less regulated and less restrictive?

Dr.McGuire: I think our guidelines for practice are clearly spelled out and there are several stages of redundancy where they have practices beginning in both at the level of the state and local medical societies, continuing on to the hospital based physicians which are subject to privileging credentialing and appear review process which to say the least, are elaborate, and finally, ending with the state division of licensure which has the authority upon sufficient evidence to revoke the license.

One of the problems that we may face in this state, is certainly the medical doctors don't want to be in the position of commenting on whether or not a given naturopath is a good naturopath, certainly it is not our area expertise, it is not our interest to do

I would however, pointout to you that I think we are capable of commenting on whether the result of pain by a particular method of treatment are favorable to the patient and whether or not they should be pursued as a group, and that I'm pointing out to you again does not mean to say that I'm applying that naturopathy isn't useful or should be used, I don't have an opinion on that, I'm expressing a concern as to how if the state takes upon itself the burden of licensing these individuals, how indeed will they ensure that the license so given speaks to the issues raised.

Number 0271

Chairman Tischer: Thank you Doctor, and one more question that I have and I appreciate those comments. Its my understanding that at this time the practitioners of naturopathy are not allowed to, don't have physician's privilege in hospitals that are normally extended to professions such as yours, and is that correct and whats your opinion about that?

Number 0277

Dr. McGuire: To my knowledge that is correct, that I think those apply simply to naturopaths or other alternative health care practitioners who do not have privileges to practice within the hospital.

I think that is a subject upon which we could spend an entire day, but there are several comments that are germaine, at the present time in Anchorage the situation is such that we are in dire shortage of hospital beds for patients who are treated by traditional means, I don't mean to point out words by medical doctors and surgeons if you will.

Providence finds itself in a position frequently of having 99 to 100% occupancy, what I've seen personally is, patients in the halls because there are no beds to put them. Now certainly we are moving in that direction with the recent approval of ... to allow building of such hospital beds and outpatient facilities are helping that burden, but I wonder if we extend these privileges to other practitioners what the practical effect would be. Now I'm concerned if that be the case the individuals who are in dire straight will

not have room for hospitalization.

Thats what I think is the first and most obvious concern, there are other significant concerns on how the practice of surgery, for example, will be regulated, at the present time there are elaborate training of requirements for any surgeon within Anchorage itself general practitioners who are medical doctors who completed medical schools and family practice residency do not have specific free standing ability, capabilities or privileges. We felt that was necessary with our own profession because we felt that the present standard of surgery is so demanding and exacting that is not something that can be practiced casually. But it would seem to me that this would apply across the board to other practitioners, now as to the areas of internal medicine, I would think that as I'm an orthopedic surgeon, particularly confident to comment on those what I would suspect that the same kind of concerns would attain.

Number 0306 Chairman Tischer: Thank you doctor and I have one more question, this is on personal basis, as far as individual physician is concerned. Would you collaborate for the best interest of a patient with a naturopath and treatment of that patient?

Number 0310 Dr. McGuire: Well I personally have not had the occasion to do so, because I've never been consulted by a naturopath nor have I been consulted by a patient with a request that I do so. I'm somewhat at a loss to respond to that for the reason that I do not consider myself an expert in naturopathy and thats why I don't know what the questions would be that would be asked of me. I think I can say this, and this I'm speaking for myself personally and not as a representative of the medical society, as far as I'm concerned my position as a physician is to see those patients for the problems that I considered myself to be expert in dealing with and I'll see those patients whether they are not they were referred by a chiropractor or by anyone else. Now whether or not it is that I collaborate with the care of that treatment by a mutual program of treatment worked out

by the naturopath or chiropractor, I think that that is not something I'm prepared to respond to. I don't know the questions about how that would work and I have a lot of questions about the ultimate benefit to the patient would be, I hope that answers your question.

Number 0325

Chairman Tischer: In part it has doctor, I just wanted to know whether or not you would be reluctant to assist or to collaborate with the treatment of a patient, if they requested that collaboration, for example if I fell down and dislocated my shoulder and my regular physician was naturopath and that I also felt as if though because it was a bone injury I should see an orthopedics, would you be offended or professionally perhaps reluctant to work with my naturopath in treatment of that dislocated shoulder?

Number 0333

Dr. McGuire: Again I'm speaking personally and not as a representative of other physicians, I personally wouldn't have any problems. I would ask the question though, how would we resolve the problem if a recommendation that I thought was important to the patient was in contra distinction to the recommendation of the naturopath had or for that matter, any other alternative health practitioner and who ultimately would hold the responsibility for the treatment outcome if one or the other is preserved.

Again I don't mean to be evasive, but I think these are complicated issues and my saying would be that I am perfectly willing to collaborate with naturopaths so it may lead me to a situation which I wouldn't be willing to. I would say again, emphasize that point I have a certain sense of the ethics of medicine and I believe in it strongly and if I don't that I would be asked to do something that I thought was not in the best interest of the patient. According to my training and experience than I think that I would not be willing to be a party to that no matter who asked me to do that, and for whatever its worth that would apply if it were another physician who wanted to do that. I would say respectfully that my opinion is to the contrary and that my recommendations are due otherwise.

Number 0352

Chairman Tischer: Thank you doctor, I appreciate those comments, its been very helpful and I guess the reason that I ask is it comes right down to what you are directing to me and that is if it were my shoulder and if it was an injury that I've asked you to look at as well as another physician, whether it be an optometrist or a naturopath or what have you, that ultimately don't you believe that it would be my decision as to who's advise I was going to take?

Dr. McGuire: I think thats absolutely true, it should be your advice and I would like to emphasize the comment that I made early on, speaking personally for certain and I thinking speaking for medical establishment as a whole. There is a perception on a part of many people that we are somehow felt that ... and that no one has the opportunity to seek the kind of care they would want and I think thats erroneous. I can say with no question at all thats erroneous as far as I'm concerned. I'm a great believer and all the freedoms that we have and everybody should be free to do whatever it is they want to do. I'm concerned however, when we take upon ourselves as members of society to legislate and to license individuals and with that it carries a responsibility to be certain that we define what in fact those individuals are, what they do and therefore, what the public can reasonably expect from them. But in another way, if we give the stamp of authority of the state to an individual and therefore allow the public to believe ...unwillingly that they are capable of doing next thing in fact they are not, than I would hold that we are amiss with the legislation and our legal responsibility.

Number 0380

Chairman Tischer: Thank you for your testimony. I think the next place is Mat-Su is it not?

Number 0384

Mark Rierdan: Good afternoon, I'm here to voice my support for HB 247. I'm married and have (3) children and the past year we have all been treated by Dr. Pettyjohn, a naturopathic doctor in Anchorage, as a matter of fact he delivered my last child.

I feel that naturopathic medicine is not

only a viable alternative ...(loud noise on tape) medical community in Alaska. Being a natural born skeptic I was at first somewhat apprehensive about being treated by naturopathic means, but after some study and talks with Dr. Pettyjohn, my mind was put at ease and now I'm quite comfortable and now go to Dr. Pettyjohn as our family doctor. In conclusion I feel would be grave judgment if HB 347 did not pass and you would be committing a disservice to this community, if you did not support this bill, thank you.

Number 0396

Chairman Tischer: Thank you very much, I'd like to now go to Fairbanks, is there another witness?

John Ghoddio: I am representing Fairbanks North Star Holistics Network which is a group of 200 concerned citizens who meet monthly for interest in having alternatives for holistic medicine including naturopathic doctors available to us. We strongly support the passage of HB 347, but would also like to say that every person that came here today is in support of HB 347. Thank you.

Rep. Koponen: Thank you Madam Chairman, John, is there a naturopathic practitioner in the Fairbanks area at this time and if so, do you have their name or any information about them?

John Ghoddio: Unfortunately there is none and a lot of people have to travel a long way to get treatment by naturopathic doctors, so we are really in need of one.

Number 0417

Rep. Koponen: Isn't there a place on Eleventh Avenue downtown that advertises naturopathic services? I have a photograph of a store down on Eleventh that advertises or are they just advertising supplies?

John Ghoddio: We have places in Fairbanks where you can get herbal supplies and other alternatives, but not naturopathic doctors.

Number 0425

Chairman Tischer: I would now like to go to Anchorage for the next witnesses.

Dr. Jay Bonner: (loud noise in background)... My first comment is to agree

with the doctor you spoken to before me and the last statement that Dr. McGuire made on the sample of approval that you will be given to the practice of naturopathic medicine by legitimizing the practice through a licensing board, I think its not in the best interest of the public. (am I coming through)? By licensing the naturopath you have given a creditation to their training, I practiced for 17 year in the Southern Mississippi as a teacher in the School of Medicine and the University of Mississippi.

I taught many of these subjects that are outlined on page 2, others that were left out were internal medicine, pediatrics and ... these are left out that are suppose to be included in their training. I am not aware that any particular licensing of these two that is nationwide as there is of medical school. The first part of this century there was a report on the medical indication in this country and it pointed out some of the problems of medical education that there were many licensing boards, many groups that joined together in approving and overlooking the ...I don't think there is that track record with naturopathic medicine in this country.

We had many years of looking into how to practice medicine and how they are taught, many of the subjects that are listed here. By giving a license to these individuals and saying that we are crediting them, we are also crediting their education, we are saying that we know that they passed these particular subjects and I do not believe they have had legitimate training on all these subjects that are listed.

Also, I don't believe that the instructors that are hired by these naturopathic have the doctor's degree in chemistry and anatomy and microbiology, etc., and that the teachers are competent to teach the individuals these particular subjects. I'm not disagreeing that people have the right to chose to go to naturopathic physician if they want to so, but I'm saying that we should not by any means say that we are giving a stamp of approval to any of these training or practice of naturopathic

medicine.

Also, you mentioned that you were going to devise a test, I'm not sure how this test could be devised, to test a naturopathic physician and licensing them. I'd like to additionally express my concern of the medications that they prescribe, animal and plant compounds or extracts and of course as pointed out earlier many of these that we prescribe as insulin, cortisone, thyroid and plant medications, etc. can be very toxic and should go in use under special circumstances. There are other substances that I know the naturopathic physicians are prescribing or they are dispensing to the patient called ...adrenal extract, valid extract and I have seen these in patients that bought these to my office. Almost a 100% of the patients that I've seen in my office that have been seen by naturopathic physicians have been mis-diagnosed and mistreated or treated inappropriately.

I think I'm surrounded by a number of people who have had very positive experience with naturopathic physicians and I'm glad that they have and had no adverse effect. But I'm just telling you the many patients here in Anchorage who had adverse effects on these treatments or negligent in the treatment because they had not seen a physician to correctly treat them early enough. And I have seen complications as a result, probably from some of these substances that are being prescribed although I cannot surmise the investigation to determine exactly whats in these substances that are given to the patients and I would call naturopathic physicians before to try to talk to them to see what is in these substances so I can determine what is the result of what they were taking or the result of something else, and they would not communicate with me. I would just get a list of what they were taking from the office shelf.

I would also like to speak to the consumer, because I have had privilege of having 3 children and I have had obstetrician who been certified in the practice of obstetrics to deliver my children. For millions of years, as long as man has been on this earth

there has been a natural childbirth and I imagine that billions of people who have been born here by far the majority have been by natural childbirth. I think in this day and age in this country that I would not personally select anything but an obstetrician or a family practitioner who's had a lot of experience in delivering children, but for my own safety and for the safety of my newborn child.

Thank you for letting me testify and at this time I would like to answer any questions. If you would propose the same question to me as you did to Mr. McGuire, would I collaborate with a naturopathic physician? I would not collaborate, I have had couple of referrals from naturopathic physicians and well, one that I can remember and I cannot collaborate with that physician. I'm not exactly sure what you mean by collaboration, however, I prescribed what I thought was best for the patient and I don't think any of them have the training that I do to determine what is best for the patient. Now if they would like to carry out or help enforce my prescriptions or my treatment of the patient I would not (loud noise in the background).

Chairman Tischer: Thank you doctor, I have a question and I would like to go back to the instances where you talked about the patients you had, obviously taken ill with some toxic substances, something like that, I'm not sure that I followed your comments, but I'd like to have you be more specific about those particular instances. Can you give me a closer vision of what you were talking about, precisely and how you got to see these patients in the first place, were they referrals and from whom?

Dr. Bonner: My current practice is limited to referrals from physicians, because I'm very busy now, I've been practicing in Anchorage for (4) years, Initially when I came here patients sought my care because they knew I was a phrenologist, there was no other practice in phrenologist in the state at that time. Majority of them were self-referred patients, the ones who had been to naturopath before.

I still do see some patients who have been to naturopaths and if the naturopath were to refer one to me I would probably see the patient, depending on whether or not it was in my field or not, I certainly would not see them for dislocated shoulder. But the ones that I did see that were mis-diagnosed, some of them had mis-diagnoses of thyroid diseases when they did not have a thyroid problem, they were taken some sort of thyroid extract. I've seen patients who had over active thyroid problems who were also taking a thyroid extract which would be against the practice of medicine, if you had an over active thyroid to additionally prescribe thyroid on a long term basis you could try on set basis for what we call suppression care, but not for a long term treatment of that particular individual.

So I do not know as I said earlier what are in these extracts, there is a ... thyroid which is made from animal gland extracts which has been prescribed for many years as a thyroid replacement for people who have under active thyroid which is ... drug approved by the FDA. I don't think any of these substances are extracts that they are using are approved by the FDA. In fact I just don't know what they are and I don't know how to find out exactly what they are, they are what they say they are, thyroid extract, adrenal extract, ... extract and they are not being used properly.

Another case would be adrenal extract, a patient was diagnosed as having an under active adrenal and our terminology would be attitude's disease or ...-adrenal problem and they were getting adrenal extract... the patient was mis-diagnosed as having adrenal insufficiency and did not need cortisone and cortisone if it isn't adrenal extract they are prescribing is ... specific indication for it. And if it is prescribed for certain doses it has very hazardous side effects like ...(loud noise in background and end of tape).

Tape 6, Side 1, 2 of 2
Recording
Number 0003

Chairman Tischer: Thank you for your testimony. There are no questions from the committee, so I would like to go back to

Anchorage to take the next three witnesses from Anchorage.

Number 0005

Virginia Pettyjohn: I'm the wife of Dr. Pettyjohn, I hold a Bachelor of Arts Degree in Physical Education and hold a teaching certificate in the State of Alaska. I feel this is important because I'm not speaking from respective of one who has not been through several years of schooling and thus have an educated approach to this. I'm also the mother of four children all whom were delivered naturally through a clinic and through my home.

It has been brought up by the speakers from the medical profession that have legitimate concerns about training and the specific things that are designated that a naturopath is able to do. The testimony, I feel that they would like to so limit the scope of the practice of naturopath that it would be non-existent and that this is through benefit not only to self, but their profession that they don't have to be in competition with anyone else. It sounds like a major grocery store limiting another alternative of store that would be in competition with him. I would like to point out to few of the legislators that before we had not heard the general public's speak in direct opposition, it has only been those who are in competition with naturopath.

I'd like to say that the general public has been here and several people had to leave and many whom have not been able to stay because of the time factor, and also the factors that this has been filled and there hasn't been a place to sit down. I think that HB 347 needs to be passed specifically because of the posture of the medical board and the Division of Occupational Licensing and ...the law needs some improvement in order for naturopaths to continue their practice. Thank you.

Number 0031

Chairman Tischer: Thank you very much Mr. Pettyjohn. Any questions from the committee? None, could I have the next witness.

Number 0033

Dr. Patton Pettyjohn: I have been practicing in Anchorage for (4) years now.

I'd like to if I may address my issues for the scope of naturopathic practice, a lot of the opposition from the medical profession is in regards to the scope of practice and whether or not have a qualification. The bill that is submitted is very closely resembles the law thats in the State of

Oregon and has been in existence there for since 1927.

Naturopathic physician decides using natural therapy which includes plants and animals, also trained as general practitioners and such. We have training in minor surgery and if we have the particular training prior than we should be allowed to practice for surgery, especially where it involves childbirth, because it would be very inconvenient if we have the quality and expertise to repair a vaginal laceration.

But because of the pressure from the medical community you feel that you do not include this into the law, than we will have to unnecessarily transport every woman who had a laceration to the hospital when its not her desire to do so, when there would be someone right in her home capable to do such.

Also, in regards to superficial lacerations again, this is something which the State of Oregon for the past 50 years had no problem with, with naturopaths. Any qualified physician can suspect malignant lesions and if they are suspicious than they can get a biopsy to exclude whether they are suspicious or not before they would attempt to do any superfluous surgery on that lesion. So it hasn't been a problem in other states and I can't see why it should be a problem in this state as it is written in the law.

There were some questions also regarding plant, animal and mineral substances that some of these products are potentially used as medicine, of course they are, thats what naturopaths are trained to do, use natural animal substances, natural plant substances as medicine. And we realize that some of these are used by the medical profession as well, but that should not exclude us from

using them if we have the training and expertise to use them. So if we feel that fox glove which the lab may ... is in the best interest of the patient than we feel that we have the expertise to treat that patient with that plant, that we feel that our training, we should be allowed to do so.

If we feel however, that a patient needs hospitalization and needs a particular prescription that is out of our field, its out of our expertise and needs to be managed by highly skilled and staff of the hospital, than we will refer that, but see every general practitioner, every family physician has the same dilemma to face. They have to practice within their qualifications, every pilot has to make decisions whether he wants to fly in certain weather and the same thing with physicians, if he does not feel competent with the specific procedure, he refers, but that doesn't necessarily mean that there would be other naturopathic physicians that would feel competent to do minor surgery, because we have been trained to do so. And these are things that would be handled under office procedure.

Number 0082

There was a statement made by one of the doctors that made reference to, she wonders who teaches these classes and wonders if they are qualified to do so. If she had made much investigation she would realize that the basic medical sciences of anatomy and physiology about chemistry, pathology and micro-biology have all been taught in schools by professionals, academic people who have Phd's in those particular basic sciences. Because of the flak that we gotten in the past relating to minor surgery, that it is made sure in our schools we are taught minor surgery by licensed surgeons from one of the medical schools in that community, to make sure that they have no misgivings the kind of qualifications that the training these naturopaths receive concerning minor surgery. The reason why we do minor surgery is to see a complete family practitioner and naturopathic schools have always taught minor surgery, have always taught natural childbirth and obstetrics, its not something new that we are asking for.

Number 0096

Because we are taught and we are trained, we should have the ability to practice our profession as trained, just like the medical doctors have the privilege of practicing as they are trained. At this time I would just like to conclude my remarks and say again that I feel that it is very important that we as naturopaths have constitutional right to practice as we are trained and that patients also can be available to our services.

At the present time there is a problem because the medical board's posture and these are made up of medical doctors, they do not want us to treat the sick anymore in any form whatsoever. It doesn't make any difference if we are using natural therapy or not, they do not want to treat the sick unless this bill is passed. So I urge the passage of this bill and will be open for questions at this time.

Number 0106

Chairman Tischer: Thank you Dr. Pettyjohn, Rep. Koponen has a question and so do I.

Rep. Koponen: Dr. Pettyjohn, during the course of the testimony this afternoon some comment was made about the problems that you have had in continuing your practice, someone mentioned cease and assist order; could you be more specific in what this regarding this disability you have currently in not being licensed?

Number 0114

Dr. Pettyjohn: Certainly, when I first came to Alaska I was told through the Attorney General, that naturopathy was an unlicensed activity and I could practice unharassed.

That was under the Hammond Administration and now we are the Sheffield Administration and there are new people in different departments and divisions. It was brought to the attention of Occupational Licensing that I was diagnosing and treating the sick and so because of that the issue to cease and assist order, saying that was a practice of medicine I needed a license to do that.

My attorney right now, went to court to keep my practice open and we have in fact a restraining order ... against that, cease and assist order, until certain hearings can

be made. After which time, we will proceed into court to declaratory judgment, but this may take several months or even a year to complete the judicial process whether or not I have the constitutional right to practice.

Naturopathy is not a sub-speciality of medicine and should not be under the jurisdiction of the medical board and it appears we need a licensing procedure so that naturopaths can diagnose and treat the sick in Alaska, unless we can go to court and get a declaratory judgment.

Number 0135 — Chairman Tischer: Dr. Pettyjohn, Rep. Davis has a question.

Number 0137 — Rep. Davis: I assume that you've seen the original bill and proposed committee substitute and I'm curious as to what your feelings are on that, and also the licensing board that you admit. There are only two people that are practicing with your profession in the state, I don't know how that would work. My second questions is; would you oppose to have other than naturopathy people on that board, having a medical doctor on that board? Thank you.

Number 0145 — Dr. Pettyjohn: I was opposed to Milo Fritz' committee substitute, because he removed the minor surgery and practice of obstetrics, the use of x-ray diagnosis and many other things that we are trained to do, moreless, said that we could treat with nutritional therapies and that was it. Of course, we do that, but he watered the bill down so much that it took out half the things that I've been trained to do. So I was in opposition to that committee substitute. I want to practice as trained, I want to practice as I'm licensed to do in Oregon and I feel I have that right.

The second question; yes, thats one of the reasons why because they are not allowed naturopaths in Alaska, thats the reason why we felt that naturopathy should first be licensed under the Department of Commerce to the Division of Occupational Licensing. We tried to set out in the legislation, the principle and the regulations which the naturopaths would be licensed, so that the

department would have to follow the law as it is written. They would have to examine the applicants, make sure that they were qualified in the different subjects that naturopaths must be trained and if there were complaints than the Department would have to handle those.

As far as I know know, there are three full-time practicing naturopaths in Alaska, and there are four others who would be qualified to become licensed if they chose to, because they have legitimate degree and these are also practicing as chiropractors in Alaska.

So those are the people that I'm aware of that have the ability to be licensed. I know of two students that want to come to Fairbanks who are graduating this year and I have not too long ago also received some letters from three other naturopathic physicians from Oregon who (one has graduated a year ago, two others that are graduating this year) would like to come to Alaska and I am waiting for this license or bill to pass and to find out the outcome of my court case, whether or not they would like to come to Alaska.

Number 0182 Chairman Tischer: Rep. Davis has one more brief question.

Rep. Davis: In prior testimony, Dr. Jamison mentioned that he learned there would be some kind of peer board versus being licensed and having an oversight by a branch of the State of Alaska at least within the Commerce Department, but do you know who is not practicing that would license in the Fairbanks area?

Number 0189 Dr. Pettyjohn: Yes, Dr. Spaulding and Dr. Hampton, both are chiropractors who have naturopathic degrees and are licensed in other states as naturopaths. And also, theres a Dr. Weaver here in Anchorage who is a chiropractor that would be qualified to be licensed, and there's a Dr. Hammond in Juneau, who is a chiropractor that would be qualified to be licensed as a naturopath.

Number 0196 Chairman Tischer: Dr. Pettyjohn, I have a couple of questions; would you read to me the cease and assist order for the record or

if you send it to me, I would appreciate it. I'm presuming that its written.

Dr. Pettyjohn: Yes, it is and after our conversation after I first received it, I took it into your office there in Anchorage and I told them to hand deliver it to you because you weren't there, but I can certainly send another copy to you.

Number 0202

Chairman Tischer: Well, if you brought it up to me, I'm sure it must have been sent down here to Juneau, the next thing I'd like to ask you is; what is your definition of "minor surgery"?

Number 0206

Dr. Pettyjohn: Minor surgery, we tried to define it as according to the way it was defined in the Oregon Statute, but minor surgery technically means, you do not go into the chest cavity or the abdominal cavity and do surgery. Those are typically referred to major surgery techniques, however, there are many minor surgery techniques that need to be done by a highly skilled surgeon that would be very high risk and should be done in hospitals, and this is the judgment of the physician, where to refer and when it would be the best interest of the patient to refer to a specialist.

Primarily as naturopaths we are interested in the surgical procedures that can be done safely in the office, repairing superficial lacerations, wart removal, hemorrhoid treatment, removing ... and minor surgery techniques related to childhood.

These are common office procedures type of techniques that we are trained to use, and if there was a technique that was under some type of legality permissible as minor surgery and we attempted to do that in our office and had not proper training in that specific technique, than we would be open to the same judicial process as all other family practitioners are, it would be malpractice negligents, or whatever. But this is up to the professionally trained clinician, physician to know when he is not qualified within that particular technique.

We have had 50 hours of professional schooling in minor surgery in school and we

had the clinical intern-ship where we are instructed in the surgical techniques through qualified physicians that are licensed in those states where we received our schooling, and those techniques which we have been trained we feel we should be allowed to use and if there are some minor surgery technique that we are not trained in, than it would be our responsibility to refer them if the case would arise if we feel that patient would be best served by going to a physician thats highly skilled in a particular technique.

Number 0243

Chairman Tischer: So vaginal lacerations under your estimations would be classified as minor surgery, is that correct?

Number 0245

Dr. Pettyjohn: That is correct, however, if there is a particular type of laceration which perhaps involves the tearing of the rectum and a particular naturopathic physician didn't feel competent to repair that, than thats where his judgment comes in, and of course he would refer so that the patient could get the best treatment possible.

Chairman Tischer: Thank you, what I'm trying to get at is, in the list of the original bill of licensure requirements, minor surgery has been a c ate. That is inclusive of the types of instruction that would be included for testing purposes and examination purposes for licensure. And as you well know the debate on what is minor surgery, it has been brought up in testimony today, is likely to be contested again.

I'm trying to the best of my ability outline some kind of a format by which the quality prevails in terms of the testing, and if i is based on the educational procedures that are given to the applicant for licensure based on the norm in terms of naturopathy study, than I think we have some basis to go on. But as you know that has been a basis of objection and I'm trying to maintain some equilibrium on that issue.

Another issue that I would like to expound on a little bit, is prescription drugs and that which was related in terms of natural

elements. Two of them were brought up, you mentioned fox glove or ..., and the other one was cocaine, and the fact that there are physicians dispensing those purity drugs in pure form if you will, under prescription and the naturopaths preference to dispense that in the form of a natural herb.

I have a theoretical question; if you were to prescribe fox glove for me for whatever reason, would I be able to overdose on that prescription in its natural form and if so what provision would be made in the prescriptions that I would not be allowed to overdose?

Number 0278

Dr. Pettyjohn: Yes, with everything that we give a patient, we would give them instructions to follow and after we give that substance to a patient, you know if they don't follow those instructions certainly they could overdose themselves, everything has potential harmful effects if misused and abused. There are some plants that have potentially toxic effects and naturopath physicians are trained to use these non-toxic, non-poisonous dosages and so if the patient wants to overdose themselves and go contrary to the order than, yes, they could potentially overdose themselves on some remedies that have potentially toxic effects, but thats the same with any type of medicines.

Number 0290

Chairman Tischer: Thank you very much Dr. Pettyjohn.

Number 0294

Moderator in Anchorage: Rep. Tischer we have a witness and several had to leave, right now we have Dr. Jasper.

Number 0297

Dr. Jasper: I'm a naturopathic physician, I grew up in Haines, Alaska & am a third generation...(loud noise in background). I feel some of the comments were unnecessary and the question whether or not the practitioners are qualified to practice is an irrelevant question (noise on tape)...

The point is every physician will diagnose a patient that others have not been able to diagnose accurately and every physician will mis-diagnose a patient, who will eventually seek health care elsewhere and they will be

able to make an accurate diagnosis. I think thats a point that should be kept in mind. I urge that this bill be passed and people ought to have that choice for their health care practitioners. I appreciate Dr. ... comments, I was available to talk to him about his feelings to the testimony, he felt that maybe if we had a naturopathic board and have at least one medical doctor on it, and keep a very close eye on our practice maybe that would be acceptable to him. I indicated to him that I didn't think that was necessary. They practice without a naturopathic physician to keep a close eye on them. He felt that was not the same situation, but I feel very much it is, the right of the physician to practice to provide health care to those patients that feel competent in their services. I don't want to be ... in my comments today, but I think that the points that are being brought up here today are largely irrelevant.

Number 0355 — We have nurse practitioners here in this state as well as physician assistants that practice in this state and other states that have wide scope of practice and are able to prescribe many drugs and perform minor surgical procedures and do all of these things. And these are physician assistants who have maybe two years of training, we have nurse practitioners who have gone on for additional training beyond their nursing, but yet we ask for the scope of practice which wouldn't exceed that which they give the nurses or physicians' assistant. Now all of a sudden they call it a question, concern over public's safety. I feel that naturopathic physicians ought to practice, at least in the same scope of a nurse or physician. If there are questions I would be glad to address them.

Number 0369 — Chairman Tischer: Thank you very much, Dr. Jasper. I see no questions coming from the committee members, if we completed the three designated people from Anchorage, we will go to Mat-Su.

Number 0376 — Moderator in Fairbanks: We have no participants left here in Fairbanks, would it be ok for me to disconnect from the teleconference?

Chairman Tischer: Yes, should you have contact with those that weren't able to testify, I would ask you to tell them if they have testimony which is pertinent they are free to send by telecopy to the committee so that we can make their testimony part of the record. I apologize for the lengthy hearings, but since all things weren't equal today, I would like to continue until at least a majority of the people are hear. Thank you Paula.

Number 0388

Georgia ... in Mat-Su: I'm speaking for myself, my husband and my two sons. We support HB 347, we are extremely concerned of the fate of the naturopathic doctor in our state, Dr. Pettyjohn has been our family doctor for four years. We are tired of going to medical doctors who knew practically nothing about nutrition and diet and absolutely nothing about herbs. Dr. Pettyjohn took the time to listen very thoroughly to our symptoms and inquired about the total picture of our health and diet. The herbs and nutritional supplements that we received from Dr. Pettyjohn are superior to others found locally. We resent tremendously the idea that people ignorant to the science of naturopathy and preventive medicine are trying to abolish the science practice in our state and worldwide. We feel it is entirely our right to seek professional (loud noise in background) ... Thank you.

Number 0416

Chairman Tischer: Thank you Georgia, are there questions from the committee? Hearing none, I would like to go back to Anchorage and take couple more testimonies from Anchorage.

Number 0419

Sandra Jay: I'm a chiropractor recently licensed in Anchorage, I'd like to testify in support of HB 347. Because our time is simply growing short, I'd like to say that I agree with the support on the statements made and the only thing that I might add is; there are many people who question the competency of medicine and medical doctors, but that is not a good reason to prevent them from practice and they do practice freely across the nation and world. I don't see any reason why there is a difference between them in that circumstance and the

naturopaths and their circumstance. Other than that, all the reports that I've heard from people who have been treated by Dr. Pettyjohn and Dr. Jasper have been very positive, and I see no reason why they should not continue to practice in the way that serves the public very well. Thank you.

Number 0434 Chairman Tischer: I have a question for you as a chiropractor; if a board of examiners were to be created for naturopathic medicine, what would be your suggestion be as to the types of expertise to sit on that board?

Number 0439 Sandra Jay: They would have to be judged by people that are trained naturopaths and those people would have to have naturopathic education for naturopathic colleges. I would suggest inclusion of a lay member, inclusion of a chiropractic board and I assume they would be included on other boards in the state. At the moment I know most board members are appointed by the Governor, I feel quarrel with that, or possibly even an elected position. Does that answer your question?

Number 0448 Chairman Tischer: Yes, Sandra, thank you very much. The dilemma that we would face at this time in creating that board would be that the same people who would be sitting on the board at this time because of the small numbers of practitioners in naturopathic medicine would also be judging themselves, unless another board outside of state, for example, might suffice until at such a time that we grew in numbers. What would be your opinion on how we would handle that?

Number 0456 Sandra Jay: I have a question in return that must have also risen when the board was first put into practice for any of the professions that are licensed, and I would think that similar guidelines could be followed in those instances.

Number 0460 Chairman Tischer: Thank you, that's a good suggestion. Do you feel that the existing original bill as it now reads at least has provisions that cover the question whether or not there are competent people in the Department of Commerce to administer an

examination? Do you think that we have covered enough basis in the bill to properly examine the potential candidates so that they could prove themselves in their profession to practice here?

Number 0469 — Sandra Jay: I briefly read over the bill that I have in my hand, it seems that the areas examined are quite complete, I don't know who in the division would be qualified to test those, as I do not know if there are professional people trained in those areas employed by the division.

Number 0475 — Chairman Tischer: Thank you for your comments, Sandra. Can we go to the next witness in Anchorage. I would like the audience to recognize that Rep. Ward has now joined the committee as an observer.

Number 0480 — Sherry...(loud noise in background)...There would be great disservice done to the people of Alaska if House Bill 347 were turned down. As a mid-wife I have been in both hospital and home birth and I did much handling of births in the hospital and very much in my personal care of mother and babies. In working with Dr. Jasper, I've seen skill, care and concern during deliveries. He hasn't hesitated to refer patients during pregnancy and during delivery if he felt there was a need to.

Number 0494 — Chairman Tischer: Thank you Sherry, could you explain a little bit further on your role as a mid-wife, are you licensed, how do you practice, do you keep an office, how do you get your referrals and so forth?

Number 0496 — Sherry...: I am what they call a mid-wife, not certified. I practice mainly for home births, do pre-natal for Dr. Jasper, (loud noise in background)... We do very many referrals for people who have been dissatisfied with hospital births and have been very happy with home births. Did I answer your question?

Number 0499 — Chairman Tischer: Yes Sherry, thank you very much, at this time I have to make this comment because you are not present here in the room. Mr. Treagor who earlier testified on behalf of the Department of Commerce and Economic Development in Licensing Division

is sitting here and closed his ears to the fact that you are a lay mid-wife and that you are not licensed, so I sent him away from here. I want to also, go on record that I credit you with the courage to come forward knowing that you may be jeopardizing your position and if anything occurs in the next forseeable future years, I believe the next two, and if you are practicing your mid-wifery that I wish that you would contact me, because I will like to know whether you are going to be harassed or not, because of your testimony. Thank you.

Jean ... from Anchorage: My family and I have been very pleased with the service and good health we enjoyed from our naturopathic doctors during the last four years. We believe so strongly in naturopath that we use Dr. Pettyjohn, even if our Blue Cross does not cover the bill. Our health in all cases have improved much better and faster with the homeopathic remedies, than with the regular antibiotics and drugs that the doctors have prescribed. I have found Dr. Pettyjohn to be conservative in his approach compared to our medical doctors and pediatricians. There have been times that Dr. Pettyjohn has had to refer to specialist and he does not hesitate to say when he (loud noise in background)... I appreciate having a natural alternative to my health care and I feel that I should have the right to chose what kind of health care I receive. Please support HB 347. Thank you.

Chairman Tischer: Thank you very much Jean, we appreciate your comments.

Ruby Pettyjohn in Mat-Su: My name is Ruby Pettyjohn and obviously I'm for HB 347; at this time I would like to make one other comment in regard to what the doctor had to say. At the present time I have been under the care of three specialists with kidney problems. One in Salt Lake, one in a prominent clinic in Seattle and one here in town. They each diagnosed a little differently and the mode of treatment was different. I also of course went to Dr. Pettyjohn and at the same time I also confirmed with a naturopath in Seattle. I think that there comes a time when the patient has the responsibility, I have had

of course had to evaluate all of the information that I've gotten and made my decision as to what I would do. I don't think you can legislate the responsibility of the patient in these matters, but I think that we have a right for a choice in what we do and I would like to support the bill.

Chairman Tischer: Thank you Ms. Pettyjohn. No questions from the committee. Lets go back to Anchorage and take the next three witnesses.

Karen Jasper in Anchorage: I would like to support HB 347, I believe that we live in a free country and that we should have the choice of the physician that tends our family ... (end of tape)

Tape 6, Side 2, 2 of 2

Recording Number 0001 — Karen Jasper continues: I know that naturopaths are qualified and trained properly to handle emergencies and illnesses, I support this bill very much. Thank you.

Number 0005 — Thank you Karen and to the moderators in both Anchorage and Mat-Su can you give us a list or a number of people who are left who would like to be heard before I continue?

Number 0008 — This is the moderator in Anchorage, we have two more witnesses who have not had a chance to testify and Dr. Bonner has an additional comment she would like to make.

Number 0011 — This is the moderator in Mat-Su, we have three people who are waiting to testify.

Number 0013 — Captain E.P. Pettyjohn: I would like to add my support to the licensing of naturopath in Alaska, I am a very strong believer in the benefit of naturopathic medicine. Several years ago my wife was severely ill and we took her to all the best MD's in the Anchorage area, and I honestly believe that she would have died, had we not found a fine naturopathic physician in Seattle who treated her successfully. We need good qualified naturopaths in Alaska and I am Captain E.P. Pettyjohn from Alaska Airlines.

Number 0021 — Chairman Tischer: Thank you Captain, I

wished you would have flown down here today so we could have come back to Anchorage to hold this hearing. Unfortunately, we are isolated from that, thank you.

Number 0024

Connie Walker in Anchorage: I would like the bill put into law, I have gone to Dr. Pettyjohn over the last four years and have found him to be a very confident physician.

I have had some rather bad experiences with the medical society here in Anchorage, but don't wish to go into detail, but this is one of the reasons that I feel that I prefer to go to a naturopath, because my experience with naturopaths has been superior to that of going to a regular medical doctor. Once more I wish to voice my opinion, I am in favor of this bill.

Number 0032

Chairman Tischer: Thank you Connie, I have a question for you, if you would answer please. If you are seeking medical advise from a naturopath, in what way do you feel that you would benefit by the authorization of dispensing the natural drugs for example, in this bill it addresses that it would allow the naturopaths to practice medicine, to practice naturopathic medicine in the manner in which they have been educated and trained to do, have you felt as though you had some restrictions on that delivery of service at this time?

Number 0042

Connie Walker: I don't feel that there has been any restrictions, however I can see what is going to take place if this bill does not become law. The doctors here will probably be asked not to practice, and this would be a disservice to people that depend on them, who do not care to go to a medical doctor. Now, Dr. Pettyjohn has referred me to a regular medical doctor for previous problems and I feel that he would continue to do such in the future and under his guidance I would go to a medical doctor for those problems. As to why I am so interested in this bill, I have always been interested in medical professions until the time I was very small. I also have been interested in all the different alternatives health practices here in Anchorage, I've also been extremely interested in naturopathic doctoring and would honestly

like to be a physician. However, I do have a family and it does require 7 years of study to become a doctor, and at this time I find that is a conflicting thing for me, I could not go to Oregon and become a physician without great difficulty to my family. I hope this answers your question.

Number 0059 Chairman Tischer: Thank you Connie, I appreciate that.

Number 0061 Paula Pettyjohn from Mat-Su: I support HB 347 and I think that it should be passed. I find it interesting to note that each and every doctor who testified earlier, when they were referring to naturopath physicians and their experience and training, they started out by saying; I don't believe and I don't know, and I don't feel, they had no real basis except for their feelings about naturopathic education and the profession itself. How can they be asked to give an expert opinion on something they haven't researched and that they know nothing about.

I doubt that when the laws were passed the license ... of dentists could do oral surgery and chiropractors that the medical profession was consulted into greater detail. Why are they than being consulted now?

The naturopathic view and treatment itself is light years away from the traditional medical profession, the naturopath's views to get the body to heal itself and the traditional medical profession is either treat the symptom and not necessarily the illness itself. They can't take care of the problem then they'll try to cut it out. The doctors and the representatives of the medical society are saying that the ... (loud noise in background). Doctors are making it very difficult for people to bear children and have traditional OB care and they are looking for alternative methods, because they just cannot afford what they are being charged right now. I've seen Dr. Pettyjohn deliver babies and I can assure you that his care is far superior to anything that I've received in the hospital.

If my doctors were even there to begin with, which most of them weren't, the nurses

delivered it. I think we should have the alternative. I completely support this bill, and I hope you guys have been listening to what we've been saying today, I think its very important for our medical care. Thank you.

Number 0114 — Chairman Tischer: Thank you Paula, and I assure you, we have been listening, we have been more than listening, we have been taking notes and we record everything down in a form of minutes for permanent record, so that I want to reassure everyone that, we are not just cursory listening to you. Could we now go back to Anchorage again?

Number 0119 — Moderator in Anchorage: We have three more witnesses and Dr. Bonner who wishes to comment. Our next witness is Bill...

Number 0123 — Chairman Tischer: Before Bill ... testifies, could you indicate if Dr. Pettyjohn is still in the room?

Moderator in Anchorage: Yes. Dr. Pettyjohn is still here.

Chairman Tischer: After the testifying of this one witness, I have one question to ask him.

Number 0127 — Bill ...: I'm a local businessman, and I'd like to go on record in favor of the bill and would like to see it passed. I am representing my wife and family, who have been treated successfully by Dr. Pettyjohn. I'll keep this brief... thank you.

Number 0132 — Chairman Tischer: Thank you Bill, before we go to Mat-Su, Dr. Pettyjohn if you will come forward for just a moment, in the committee substitute that was offered by Dr. Fritz, there is one line that I would like to consult you with and get your reaction on it. It has to do with the disciplinary sanction section, it states that; after a hearing the department may deny, suspend or revoke a license or censor a licensee, if the person;

(1) habitually overusing alcoholic beverages,

(2) impersonating a health care provider,

(3) performs or assists in the performance of abortions,

What is your reaction to that specification?

Number 0146 Dr. Pettyjohn: Well, concerning abortions, as far as I'm concerned you could put in a law that naturopaths are not allowed to do abortions, and that philosophy of naturopathic profession, is to do no harm to the patient, and I feel that personally that, that would be no problem. Naturopaths as far as I know are not licensed to do abortions in any other state and the United States and that it would be a conflict of the philosophy of natural treatment and to do no harm to the patient. So that would be no problem with me personally.

Number 0156 Chairman Tischer: Thank you doctor, now could we hear from the witness.

Number 0158 Tom Pettyjohn in Mat-Su: I'm the brother of Dr. Pettyjohn and I don't have a lot more to add to the comments today, but I do agree with the passage of HB 347. I would just like to add that I am personally acquainted with my brother and his dedication of the well being and the health of his patients and I know that he spent many years of service of trying to gain and educate, and trying to do the best that he can. He can take care of the health of the people and this is one of the true goals in his life, its to provide good health for those people that seek him out and this is my comment.

Number 0172 Chairman Tischer: Thank you very much Tom. There are no questions from the committee members, so lets go back to Anchorage for the next witness there.

Number 0175 Cindy Ziegler in Anchorage: Good afternoon, I'm here to support HB 347, and I would like to say basically that I am as far as for medical care I seek traditionally with the traditional medical establishment probably 90% of the time. I have used naturopath medicine about 2 or 3 occasions and I found it to be very satisfactory when I was at dead end wall with traditional medical help. It did not automatically transfer me over to constantly using the naturopathic way, however, it was very comforting at the time

to know when I reached the dead end at one point that there was an alternative that I could go to and make an intelligent decision of my own.

As near as I can gather from the research that I've done, the study areas and the training of the naturopathic physicians and much of the training is exactly the same or very similar to what the traditional medical physicians receive. If the naturopathic approach and use of that material is different than I'm not too sure why that upsets the many people it seems to upset. I resent very much the idea the medical profession or the legislature or anyone else to come forward in a protective role and concern for my welfare. I am a totally rational, intelligent human being and not someone who doesn't know anybody or doesn't know what she is talking about and that choices should be taken out of my hand because these people are more educated and know what is good or bad for me.

The other question that I would like to mention or address which prompted me to get up and speak; one of the last remarks about the misuse of drugs and their concern that naturopath may in fact misuse drugs. If there hasn't been enough television programs and books on the subject of doctors misusing drugs, and doctors giving out valium prescription and etc., to people who misuse them or handing them out like candy, I really fail to see much difference between the abuse of a prescription under a naturopath is and to the abuse of a prescription under a physician's use. That is a person's choice. It seems to me a person's choice should be something that they can't take away from and should be something that we should be allowed to have a little bit of say in. Thank you.

Number 0202

Chairman Tischer: Thank you Cindy, I appreciate your comments. Now could we go to Mat-Sue and is this the last witness?

Moderator in Mat-Su: Madam Chairman there are no more witnesses.

Chairman Tischer: Thank you, are there any more witnesses in Anchorage that would like

to speak?

Number 0209 — Cathy ...: I'm a registered nurse and I'm very enthusiastic of HB 347, if it passed it would mean the fostering and encouraging the naturopathy in the State of Alaska. Not only would the licensing of naturopathic physicians would be a means of quality control, I believe it would also encourage more naturopaths to relocate to Alaska and making this method of healing available to more Alaskans. I urge you to pass this bill for the benefit of the profession and the health and welfare of all Alaskans.

Number 0219 — Chairman Tischer: Thank you very much Cathy. We appreciate your comments, there are no questions from the committee members, so are there other people who would like to speak in Anchorage?

Number 0225 — Dr. Bonner: Thank you for allowing me to speak again, the main reason that I wanted to speak again; was to say that after listening to many patients here and people who testified about naturopathic medicine, I did want to make a point that a lot of people seem to be confusing the issue of natural childbirth with the practice of naturopathic medicine. Remember I said earlier that billions of people of course we all know have been delivered by natural childbirth or none of us would be here today. And of course natural childbirth, majority of people are able to do very well with natural childbirth, it seems a lot of women confuse natural childbirth with the practice of naturopathic medicine and we are not opposed to natural childbirth of course in the practice of medicine. I would be remiss of course rebutting some of things that were said about my earlier testimony and so I would like to say something about that right now.

Number 0240 — The comments were made that said I did not investigate whether or not the naturopathics were well staffed or whether they were well trained, and there is a position paper that you are pretty well aware of that was put forth last year on HB 347, in which it said, in 1968 studies, U.S. Department of Health, Education & Welfare stated that naturopathic theory and practice are not based upon the

body and basic knowledge relating to health diseases and health care which has been ...of course this division has been willing to unchange today. They are not in the line of the usual customary practice in standard medical practice in the community, and this is where I based some of my comments about that they had mis-diagnosed patients.

I know that physicians do not always make correct diagnosis, but I think the majority of the physicians could pursue a diagnostic or scientific approach through the procedure of the diagnosis and disease that is based on scientific evidence in the scientific community, thats why they accept this throughout the entire medical community in the world. The naturopathic physicians do not use this same methodology, as far as I concerned.

Number 0256

An early comment by the naturopathics today; it was opposed to abortions, and I respect that opinion. I am certain he was sincere in his opposition to abortion, however, the Anchorage Medical Society had a meeting the other night and an obstetrician testified and said someone here locally, practicing naturopathic medicine who used such an abortion in the home and did an episiotomy.

It is unfortunate that the obstetrician could not come this afternoon, because the obstetrician was involved in the delivery of a baby in the hospital, but I don't know whether or not this is hearsay or this is sufficient. I think this physician has actual evidence that this was practiced by someone who says they are practicing naturopathic medicine whether they fall into the same category as these other naturopaths, I do not know. Thats the end of my comment.

Number 0271

Chairman Tischer: Thank you doctor, one thing I would like to make the committee aware is that, if such a statement from the physician although it was a statement, I caution you to understand that that was hearsay and unless those accusations can be proven to us we will strike it from the record, dealing with the abortion issue on the naturopath. I would do the same for any physician, unless they were present and in

the room to answer such an accusation. With that than I believe we had satisfied all the stations in Anchorage who wish to testify as far as I know. We can close the network now.

Number 0280 Moderator in Anchorage: Dr. Jasper did also want to make additional comment to the committee.

Number 0286 Dr. Jasper: I appreciate the opportunity to address the committee again. I made a list of specific points I wanted to address.

The slanderous statement made by Dr. Bonner is typical of ill will among people who make the statement that such a practice is going on in the naturopathic medicine, and than not to substantiate it with a name, date or place is the worst type of dirty politics that I'm aware of. I find it reprehensible that she would make that statement. I feel that the statement was slander in its nature and that she owes an apology.

The people who have come to this hearing in good faith, expecting to have a chance to hear things and not to hear that type of slander or statement.

Going off of that, Dr. Bonner's statement that she supports natural childbirth in the practice of medicine is the medical establishment's idea of natural childbirth and the practice of medicine is in a room located in the hospital which is made up to look like a hotel room, wallpapers, lamps and etc. And if the person did not ...(loud noise on tape) the situation they will have the baby there, otherwise they take them up one flight of stairs in an elevator and have a standard hospital delivery. Many hospitals in the country are now doing this, they only did that in response to the movement, the grass-roots movement to seek out better obstetrical care. There was only mid-wives and naturopathic physicians begin ... and becoming more and more prominent than a competitive measure, the hospitals began trying to offer a service similar to try and regain the market there.

Number 0311 I think the reason people confuse natural

childbirth with the naturopathy is because, by and large, naturopathic physicians are the ones who do natural delivery, the home delivery. So I can see why that confuses what exists, and its not a confusion, its a fact.

Medical doctors by and large don't do natural childbirth today, or were trained in and more appreciative of the medicated standard type of delivery. Its not a confusion, its a fact there. The report that she made in reference to the 1968 report from the U.S. Department of Health, the fact that that report is (16) years old, was also issued by the United States Department of Health which was all staffed by medical doctors. Now this is very similar to, I use these names only as an example, but because the case is similar; that Chevron Gas Company issuing a report that Texico doesn't have good of a gas, that really doesn't mean that Texico doesn't have good gas, but only that Chevron is anxious to sell their product.

As far as our profession that we are pursuing scientific basis in our diagnostic procedures, again I find that to be an error. We pursue the same diagnostic techniques that their profession uses, the terms of radiological work-up, the pathological reports, etc., and for her to say that we don't use that as a basis of our diagnostic work-up, she is in error on that.

Number 0330

I think what's important here is this is a human rights issue, its the right of people to make their own choices in ways that affect their lives. And just because one particular profession does not understand the things that we understand and are not aware of the knowledge we have doesn't make our knowledge any less beneficial. We all know that for over fifty years the treatment of scurvy with vitamin C was considered a quack treatment, because the standard accepted medical society did not accept the treatment of vitamin C, but that story also goes farther. It took fifty years for the Royal British Navy to accept the vitamin C as a treatment for scurvy, it took eighty years for the British Medical Society to accept vitamin C in the treatment of scurvy.

And so, here we have the same thing, the summary of today's hearing is that those of us who are in favor and of the established medical community who are against it. This is why there needs to be a choice in health care through a choice establishing ...certainly both professions have a lot to offer, both professions utilize quite a lot of people when their services or desires are most appropriate. Thank you.

Number 0352 Chairman Tischer: Thank you, Dr. Jasper. Since there are no other witnesses in Anchorage, is that correct?

Moderator in Anchorage: Dr. Center has asked for a minute to testify.

Chairman Tischer: Well, we have the minute but two committee members have already left, because of the bad weather and they are fearful that they won't get home tonight.

We could extend this hearing to another time, may I suggest that Dr. Center perhaps submit a written comment to the committee and we could make it part of the record in that fashion if that's acceptable procedure to him.

Number 0364 Moderator in Anchorage: Dr. Center will forward his comments to you.

Number 0366 Chairman Tischer: Thank you, I also extend that invitation to anyone else that may have additional comments to make or rebuttals to comments that were made and so forth. The committee is open to any type in that way before the deliberations finish on this particular piece of legislation, with that I'll ask the moderators to close down the network.

Number 0375 Chairman Tischer: For the record before we adjourn this meeting, I'd like to indicate that committee has not yet received a fiscal note from the Department of Commerce and Economic Development. We do have a HESS Department fiscal note on this, which is a zero fiscal note. The committee will be asking for a fiscal note from Legislative Finance also. It will be the practice of this Chair to require that the legislative fiscal arm of the Legislature provide us

with fiscal notes. As you well know sometimes fiscal notes that come down are tainted by favoring or disfavoring any particular piece of legislation, and I feel it is necessary to qualify those fiscal notes by an independent fiscal note based on information that we are able to garner or wishes of this committee. So don't be surprised if we recommend a fiscal note passed on with a bill from Legislative Finance. With that than, are there any comments from the committee?

Number 0394 — Rep. Davis: I will be writing to Dr. Hampton and Dr. Spaulding who are chiropractors or naturopaths in Fairbanks, I'll be asking for their comments and will give you a copy.

Number 0398 — Chairman Tischer: Can you do that with rapid haste? I would appreciate that. I will be directing staff and I worked on this personally and have put together and have already developed some language that I think we've already asked the drafter to include.

What I want to do is to bring that draft for you independently so that you will have an opportunity to study it and next time we meet on this, it will be from the limbo file and expect it practically any time. We have taken testimony last year and this year and I think we've exhausted our external differences.

Number 0422 — Chairman Tischer adjourned the meeting.

POSITION PAPER/Department of Health & Social Serv

POSITION PAPER

DRAFT COMMITTEE SUBSTITUTE FOR HOUSE BILL NO. 225 (HESS)

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

This draft Committee Substitute differs from the original Bill in several significant ways:

1. It permits the board of optometry to impose disciplinary sanctions on optometrists who fail to refer a patient to an appropriate health care practitioner for treatment of conditions beyond the scope of the licensee's training.

2. It forbids use of controlled substances.

3. It permits use of topical ophthalmic drugs only in contrast to the original Bill which would have permitted use of systemic drugs.

4. It defines the types of topical drugs which can be used and eliminates a role for the board in determining what drugs can be used.

5. It defines the type of training which must be obtained before a license endorsement can be issued in contrast to the original Bill which required the board to issue regulations prescribing training.

6. It prohibits the practice of surgery by optometrists.

This draft Committee Substitute, in the view of the Department, is a definite improvement over the original Bill. The Department would still prefer to restrict the types of topical drugs which are authorized to diagnostic drugs.

Recommended by: _____

E. S. Rabeau, M.D.
Director
Division of Public Health

Date: _____

Approved by: _____

Robert London Smith, Ph.D.
Commissioner
Department of Health and
Social Services

Date: _____

Alaska State Legislature

REP. MAE TISCHER
CHAIRMAN

POUCH V
STATE CAPITAL
JUNEAU, ALASKA 99811
(907) 465-3777

House of Representatives
HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE
Wednesday, 22 February 1984

Agenda

Call to Order

Comments by Representative Tischer, Chairman

Consideration of HB 225, "An Act relating to the practice of optometry and authorizing the use of certain drugs by optometrists."

Comments by members

Announcements

Adjournment

Article 2. Licensing.

Collateral references. — 61 Am. Jur. 2d, Physicians, Surgeons and Other Healers. §§ 5, 19-23, 30-43.

70 C.J.S., Physicians and Surgeons, §§ 11-13.

Pardon as restoring public office or license or eligibility therefor. 58 ALR3d 1191.

Statute of limitations relating to medical malpractice actions as applicable to actions against unlicensed practitioner. 70 ALR3d 114.

Sec. 08.64.170. License to practice medicine or osteopathy. (a) A person may not practice medicine, podiatry, osteopathy or acupuncture in the state unless the person is licensed under this chapter, except that

(1) a physician assistant may examine, diagnose or treat persons under the supervision, control, and responsibility of either a physician licensed under this chapter or a physician exempted from licensure under AS 08.64.370;

(2) a physician-trained mobile intensive care paramedic may render emergency lifesaving service; and

(3) a person licensed under AS 08.36 may perform acupuncture in the regular practice of dentistry, subject to the regulations of the Board of Dental Examiners.

(b) Repealed by § 4 ch 101 SLA 1974.

(c) A chiropodist practicing in the state on May 16, 1972 is exempt from this section.

ment. The statement, together with the written decision of the board, shall remain of record in the department. (§ 35-3-89 ACLA 1949; am § 23 ch 77 SLA 1969)

Sec. 08.64.350. Certification of revocation. When a license is revoked, the fact of revocation shall be certified by the secretary of the board to the clerk of the superior court in the judicial district where the license is on file. The clerk shall endorse the fact of revocation and the date of revocation on the face of the license or a certified copy of it which is on file. The same information shall be noted in the registry book provided for in AS 08.64.280. (§ 35-3-94 ACLA 1949; am § 24 ch 77 SLA 1969)

Article 3. Unlawful Acts.

Section

360. Penalty for practicing without a license or in violation of chapter

Sec. 08.64.360. Penalty for practicing without a license or in violation of chapter. Except for a physician assistant and a physician-trained mobile intensive care paramedic under AS 08.64.170, a person practicing medicine or osteopathy in the state without obtaining and filing an appropriate license is guilty of a misdemeanor and upon conviction is punishable by a fine of not less than $50 nor more than $100, or by imprisonment for not less than 10 days nor more than 90 days, or by both. Evidence that the defendant has failed to file a license with the clerk of the court is prima facie evidence that the defendant is not licensed. Each day of illegal practice is a separate offense. (§ 35-3-93 ACLA 1949; am § 25 ch 77 SLA 1969; am § 2 ch § SLA 1972; am § 11 ch 101 SLA 1974)

Collateral references. — Illegal practice of medicine under statute, ordinance or other measure involving chemical treatment of water supply. 43 ALR2d 453.

Hypnotism as illegal practice of medicine. 85 ALR2d 1128.

Single or isolated transaction as falling within provisions of licensing requirements. 93 ALR2d 129.

Practicing medicine, surgery, dentistry, optometry, podiatry, or other healing art without license as a separate or cocurring offense. 99 ALR2d 654.

Acupuncture as illegal practice of medicine. 72 ALR3d 1257.

Article 4. Miscellaneous Provisions.

Section

365. [Repealed]

366. Liability for services rendered by a physician-trained mobile intensive care paramedic

Section

367. Prescription or administration of laetrile by physicians

368. [Repealed]

Article 1. Board of Examiners in Optometry.

Sec. 08.72.010. Creation and purpose of board of examiners. There is created the Board of Examiners in Optometry to regulate and control the practice of optometry and to protect and promote the public health, welfare, and safety. (§ 35-3-132 ACLA 1949; am § 2 ch 75 SLA 1980)

Effect of amendments. — The 1980 amendment added "to regulate and control the practice of optometry and to protect and promote the public health, welfare, and safety."

Sec. 08.72.020. Membership of board and terms of office. The board consists of five persons, appointed by the governor. Members serve staggered terms of four years. (§ 35-3-132 ACLA 1949; am § 23 ch 102 SLA 1976; am § 3 ch 75 SLA 1980)

Effect of amendments. — The 1980 amendment substituted "four" for "three" and deleted the former third sentence, which read: "The terms of the public members of the board shall be set so that they do not expire at the same time."

Sec. 08.72.025. Removal of board members. A member of the board may be removed from office by the governor for cause. The board may by regulation provide that unexcused absences from meetings constitute cause for removal. (§ 4 ch 75 SLA 1980)

Sec. 08.72.030. Vacancies. The governor shall fill vacancies on the board by appointment for the unexpired term. (§ 35-3-132 ACLA

Sec. 08.72.040. Qualifications. Four board members shall be licensed, practicing optometrists who have been residents for at three years. One board member shall be a public member. A who has served two successive complete terms may not be until four years from the expiration of the second term that served. (§ 35-3-132 ACLA 1949; am § 23 ch 102 SLA 1976; 75 SLA 1980)

Effect of amendments. — The 1980 amendment substituted "Four" for "Three," and the materinl beginning, "One board member" and ending "term that he served" for the former second sentence, which read: "Two shall be have no direct health care industry."

Editor's note. — redrafted by the

remove personal pronou with AS 01.05.031(c) and SLA 1982.

Sec. 08.72.050. shall adopt rules a (1) necessary for (2) governing th (3) for the regis (4) necessary to (5) prescribing chapter must mee (§ 35-3-133 ACLA

Effect of amendm amendment added pa

Sec. 08.72.060 The board or a m administer oaths jurisdiction.

(b) The board (1) adopt a se (2) define pro duct.

(c) The board (1) elect a pr (2) order a li of the licensee' (d) Repealed (e) Repealed (f) Repealed (g). am § 3

...ve personal pronouns in conformity ... AS 01.05.031(c) and § 4, Chapter 58, SLA 1982.

Sec. 08.72.050. Power of board to adopt regulations. The board shall adopt rules and regulations

(1) necessary for the proper performances of its duties;

(2) governing the applicants and applications for licensing;

(3) for the registration of optometrists;

(4) necessary to govern the practice of optometry;

(5) prescribing requirements which a person licensed under this chapter must meet to demonstrate continued professional competency. (§ 35-3-133 ACLA 1949; am § 6 ch 75 SLA 1980)

Effect of amendments. — The 1980 amendment added paragraph (5).

Sec. 08.72.060. Miscellaneous powers and duties of board. (a) The board or a member designated by the board, may issue subpoenas, administer oaths and take testimony concerning any matter within its jurisdiction.

(b) The board may

(1) adopt a seal;

(2) define professional conduct and adopt rules of professional conduct.

(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 the licensee's physical capacity to practice safely is at issue.

(d) Repealed by § 3 ch 59 SLA 1966.

(e) Repealed by § 23 ch 75 SLA 1980.

(f) Repealed by § 3 ch 59 SLA 1966. (§§ 35-3-133, 35-3-140 ACLA 1949; am § 3 ch 59 SLA 1966; am §§ 7, 8, 23 ch 75 SLA 1980)

Effect of amendments. — The 1980 amendment rewrote subsections (b) and (c), and repealed subsection (e), which read "The board may define professional conduct and adopt rules of professional conduct."

Editor's notes. — This section was redrafted by the revisor of statutes to remove personal pronouns in conformity with AS 01.05.031(c) and § 4, Chapter 58, SLA 1982.

Sec. 08.72.070. Applicability of Administrative Procedure Act. Repealed by § 23 ch 75 SLA 1980.

Sec. 08.72.080. Compensation of board and secretary. Repealed by § 3 ch 59 SLA 1966.

Collateral references. — Right of corporation, or individual not himself licensed, to practice optometry through licensed employee. 102 ALR 343; 128 ALR 955.

One who fills prescription under reciprocal arrangement with optometrist, as subject to charge of practice of optometry without license. 121 ALR 1455.

Practicing medicine, surgery, dentistry, optometry, podiatry, or other healing arts without license as a separate or continuing offense. 99 ALR2d 654.

Sec. 08.72.115. Malpractice insurance.
Repealed by § 40 ch 117 SLA 1978.

Editor's notes. — The repealed section derived from § 24, ch. 102, SLA 1976.

As to purpose of repealing act, see § 1, ch. 177, SLA 1978 as amended by § 7, ch. 46, SLA 1982, in the 1982 Temporary and Special Acts and Resolves.

Sec. 08.72.120. Registration. It is unlawful for a person to practice, or attempt, or offer to practice, optometry without first obtaining a certificate of registration from the board, and without filing the certificate with the clerk of the superior court in each judicial district in which the person practices. (§ 35-3-135 ACLA 1949)

Editor's notes. — This section was redrafted by the revisor of statutes to remove personal pronouns in conformity with AS 01.05.031(c) and § 4, Chapter 58, SLA 1982.

Sec. 08.72.125. Registration of branch offices. (a) The board shall issue a branch office certificate of registration to an Alaskan licensee who maintains a full-time practice in the state but who serves other communities in the state on a part-time basis.

(b) It is unlawful for a person to practice, or to attempt or offer to practice, optometry in communities on a part-time basis without obtaining a branch office certificate of registration from the board, and without filing the certificate with the clerk of the superior court in each judicial district in which the person maintains a branch office.

(c) The board shall prescribe in the regulations the factors to be considered in issuing a branch office certificate of registration. (§ 2 ch 78 SLA 1969; am § 9 ch 75 SLA 1980)

Effect of amendments. — The 1980 amendment substituted "shall" for "may," and inserted "a branch office certificate of registration" in subsection (a).

Editor's notes. — This section was redrafted by the revisor of statutes to remove personal pronouns in conformity with AS 01.05.031(c) and § 4, Chapter 58, SLA 1982.

Sec. 08.72.130. Optometry register. The clerk of the superior court in each judicial district shall keep a record known as the "Optometry Register" and record the certificate of registration of each optometrist who files a certificate. The clerk shall charge the regular filing fee for registration. When an optometrist dies, or when the

Sec. 08.72.230. Fees and disbursements. The department shall collect all fees and keep a record of each transaction, and shall remit to the Department of Revenue all money received. (§ 35-3-138 ACLA 1949; am § 12 ch 76 SLA 1969)

Sec. 08.72.240. Grounds for imposition of disciplinary sanctions. The board may impose disciplinary sanctions when the board finds after a hearing that a licensee

(1) secured a license through deceit, fraud, or intentional misrepresentation;

(2) engaged in deceit, fraud, or intentional misrepresentation in the course of providing professional services or engaging in professional activities;

(3) advertised professional services in a false or misleading manner;

(4) has been convicted of a felony or other crime which affects the licensee's ability to continue to practice competently and safely;

(5) intentionally or negligently engaged in or permitted the performance of patient care by persons under the licensee's supervision which does not conform to minimum professional standards regardless of whether actual injury to the patient occurred;

(6) failed to comply with this chapter, with a regulation adopted under this chapter, or with an order of the board;

(7) continued to practice after becoming unfit due to

(A) professional incompetence;

(B) failure to keep informed of or use current professional theories or practices;

(C) addiction or severe dependency on alcohol or other drugs which impairs the licensee's ability to practice safely;

(D) physical or mental disability;

(8) engaged in lewd or immoral conduct in connection with the delivery of professional service to patients;

(9) failed to refer a patient to the appropriate health care practitioner after ascertaining the possible presence of ocular disease, (§ 35-3-140 ACLA 1949; am § 32 ch 177 SLA 1978; am § 17 ch 75 SLA 1980)

Effect of amendments. — The 1978 amendment added paragraph (4) of this section as it existed prior to the 1980 amendment.

The 1980 amendment rewrote the section.

Revisor's notes. — This section was renumbered by the revisor of statutes to remove personal pronouns in conformity with AS 01.05.031(c) and § 4, Chapter 58, SLA 1982.

As to the purpose of the 1978 amendatory act, see § 1, ch. 177, SLA 1978 as amended by § 7, ch. 46, SLA 1978, in the 1982 Temporary and Special Acts and Resolves.

Sec. 08.72.250. Disciplinary sanctions. (a) When it finds that a licensee is guilty of an offense under AS 08.72.240, the board may impose the following sanctions singly or in combination:

Sec. 08.72.275. Lenses and frames for eyeglasses and sunglasses. (a) A person may not fabricate, distribute, sell, exchange, deliver or possess with intent to distribute, sell, exchange or deliver eyeglasses or sunglasses unless they are fitted with plastic lenses, laminated lenses, heat-treated glass lenses, or glass lenses made impact resistant by other methods. All plastic and heat-treated glass lenses, before they are mounted in frames, shall be capable of withstanding the impact of a five-eighths inch steel ball dropped on the lens from a height of 50 inches. The impact test shall be conducted at room temperature, with the lens supported by a plastic tube one inch inside diameter, one and one-fourth inch outside diameter, with a one-eighth inch by one-eighth inch neoprene gasket on the top edge.

(b) A person may not fabricate, distribute, sell, exchange, deliver or possess with intent to distribute, sell, exchange or deliver eyeglasses or sunglasses having frames manufactured from cellulose nitrate or other highly flammable materials.

(c) A person who violates this section is punishable by a fine of not less than $50 nor more than $100.

(d) A licensee may sell, exchange or deliver eyeglasses or sunglasses which do not meet the requirements of (a) of this section if the sale, exchange or delivery is authorized in a written request signed by the patient. (§ 1 ch 220 SLA 1968; am § 1 ch 48 SLA 1973; am § 20 ch 75 SLA 1980)

Effect of amendments. — The 1980 amendment added subsection (d).

Editor's notes. — This section was redrafted by the revisor of statutes to remove personal pronouns in conformity with AS 01.05.031(c) and § 4, Chapter 34, SLA 1982.

Sec. 08.72.280. Violations. A person may not falsely personate a registered optometrist, or buy, sell or fraudulently obtain a certificate of registration issued to another or advertise the practice of optometry in violation of rules of the board. Practicing or offering to practice optometry is sufficient evidence of a violation of this chapter. (§ 35-3-144 ACLA 1949)

Sec. 08.72.290. Penalty. A person who violates this chapter is guilty of a misdemeanor and is punishable by a fine of not less than $100 nor more than $500, or by imprisonment for a term of not less than 30 days nor more than 90 days, or by both. (§ 35-3-145 ACLA 1949)

Article 4. General Provisions.

Section
300. Definitions
310. Short title

Sec. 08.72.300. Definitions. As used in this chapter

(1) "board" means the Board of Examiners in Optometry;

(2) "optometry" is the examination, other than by the use of drugs, 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 or application of lenses, prisms or ocular exercises for the correction or relief of the human eye;

(3) "practicing optometry" is an examination, other than by the use of drugs, 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;

(4) "lenses" means conventional or contact lenses;

(5) "recognized school or college of optometry" is one which is approved by the American Optometric Association or one of its committees;

(6) "department" means the Department of Commerce and Economic Development. (§ 35-3-131 ACLA 1949; am § 2 ch 95 SLA 1966; am § 13 ch 76 SLA 1969, am § 53 ch 218 SLA 1976; am §§ 21, 22 ch 73 SLA 1980)

Cross references. — For professional examination requirements for optometrists, see AS 08.02.010.

Effect of amendments. — The 1980 amendment rewrote paragraphs (2) and (3).

Sec. 08.72.310. Short title. This chapter may be cited as the Optometry Law. (§ 35-3-150 ACLA 1949)

Collateral references. — Optometry, what constitutes practice of. 88 ALR2d 1201.

Fitting of contact lenses as practice of optometry. 77 ALR3d 817.

Chapter 76. Pawnbrokers and Secondhand Dealers.

Sections

Transactions to be entered in book kept at place of business

Manner of recording entry

Section

30. Criminal liability

40. Disposition of unredeemed property

Josephson
5/10/83

Original sponsor: Josephson

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR SENATE BILL NO. 189 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTEENTH LEGISLATURE - FIRST SESSION

A BILL

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

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

* 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.

* Sec. 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 physician licensed in this state. A person who has served two successive complete terms may not be reappointed until four years from the expiration of the second term that the person served.

* Sec. 3. AS 08.72.050 is amended by adding a new paragraph to read:

(6) concerning the use of diagnostic drugs and the educational requirements for a license validation for their use.

* Sec. 4. AS 08.72.060(c) is amended by adding new paragraphs to read:

(3) with the advice and [guidance] consent of the state medical board, develop a list of specific diagnostic drugs and their dosages that may be used in the practice of optometry in this state by a

person licensed and registered by the board and with a license validation for the use of diagnostic drugs; and

(4) provide for continuing education, including an examination, for optometrists desiring to use diagnostic drugs.

* Sec. 5. AS 08.72.120 is amended by adding a new subsection to read:

(b) An optometrist may not be registered or certified to practice optometry in this state beyond the scope of the optometrist's training. The board of optometry shall determine the optometrist's qualifications.

* Sec. 6. AS 08.72 is amended by adding a new section to read:

Sec. 08.72.235. REFERRAL TO MEDICAL SPECIALIST. An optometrist who determines during the examination of a patient that a pathological condition may exist shall

(1) advise the patient of the possible condition; and

(2) refer the patient to an appropriate medical specialist for further evaluation.

* Sec. 7. AS 08.72.240 is amended by adding a new paragraph to read:

(10) has used the prefix "Dr." or "Doctor" before the licensee's name without using the word "optometrist" as a suffix to the licensee's name or in connection with it.

* Sec. 8. AS 08.72 is amended by adding a new section to read:

Sec. 08.72.257. DIAGNOSTIC DRUGS. (a) An optometrist registered and certified to practice in this state who desires to employ the use of diagnostic drugs shall

(1) submit to the board evidence of satisfactory completion of the educational requirements of the board for the use of diagnostic drugs; and

(2) pass an examination administered by the board.

(b) An optometrist seeking to be registered and certified to

practice in this state with a license validation for the use of diagnostic drugs shall

(1) submit to the board at the time of the licensing examination evidence of satisfactory completion of the board's educational requirements for the use of diagnostic drugs; and

(2) pass an examination administered by the board.

(c) Upon a determination that the applicant in (a) or (b) of this section has met the requirements for the use of diagnostic drugs, the board shall validate the license of the optometrist or successful applicant to allow the use of diagnostic drugs.

(d) An optometrist with a license validation for the use of diagnostic drugs shall undertake the continuing education requirements established under AS 08.72.060(4). Failure to fulfill the continuing education requirements shall be grounds for revocation of the license validation for the use of diagnostic drugs.

(e) An optometrist with a diagnostic drug validation may by written order or prescription sell, give away, barter, exchange, or distribute diagnostic drugs.

Orig. Amendment

* Sec. 10. 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 limited by this Act, 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 or application of lenses, prisms or ocular exercises for the correction or relief of the human eye;

* Sec. 10. 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 limited by this Act. 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;

* Sec. 12. AS 08.72.300 is amended by adding a new paragraph to read:

(7) "diagnostic drug" means a cycloplegic, mydriatic or topical anesthetic that is listed in the official United States Pharmacopoeia, or official National Formulary, or in a supplement to either of them, and approved in accordance with AS 08.72.060(c)(3)

Sec. 9. AS 08.72.290 is repealed and reenacted to read:

Sec. 08.72.290. PENALTY FOR PRACTICING WITHOUT A LICENSE OR IN VIOLATION OF CHAPTER. A person practicing optometry in the state without a valid license or permit or who violates this chapter is guilty of a class B misdemeanor. Each day of illegal practice is a separate offense.

Sec. 13. AS 08.64 is amended by adding a new Sec. 08.64.108

Sec. 08.64.108. Regulation of diagnostic drugs as used in the practice of optometry. The board shall adopt regulations necessary to carry into effect the provisions of AS 08.72.060(c)(3).

WEST VIRGINIA BOARD OF OPTOMETRY

JOHN E. CASTO, O.D.
SECRETARY-TREASURER
WEST VIRGINIA BOARD OF OPTOMETRY
611 SIXTH AVE.
P.O. BOX 710
ST. ALBANS, W.VA. 25177

February 27, 1981

(Updated spring 1983, as shown below)

The Honorable Warren R. McGraw
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 McGraw 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 updated 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 thirty-five ~~(135)~~ 153 West Virginia registered optometrists now certified by this Board for drug usage is as follows:

1. A total of seventy-two ~~(72)~~ 79 different drugs prescribable for the human eye have been employed by these West Virginia certified optometrists since the law was enacted.

2. Forty-seven thousand one hundred twenty-one ~~(47,121)~~ 100,000 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.

3. 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 formerly were referred, would have had to travel would have required that over ~~620,000~~ 1,800,000 aggregate miles be traveled by the ~~47,121~~ 100,000 patients.

4. Fifty-two ~~(52)~~ 53 different pathological conditions have been diagnosed and treated by these West Virginia certified optometrists.

These ~~135~~ 153 West Virginia optometrists who have been certified in every county of the state are now, faithfully and well, providing updated 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.

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 are encouraged to call upon this Board for any additional information which may be helpful.

Sincerely yours,

John E. Casto, O.D.

John E. Casto, O.D.
Secretary-Treasurer

JEC/scp

* Sec. 6. AS 08.72 is amended by adding a new section to read:

Sec. 08.72.305. Legend drugs permitted. A licensee holding a certificate issued under AS 08.72.277 may employ or prescribe only those legend drugs specified under the following classifications:

(a) Topical anesthetics

(1) Benoxinate

(2) Proparacaine

(b) Anti-infectives

(1) Bacitracin

(2) Chloramphenicol

(3) Erythromycin

(4) Gentamycin

(5) Polymixin B

(6) Sulfacetamide

(7) Tetracycline

(8) Tobramycin

(c) Anti-glaucoma agents

(1) Acetazolamide

(2) Epinephrine

(3) Pilocarpine

(4) Timolol

(d) Antihistamines

(1) Antazoline

(2) Pyrilamine

(e) Anti-inflammatory agents

(1) Dexamethasone

(2) Flurometha lone

(3) Hydrocortisone

(4) Prednisolone

(f) Antivirals

(1) Idoxuridine

(2) Trifluridine

(3) Vidarabine

(g) Decongestants

(1) Naphazoline

(h) Hyperosmotics

(1) Sodium Chloride 2%, 5%

(2) Glycerin

(i) Mydriatic/Cycloplegics

(1) Cyclopentolate

(2) Homatropine

(3) Phenylephrine 2.5%

(4) Tropicamide

Note: This replaces section 6 in the proposed committee substitute previously submitted and in the original bill. The original section 6 will not be needed if the new medical practice act (Senate CS for Bill 169) is enacted.

Anesthetics	Benoxinate	Fluress	0.4%
	Proparacaine	Ophthaine	0.5%
Antiglaucoma	Acetazolamide	Diamox	250 mg.
	Glycerin	Osmoglyn	50%
	Pilocarpine	Isoptocarpine	1,2,& 4%
	Timolol	Timoptic	0.25 & 0.50%
Antihistamines	Antazoline	Vasocon	1%
Anti-infectives	Sulfacetamide	Isoptocetamide	15%
	Gentamicin	Garamycin	0.3%
	Chloramphenicol	Chloroptic	1%
	Tobramycin	Tobrex	0.3%
	Tetracyline	Achromycin	1%
	Erythromycin	Ilotycin	5 mg/3.5g
	Zinc sulfate	Zincfrin	0.25%
-(Combinations)	Sulfacetamide/Prednisolone	Blephamide	10%/0.2%
	Polymyxin B/Bacatracin	Polysporin	10000/500 units
- Antivirals	IDU	Stoxil	0.5%
	Vidarabine	Vira A	3%
	Trifluridine	Viroptic	1%
- Antifungals	Natamycin	Natacyn	5%
Artificial Tears	Mucomimetics	Hypotears	
	Ointments	Lacrilube	
Corticosteroids	Prednisolone	Pred Forte	1%
	Fluoromethalone	FML	0.1%
	Dexamethasone	Decadron	0.1%
	Hydrocortisone	Hytone	0.5%, 1%
Decongestants	Naphazoline	Vasoclear	0.02%
	Phenylephrine	Prefin	0.12%
-Combination	Naphazoline/Zinc Sulfate	Vasoclear-A	0.02%/0.25%
Dyes	Sodium Fluorescin	Barnes Hind Sterile Strips	0.6 mg.
	Rose Bengal	" " "	1%
Hyperosmotics	Sodium Chloride	Adsorbonac	2, 5%
	" " Oint.	Muro #128	5%
Irrigations	Buffered Solution	Dacriose	0.9%
	" Saline	Eye Stream	0.9%
Mydriatic/Cycloplegias	Cyclopentolate	Cyclogyl	0.5, 1 & 2%
	Homatropine	Isoptohomatropine	2 & 5%
	Tropicamide	Mydriacyl	0.5 & 1%
	Phenylephrine	Neosynephrine	2.5%
	Hydroxyamphetamine	Paradrine	1%

PENNSYLVANIA COLLEGE OF OPTOMETRY 1919

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

Office of Academic Affairs

Pennsylvania College of Optometry

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

March 3, 1981

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 catagories 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 catagories of pharmaceutical agents commonly utilized in the patient care setting of the College. Examples are given of different drugs in each catagory. This is not to be interpreted that other drugs within these catagories 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. Antibioltics
      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-glaucomma
   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

Nancy Dietrick at Senate HE&S says DRAFT CS won't be ready for 2 hours - I saw the draft before it was cleared out of legal services. The bill is quite a bit different than the 225, I'd say schedule AGAIN or wait for CSSB 189 (if it gets out of Senate).

Has Dr Rabkin had
input into the Senate Sub
n do you know.

He wrote the position papers, but
I don't know what he's done on
the CS - I think it comes out of
comm. tee - Doubt he's been too
involved, but don't know for sure.

SPECIFIC LEGISLATION: 32 States

The list (and dates of enactment) of the 32 states with current legislation specifically authorizing optometrists to utilize pharmaceutical agents is as follows:

STATE	DATE OF ENACTMENT
Rhode Island	July 16, 1971
Pennsylvania	March 1, 1974
Tennessee	May 8, 1975
Oregon	May 20, 1975
Maine	June 24, 1975
Louisiana	July 6, 1975
Delaware	July 10, 1975
West Virginia*	March 4, 1976
California	July 9, 1976
Wyoming	February 17, 1977
New Mexico	March 4, 1977
Montana	April 12, 1977 (at 10:10 a.m.)
Kansas	April 12, 1977 (at 2:00 p.m.)
North Carolina*	June 3, 1977
Kentucky	March 29, 1978
Wisconsin	April 29, 1978
Nebraska	February 13, 1979
South Dakota	March 15, 1979
Utah	March 21, 1979
North Dakota	March 22, 1979
Arkansas	April 2, 1979
Nevada	May 25, 1979
Iowa	June 8, 1979
Georgia	February 14, 1980
Arizona	April 25, 1980
Idaho	March 23, 1981
Oklahoma	April 6, 1981
Washington	April 2[illegible] 1981
Missouri	July [illegible] 1981
Minnesota	March [illegible] 1982
Mississippi	March 17, 1982
Virginia	February 25, 1983

*both diagnostic and therapeutic use

NOTE: None of these laws has ever been repealed. However, a July 30, 1982 opinion of the Texas state attorney general has rendered that state's unusual provision (an amendment to the medical practice act), which was enacted on August 5, 1981, inoperative.

SOURCE: Dennis Swarner O.D & Robert O'Connell, O.D.

GENERAL LEGISLATION: 4 states

There are four states which authorize the use of pharmaceutical agents by optometrists by extant general law or favorable attorney general opinion:

Alabama	(diagnostic use)
Florida	(diagnostic and therapeutic use)
Indiana	(diagnostic use)
New Jersey	(diagnostic use)

NOTE: In addition, in Michigan, while there is no statutory prohibition of the use of pharmaceutical agents by optometrists, there is a negative opinion of the state attorney general.

For your information we are including an updated map showing, geographically, the utilization of pharmaceutical agents by optometrists.

Note: Section 39, chapter 842, Oregon Laws 1977, is operative July 1, 1986, and provides:

Sec. 39. ORS 683.010, 683.020, 683.030, 683.035, 683.040, 683.050, 683.060, 683.070, 683.080, 683.100, 683.110, 683.120, 683.130, 683.140, 683.155, 683.170, 683.180, 683.190, 683.210, 683.250, 683.260, 683.270, 683.275, 683.280, 683.290 and 683.990 relating to optometrists are repealed.

GENERAL PROVISIONS

683.010 Definitions. As used in this chapter, unless the context requires otherwise:

(1) "Board" means the Oregon Board of Optometry.

(2) "Practice of optometry" means the employment of any means other than the use of drugs, except diagnostic agents, topically applied, known generically as cycloplegics, mydriatics, topical anesthetics, dyes such as fluorescein, and, for emergency use only, miotics, for the measurement or assistance of the powers or range of human vision or the determination of the accommodative and refractive states of the human eye or the scope of its functions in general or the adaptation of lenses or frames for the aid thereof, subject to the limitations of ORS 683.040.

(3) "Trial frames" or "test lenses" means any frame or lens used in testing the eye which is not sold and not for sale. [Amended by 1971 c.102 §1; 1975 c.175 §1]

683.020 Certificate of registration required to practice optometry. No person shall engage in the practice of optometry or display a sign or in any other way advertise or hold himself out as an optometrist without having first obtained a certificate of registration from the board as provided for in this chapter. In any prosecution for the violation of this section, the use of test cards, test lenses or of trial frames is prima facie evidence of the practice of optometry. [Amended by 1971 c.102 §2]

683.030 Persons and practices not affected. This chapter shall not be construed to prevent any person duly licensed to practice medicine and surgery from treating or fitting glasses to the human eye, nor to prohibit the sale of complete ready-to-wear eye glasses as merchandise from a permanent place of business in good faith and not in evasion of this chapter by any person not holding himself out as competent to examine and prescribe for the human eye.

683.035 Discrimination against optometrists prohibited. No official, board, commission or other agency of the state or of any of its political subdivisions or municipalities shall discriminate between duly licensed optometrists and any other person authorized by law to render professional services which a duly licensed optometrist may render, when such services are required. Such services shall be paid for in the same manner and under the same standards as similar professional services. [1963 c.121 §1]

LICENSING

683.040 Qualifications of applicants. (1) Every person desiring to commence the practice of optometry in this state must show by satisfactory evidence that he is of good moral character and has graduated from a school of optometry which is recognized and approved by the board and which maintains a standard of four school years of at least nine months each.

(2) Every person desiring to commence the practice of optometry after January 1, 1976, or employ the use of diagnostic agents shall in addition to the requirements of subsection (1) of this section have satisfactorily completed a course in pharmacology, as it applies to optometry, by an institution accredited by a regional or professional accreditation organization which is recognized or approved by the National Commission on Accrediting or the United States Commissioner of Education, with particular emphasis on the topical application of diagnostic agents to the eye for the purpose of examination of the human eye and the analysis of ocular functions, approved by the Oregon Board of Optometry. [Amended by 1971 c.102 §3; 1975 c.175 §2]

683.050 Persons licensed in another state. In lieu of the educational requirements of ORS 683.040, it shall be deemed equivalent if an applicant submits satisfactory proof to the board that he:

(1) Has passed an examination in optometry before a state board of examiners in another state of the United States and that the certificate granted in token thereof is then in force; and

(2) Was actually engaged in the practice of optometry in such state for the full period of three years subsequent thereto.

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

HB225

November 30, 1982

The Honorable Mae M. Tischer
Alaska State House of Representatives
3305 Oregon Drive
Anchorage, Alaska 99503

Dear Representative Tischer:

Alaska's doctors of optometry (O.D.) are preparing to introduce legislation that will allow qualified Alaskan ODs to use prescription drugs in the treatment of infections, allergic inflammations and minor injuries of the eyes not requiring the services of a specialist. Many such conditions are treated by general practitioners, who have minimal training in this area (see attached article on ophthalmology training in medical schools). However the optometrist, who is considerably better qualified by training, experience and instrumentation than a general practitioner, must refer his patient to an MD (usually an ophthalmologist), at additional expense to the patient. We hav estimated, based on the experience of West Virginia (report to the West Virginia Legislature attached), that the elimination of extra visits would save Alaskans $235,000. in the first 3 years, not counting travel and lost time.

A majority of Alaska's ODs have recently completed a 120 hour course of postgraduate education and training in ocular therapy. A copy of the course outline and prospectus are attached. While 120 hours (and an equal amount of home study) is extensive for working practitioners, it should be considered only against a background of 4000 hours of professional training, much of it in the background medical sciences (copy of Pennsylvania College of Optometry curriculum attached). The combination provides a medical background equaling or exceeding dentistry (dental curriculum attached. Basic medical sciences in both curricula highlighted). Dentists, like physicians, have unrestricted drug prescribing privileges, though in practice they limit themselves to drugs appropriate to their field.

Drug legislation in more restricted form was originally introduced in 1978, when it passed the House. However ophthalmologists, who oppose the bill, have been able to tie it up in one committee or another since that time, despite a two thirds favorable majority in each house. If passage is further delayed, the skills gained or sharpened in this training will begin to deteriorate and problems of "grandfathering" may arise.

We will present further backup information at hearing. In the meantime, please feel free to contact me if you need any additional information.

Very truly yours,

Phillip W. Bach

Phillip W. Bach, O.D., Ph.D.
Legislative Chairman
Alaska Optometric Association

PWB/lr

1
8 attachments
(W. Va. report to follow)

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

January 14, 1983

The Honorable Mae M. Tischer
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Tischer:

The attached report of the West Virginia Board of Optometry to the West Virginia Legislature was cited as an attachment in my November 30 letter to you concerning the forthcoming optometric drug bill. Please include this material with that letter and let me know if you should need a copy of the letter or its attachments.

Respectfully yours,

Phillip W. Bach

Phillip W. Bach, O.D.
Legislative Chairman
Alaska Optometric Association

PWB/lr

Attachment

WEST VIRGINIA BOARD OF OPTOMETRY

JOHN E. CASTO, O.D.
SECRETARY-TREASURER
WEST VIRGINIA BOARD OF OPTOMETRY
611 SIXTH AVE.
P.O. BOX 710
ST. ALBANS, W.VA. 25177

February 27, 1981

The Honorable Warren R. McGraw
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 McGraw 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 updated 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 thirty-five (135) West Virginia registered optometrists now certified by this Board for drug usage is as follows:

1. A total of seventy-two (72) different drugs prescribable for the human eye have been employed by these West Virginia certified optometrists since the law was enacted.

2. Forty-seven thousand one hundred twenty-one (47,121) 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.

3. 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 formerly were referred, would have had to travel would have required that over 620,000 aggregate miles be traveled by the 47, 121 patients.

4. Fifty-two (52) different pathological conditions have been diagnosed and treated by these West Virginia certified optometrists.

These 135 West Virginia optometrists who have been certified in every county of the state are now, faithfully and well, providing updated 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.

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 are encouraged to call upon this Board for any additional information which may be helpful.

Sincerely yours,

John E. Casto, O.D.

John E. Casto, O.D.
Secretary-Treasurer

JEC/scp

STATE OF ALASKA 1984 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: Feb. 24, 1984

REQUEST
Bill/Resolution No.: CSHB 225
Title: "An Act relating to optometrist & use of drugs"
Sponsor: H.E.S.S. Comm.
Requestor:
Date of Request:

FISCAL DETAIL
Agency Affected: Commerce & Economic Dev.
Program Category Affected: Public Protection
BRU, Program or Subprogram(s) Affected: Occupational Licensing

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

N/A

ANALYSIS: Attach a separate page for analysis

Prepared By: Darrell Miller (Darrell Miller) Phone: 465-2535
Division: Occupational Licensing Date: Feb. 24, 1984

Approved by Commissioner: Richard A. Lyon Date: 2/28/84
Agency: Commerce & Economic Development

Distribution (by Agency preparing fiscal note):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

12/1/83

OPHTHALMIC ASSOCIATES
A PROFESSIONAL CORPORATION

KENNETH T. RICHARDSON, M.D., F.A.C.S.
EDWARD E. CROUCH, M.D.

AHARON STERNBERG, O.D., F.A.A.O.

January 26, 1984

Representative May Tisher
State Capitol
Pouch V
Juneau, AK 99811

Dear Representative Tisher:

I would like to take this opportunity to voice my opposition to House Bill 225 which is due to appear before your committee. This bill is designed to allow optometrists the use of prescription medications for diagnosis and treatment of eye disorders.

Without taking too much of your time I would like to state that I feel this is likely inappropriate for various reasons. One, when freedom to prescribe medications to patients is given to a paramedical personnel, generally it is tied to a supervisory provision in which the provider is suppose to be under the auspices of someone in the medical profession. This, while being admirable in its intent, is impossible in its application. Having recently arrived to Alaska from North Carolina, which happened to have been the second state in the Union to allow optometrists use of medications, I was able to observe such a bill in action for a period of time. In general I do not feel that this right was abused by the optometrist, but in point of fact, there is no way to supervise such usage of medications and pharmacists seem uniformly willing to fill any prescription from an optometrist and provide absolutely no policing effort themselves. Two, once a group of medications is approved for use, a whole new spectrum of medications are available for use in that the medicines tend to be grouped together under certain general headings by the Food and Drug Administration. While I feel it is probably desirable to have optometrists free to use topical anesthetics and diagnostic pupillary agents to aid in the examination of patients, it is essentially impossible to restrict their use of medications to only these agents. If it were possible, I would feel that this is a favorable approach to take to broadening their health care.

A further point would be one to defend my view point. It seems many people hold the view that opposition to such a measure comes from a competitive basis from the medical profession and not one with the patients' true concern at heart. I would like to

542 WEST SECOND AVENUE ANCHORAGE, ALASKA 99501-2242 Telephone 907/276-1617

emphasize that whether or not the bill is passed will have little or no impact on the type of practice any of the ophtnalmologists in the community have. Rather it provides a greater freedom for patient misuse than a loosening of any trade restrictions imposed by present regulations.

Please give thoughtful consideration to the bill when it is presented with these points in mind.

Sincerely,

Edward E. Crouch, M.D.

EEC:lp

A responding letter went out 4/29/83

COOK INLET NATIVE ASSOCIATION

670 West Fireweed Lane
Anchorage, Alaska 99503
(907) 278-4641

APR 2 = 1983

April 21, 1983

Prepresentative Mae Tischer
Pouch V
Juneau, Alaska 99811

Dear Representative Tischer:

Senate Bill #189 and House Bill #225 should be applicable in the practice of Optometry only in remote areas where medical personnel (M.D./D.O.) are not available. In Anchorage for example, medical personnel are available to treat patients with eye disorders.

On the other hand, Optometrists should be permitted to use such medications as necessary in examining eyes, measuring errors in refraction and prescribing glasses to correct these defects.

Sincerely,

Dr. Kenneth Y. E. Chang, M.D.

tll