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189

SECTIONAL ANALYSIS OF SB 189 "AN ACT RELATING TO THE PRACTICE OF OPTOMETRY AND AUTHORIZING THE USE OF PRESCRIPTION DRUGS BY OPTOMETRISTS"

SECTION 1 ADDS A NEW SECTION TO THE STATUTES TO AUTHORIZE THE USE OF, AND PRESCRIPTION OF ALL PRESCRIBED(OR LEGEND) DRUGS BY OPTOMETRISTS.

SECTION 2 (a) AUTHORIZES THE OPTOMETRY BOARD TO IDENTIFY AND APPROVE BY REGULATION UNDERGRADUATE AND POST GRADUATE PROGRAMS THAT TRAIN OPTOMETRISTS IN THE USE OF PRESCRIPTION DRUGS. ALSO AUTHORIZES THE PROMULGATION OF CONTINUING EDUCATION REGULATIONS.
(b) PROHIBITS THE USE BY OPTOMETRISTS OF ANY DRUGS OTHER THAN LEGEND DRUGS, AND ONLY WITH THE APPROVAL OF THE BOARD BY LICENSE ENDORSEMENT.
(c) A LICENSE ENDORSEMENT ATTACHES TO THE LICENSE FOR EXPIRATION PURPOSES AND MAY BE RENEWED UPON EVIDENCE OF COMPLETION OF REQUIRED CONTINUING EDUCATION.
(d) THE BOARD SHALL ADOPT REGULATIONS FOR THE USE AND PRESCRIPTION OF LEGEND DRUGS AND MAY IMPOSE SANCTIONS AGAINST VIOLATORS.
(e) THE BOARD OF OPTOMETRY WILL NOTIFY THE BOARD OF PHARMACY OF ALL LICENSEES HOLDING A LICENSE ENDORSEMENT.

SECTION 3 REMOVES FROM STATUTE THE PROHIBITION AGAINST THE USE OF DRUGS BY OPTOMETRISTS, AND ALLOWS THE USE OF DRUGS FOR DIAGNOSIS AND TREATMENT OF INFLAMMATIONS, INFECTIONS AND INJURIES OF THE EYE AND EYELID.

SECTION 4 SAME AS SECTION 3 IN AMENDING THE DEFINITION OF THE PRACTICE OF OPTOMETRY.

SECTION 5 DEFINES LEGEND DRUGS AS THOSE REQUIRING A PRESCRIPTION.

SECTION 6 INCLUDES OPTOMETRISTS IN THE STATUTE AS THOSE ALLOWED TO PRACTICE MEDICINE AND THEREFORE LIABLE FOR VIOLATION OF PRACTICING WITHOUT A LICENSE.

"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 ophthalmologic 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.

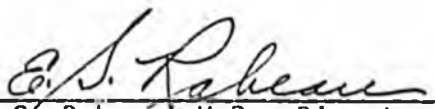
Limitations are placed on the use of certain diagnostic drugs by legislation in some states. In Oregon, for example, the Board of Optometry is empowered to designate the diagnostic pharmaceutical agents for topical use, but provides that the designation shall be with the advice and guidance of the Board of Medical Examiners.

POSITION PAPER / Department of Health and Social Service

Some states define the type of training in pharmacology which would be required before an optometrist would be permitted to use even diagnostic drugs. SB 189 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.

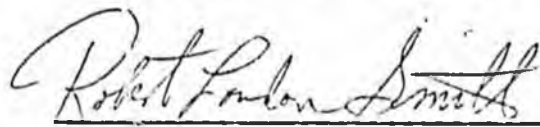
Recommended by:


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

Date:

March 23, 1983

Approved by:


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

Date:

3/30/83

I. REQUEST
 Bill/Resolution No.: SB No. 189
 Title: "Relating to the practice of optometry."
 Sponsor: HESS (Josephson)
 Requestor: _____

II. FISCAL DETAIL
 Agency Affected: Health & Social Services
 Program Category Affected: 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		0	0	0	0	0
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

CAPITAL						
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REVENUE						
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FUNDING: (Thousands of Dollars)

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

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY		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. *DFT* Phone: 465-2113
 Division: Public Health Date: 3/23/83

Approved by Commissioner: *Robert Josephson* Date: 3/30/83
 Department: Health and Social Services

Distribution:

- Original to Legislative Finance
- Copy to Office of Management and Budget (for Legislature introduced bills)
- Copy to Department (for Governor introduced bills)
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In reviewing House Bill #75 and Senate Bill #79, Section 2, Subsection 08.72.305 - Use of Drugs for Diagnosis, included in the list of drugs proposed to be used is a class of drugs called miotics. This group of drugs is only therapeutic and has no diagnostic use. They are used for treating chronic glaucoma and acute angle closure glaucoma. What is a therapeutic drug doing in a "diagnostic" bill? Mr. George Hall's and Mr. Sternberg's (both Anchorage optometrists) response to this question at the March 1, 1978 meeting of the Legislative Coalition of Health Care Professionals in Anchorage and at the 1978 hearings on a similar bill introduced and defeated last year respectively was: "To take care of angle closure." "To use this as a first aid measure." This is treatment.

Treating angle closure glaucoma is very difficult and requires more than just putting a miotic eye drop in the eye. Treatment of this condition requires surgery in 1 cases. To break the angle closure attack before surgery, hospitalization, Diamox and intravenous Mannitol is necessary in many cases. If angle closure glaucoma goes untreated, blindness results. All cycloplegics and mydriatics (dilating drops) can cause angle closure glaucoma.

It has been suggested to you by the optometrists that the incidence of angle closure glaucoma is only 1 in 18,400 cases. What they do not tell you is that a unique situation exists with the native Alaskan. The incidence of angle closure is 1 in 1,900 cases and even higher if dilating drops are used. This problem usually takes several hours to develop, long after the optometrist would have left the village. If we were to allow the optometrists to use dilating drops, this would result in many more unnecessary surgical emergencies and possible blindness. In view of this well known fact, ophthalmologists are hesitant to use mydriatics and cycloplegics in the Alaska native, especially in the bush areas.

Miotics are a therapeutic class of drugs and are listed incorrectly in the proposed bills as diagnostic drugs. Either the optometrists do not have a thorough understanding of the eye medications, or they are asking the legislators to allow them to treat glaucoma and other eye conditions. The proposed bill lists only broad general categories of the desired eye medications, no specific drug names and concentrations. The classes of drugs include such potent substances as Cocaine, Atropine, Scopolamine, Phenylephrine and Phospholine Iodide. All these drugs when applied to the eye are readily absorbed into the bloodstream and are capable of producing a wide range of total effects.

Cocaine, a topical anesthetic and mydriatic (dilator of the pupil) is a Class II narcotic controlled substance which is subject to wide spread abuse by addicts and requires a controlled substance registration certificate to dispense or use.

Optometrists are not medical doctors and cannot get a federal narcotics certificate. These drug bills are inconsistent with federal regulation on this point.

Atropine and Scopolamine are cycloplegic agents which paralyze the eye's focusing power and in sufficient doses produce irritability, hallucinations and even coma. Phenylephrin (a mydriatic) has the ability to raise the blood pressure markedly and to alter the rhythm of the heart and has been implicated in deaths in older people through strokes and in children through cardiac arrhythmias. Phosoline Iodide, a miotic which constricts the pupil, is used in the treatment of glaucoma (elevated pressure in the eye) and in certain cases of crossed eyes. The active ingredients are related to the active substance in certain insecticides and nerve gas. This medication has been shown to produce retinal detachments and cataracts.

The above are only a few examples demonstrating what potential dangers exist in the various classes of drugs listed in the proposed bills. By allowing wide spread use of these drugs by nonmedical persons, the overall risk to the general public of potentially serious side effects or untoward reactions are markedly increased.

I. EYE HEALTH CARE PROVIDERS OF THE CONSUMING PUBLIC

The American Optometric Association defines an optometrist as:

"...a health care professional who is specifically educated, highly trained and state licensed to examine, diagnose, and treat conditions of the vision system. Optometrists are highly skilled individuals who examine the eyes and related structures to determine the presence of vision problems, eye diseases and other abnormalities. They gather information on the vision system during the optometric examinations, diagnose any conditions discovered and prescribe optometric treatment such as contact lenses or vision therapy that may be required to provide the patient with clear efficient vision."¹

Although this definition is broad, the Alaska legislators have specifically narrowed the definition down considerably. According to the Alaska State Statutes, Title 8, Business and Professions Section 08.72.300, the Statutes define optometry as:

1. "Optometry" is the employment of means or methods, other than the use of drugs, for the diagnosis of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription or application of lenses, prisms or ocular exercises for the correction or relief of the human eye:
2. "practicing optometry" means the diagnosis, by means or methods other than the use of drugs, of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription of lenses, prisms or ocular exercises for the correction or relief of the human eye, or the holding of oneself out as being able to do so.

The optometrists will or have suggested to you that they are legally bound to diagnose eye diseases and that they are in a dilemma in that they cannot diagnose eye diseases without the use of drugs. They are only in a dilemma if the broader sense of the definition is used as set forth recently by the American Optometric Association. However, the Alaska State Legislators have ingeniously removed that dilemma for the optometrists by limiting them to the diagnosis of visual anomalies, muscular anomalies, optical deficiency or deformities and not eye diseases.

Furthermore, this construed dilemma is removed by a landmark decision by Judge James M. Fitzgerald, United States District Judge for Alaska in the Timothy Steele case in Fairbanks, Alaska. This is the case where an optometrist in Fairbanks used a dilating drop and noted an abnormality and did not refer the child to a medical doctor. The following is a direct and full quote of the Judge's conclusion:

"I conclude that competent optometric practice required that Timothy's parents be notified and that the child be referred. The failure to inform and refer was not a 'judgment call' but a violation of the governing principles of professional standards.

Optometrists are trained to recognize symptoms of many diseases which may be discovered by eye examination. They are not permitted under recognized optometric standards to undertake a definite diagnosis but recognize this as the responsibility of a medical doctor. Obviously, it is foreseeable that failure to refer to a qualified medical practitioner, when required to do so, will result in delay of diagnosis and the institution of treatment; so it proved to be in Timothy's case. At the time the referral was finally made to an ophthalmologist, it was too late. Time had run out, and the only thing that could be done was to remove the eye.

I conclude that the plaintiff is entitled to recover in this action from the United States for the loss of Timothy's right eye.

DATED at Anchorage, Alaska, this 20th day of October, 1978."

ss: James M. Fitzgerald
United States District Judge

If these bills passed, the statutory law would be inconsistent with common law or court decisions. Let us examine the optometrist's construed dilemma a bit closer. In an article "How the General Practitioner Can Determine the Need for Ophthalmologic Referral", it has been shown that the initial clues to eye disease are determined by history, visual acuity and external examination by handheld flashlight. Only .1% of eye disease is initially determined by using dilating drops. See Table A.

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

Most importantly, do not dilate the pupil. Routine tonometry according to established standards and viewing the fundus oculi through the undilated pupil are the additional needed methods. The use of mydriatic drugs to dilate the pupil risks precipitating acute narrow angle glaucoma by a 9:1 ratio over uncovering any hidden disease process. Thus it is obvious that there is no dilemma at all. This dilemma was construed by the optometrist for legislative purposes.

By now you have heard from the optometrists that there is another law suit filed against an Anchorage optometrist. They also state that if they could dilate the pupil to look in that the law suit would not have been filed. Well, the optometrist dilated Timothy Steele's pupil and still a law suit was filed and was won by Timothy Steele. The fallacy of this statement by the optometrists is clear in light of Judge Fitzgerald's decision and the article on what people need ophthalmologic referral.

The ophthalmologist is a medical doctor who has completed a 3-5 year residency program after one year internship preceded by 4 years of college and 4 years of medical school. He is trained in the diagnosis and treatment of ocular dysfunction and disease and in the use of all techniques or treatment including drugs, surgery, laser photocoagulation, radiation, etc. Because he has been trained as a general physician first, his perspective of the eye is broader than the optometrist. He views the eye and its diseases within the context of the whole body physiology and pathology. Further, refraction to the ophthalmologist is viewed as only one necessary step in a differential diagnosis of the patient's complaint. Table 1 demonstrates the overall education and numbers of optometrists and ophthalmologists. From Table 1 it is evident that the ophthalmologists have much more training in pharmacology and pathology than the optometrists. Still the optometrists continue to compare their curriculum hours to dental school hours. They continue to say that if the dentists can use medications, why can't we. This is like comparing apples to oranges. They are not asking to use the drugs dentists use or to diagnose oral pathology. They are asking to do what the ophthalmologist does.

Therefore, it is more appropriate to compare ophthalmologists curriculum hours to optometric curriculum hours. (Please read Ref.#43, which explains this point in detail for the State of Alaska.) It is immediately obvious that the ophthalmologist has many more hours of classroom or book learning and many more years of clinical experience. The optometrists indicate that they can also take courses, but where do they get the years of clinical experience of putting drugs into the eyes of patients under close supervision of the clinical medical professors who are medical doctors. Optometrists simply do not get this type of training. Book learning is one thing, but clinical experience is most important.

Table 2⁴ gives a comparison of consumer services offered by ophthalmologists and optometrists. It is quite apparent that there is considerable overlap. This is most apparent with respect to refractions. The optometrist obviously can do some of the things the ophthalmologist can do; the ophthalmologist can do all of the things the optometrist can do, has the education to better interpret the data acquired, and provide medical/surgical treatment. The ophthalmologist is trained to provide complete eye care and to evaluate ocular dysfunction in the context of total body physiology and pathology. The ophthalmologist is a complete eye care provider. Although the overlap of professional services is greatest for refractions, this is a source of considerable consumer spending in both professions.

ECONOMICS (AND PRACTICE)?

Table 3⁵ shows the substantial number of public dollars which are expended for eye care. A total of approximately \$4,135 million dollars were spent in 1975 for vision care services.⁶ The national consumer spending for ophthalmic surgery is not listed. This would make the total ophthalmologic dollar spent on eye care far greater than the optometric dollar. If optometrists are allowed to expand the scope of their practice through the use of diagnostic drugs, the price of the basic eye examination would undoubtedly rise. Proposed national health care legislation can be expected to impact heavily upon these figures. For example, if the Kennedy-Mills National Health Insurance proposal were to include coverage of sight correction services, total spending for these services would rise by 21% or \$866 million dollars per year. It is obvious that there will be considerable effort by optometrists to ensure their fullest possible participation in this program. The economic stakes are very high.⁷ This makes it very clear why optometry has put on an aggressive nationally organized push to legislate themselves into a better position to compete for this consumer dollar. Even though

the optometrists in the State of Alaska suggest that this is not a "money bill"-- it is. It is merely the first step toward the national optometric goal to attempt to become primary eye care providers.

This image change is being sold to the public by a sophisticated national advertising campaign. This multi-million dollar campaign is funded by the national optometric organization through dues and special assessments. They are trying to sell themselves as "your family doctor of optometry...the one to see and keep seeing". Calling themselves family doctors in the opinion of the ophthalmologists is misleading since they are not medical doctors as are the family practitioner or family doctor. These adds are occurring on national T.V., radio and magazine; such as, The Ladies Home Journal, Better Homes and Gardens, etc. Adds that show stethoscopes hanging around the neck of the optometrist is also misleading, as the general public associates the medical doctor with the stethoscope. One article in the Anchorage Times even referred to a group of optometrists as physicians and the word ophthalmologist was used. (See supporting documents)

We should expect that in the future the Alaskan optometrists will follow the attempt of other state optometric associations to next try for the privilege to use these same diagnostic drugs as therapeutic agents. An attempt was made in West Virginia to legislate the privilege of eye surgery, but this was defeated.

The optometrists have claimed at their bill hearings in the lower 48 that they see 70% of the eye consumers and therefore are the point of first entry into the eye care system. Looking first at the source of this claim and national statistics, the fallacy of this claim is demonstrated. They have erroneously assumed that the average number of eye consumers seen by each practitioner is the same. Thus the source of the fallacy: that since they compose 70% of the national work force they see 70% of the eye consumers.

Table 1 indicated the total number of practitioners in each group.⁸ The median number of patients seen per week by optometrists was 43.2; the median seen by ophthalmologists was 102.9. The ophthalmologist sees more than twice as many patients as the optometrist while he comprises only 30% of the work force. It is therefore, clear that the ophthalmologists care for half the patients, while the optometrists, comprising 70% of the national work force, care for the other half. The statistics in Alaska show that there is a total of 40 optometrists¹⁰ and 25 ophthalmologists¹⁰. Thus the ophthalmologists make up 39% of the state work force

people in all sections of the state and in many small communities through the itinerant program.

In the states where optometric drug laws are in effect, optometrists who wish to use drugs much take short slide and lecture courses on pharmacology. This has or will create two classes of optometrists, which can only lead to additional consumer confusion about a profession already shrouded in confusion. In addition, the use of drugs by optometrists could falsely lead patients to believe diagnostic expertise is available from optometrists.

It is misleading to the consumer and legislature to imply that any drug is purely diagnostic. Each of the classes of drugs asked for by optometry have therapeutic uses. Will the optometrists resist the temptation to use these drugs to treat conditions beyond their knowledge and skill?

It has been said by the optometrists that they would like to use dilating eye drops also in the their bush clinics when they see Alaska natives. A unique situation exists within the native population of Alaska. The incidence of angle closure glaucoma is 1 in 1,800, not 1 in 20,000 as in caucasians. To allow the optometrist to use these dilating eye drops would result in many more cases of acute angle closure glaucoma, for which they are not trained to treat, and which requires quick and effective treatment to prevent blindness. Sometimes angle closure glaucoma requires administration of intravenous Diamox, Manitol or urea. This would result in further expenditure of health care dollars.

III. LEGISLATIVE DUTY FOR THE EYE CARE CONSUMER:

As practitioners of an occupation which deals with the integrity of eyesight, optometrists have been recognized by the Washington Legislators as members of a "learned profession".¹² Professionals who deliver health care may be regulated by the state via its

and the optometrists 61%. Applying the same national ratio of eye consumers seen by optometrists and ophthalmologists, it is evident that the ophthalmologists see 56% of the eye care consumer, but makes up 39% of the state work force. The accuracy of the ratio of two to one was checked in the city of Anchorage by comparing the number of eye consumers seen by the most active ophthalmologist in town - 40-50 eye consumers, as compared to the most active optometrists in town - 20-25 eye consumers seen in one day. The average ophthalmologist in Anchorage sees 30 people per day. The average optometrist sees 15 people per day. These figures would seem to indicate that although ophthalmologists are a smaller group than optometrists, the public will seek out their services given a free market choice.¹¹ On this point, the eye consumer in the state of Alaska has ready access to the ophthalmologic eye care providers. Some of the states in the lower 48 are mainly rural and ophthalmologists are congregated in the metropolitan areas and the optometrists are distributed over the rural areas. However, much of Alaska is "bush country", so that the ophthalmologists and optometrists are both congregated in Anchorage, Fairbanks, Kenai Peninsula and the southeast. There are only two areas (Kodiak and Bethel) that have a full time optometrist and no full time ophthalmologist, Table-Map 5,6. However, there are other medical doctors in these communities with "medical know how" and there are airports for evacuation in the case of eye emergencies. Furthermore, Kodiak and Bethel are visited on a regular basis by itinerant ophthalmologists. In fact, most areas in Alaska are served by itinerant ophthalmologists both by Alaska Native Service and by private practicing ophthalmologists, Table-Map⁶. In the 14 other states where a similar bill was passed, these states were mainly rural with a maldistribution of ophthalmologists. In these states, this was the main reason for passing the legislation. Therefore, this argument for passing House Bill 74 or Senate Bill 75 does not apply to the State of Alaska, because the distribution of ophthalmologists is essentially identical to that of the optometrists. Thus, the health services of ophthalmologists are readily available to

police powers to oversee those activities which are involved with health, education and welfare.¹³ The healing arts particularly have been the subject of regulatory legislation which specifies strict requirements for the practice of such professions.¹⁴ The intent of such restrictive legislation is avowedly the protection of the public against injuries it may suffer from the conduct of such business or calling.¹⁵ The state may reasonably impose any condition precedent to the grant of its consent to practice a healing art, which has a real and rational relation to that objective.¹⁶

The usual means taken by the state in applying these conditions as quality standards has been by imposing licensing requirements and by carefully defining the particular professions involved.¹⁷ Constitutional challenges to this power of the state have been universally defeated when that power has been reasonably exercised.¹⁸

Licensing requirements usually specify minimum standards of professional competence for the profession covered and frequently the definition of the profession gives broad areas of practice which will be considered appropriate for the practitioner seeking licensure. Additional restrictions upon the practice can be found in state statutes which define unprofessional or unethical conduct.¹⁹

The above state powers are broad and greatly influence the scope and freedom of practice by the health care provider. Although the right to follow a profession is recognized as a valuable property right which is constitutionally protected,²⁰ such a right is not absolute; there is no natural or vested right to practice within the healing professions. Any such right is a conditional use.²¹

The justification for such regulations lies in a perceived right and duty of the legislature to protect the citizens of the state from incompetents and fraudulent health practitioners.²² The Washington Constitution specifically vests exclusive authority in the legislature to:

"...regulate the practice of medicine and surgery and the sale of drugs and medicines."²³ From this, courts have construed legislative authority to regulate, by means of separate statutory licensing requirements, all of the various professions and occupations engaged in health care delivery. This includes many professions which are not obviously included in "...the practice of medicine..."²⁴ Further, the state has the power to define what constitutes the practice of any profession and may then confine practitioners of various health disciplines to the particular system of practice in which they have been educated.²⁵

This is a logical stance for the legislature to take. If the legislature has an avowed interest in protecting the public,²⁶ it must make some attempt at defining the scope of appropriate practice which each class may safely employ and to license those within each class to practice upon the public only those skills for which they have demonstrated competent training. That includes courses, testing and most important of all, clinical experience under supervision. This is the legislative intent in enacting licensing statutes.²⁷ This reasoning is followed with consistency in cases involving almost every viewpoint and aspect of health care.²⁸

Great latitude is given by the courts to the legislature in defining its public health goals. However, the goal is universally stated to be the protection of public health. Health legislation is not passed to promote the personal ends of individuals or to enhance the status or prestige of any given class of practitioners.²⁹ Although the legislature may enact such regulatory legislation as it may consider necessary, there must be a rational basis upon which the legislative determination rests.³⁰ This cannot be interpreted as meaning anything less than that such legislation must appear to be rationally directed toward the achievement of the stated legislative goal and to be reasonably rational in the means which it seeks to achieve that goal.

is made with 'whole body' disease/function. The eye is studied in isolation as an optical instrument. To use an analogy, an operating room nurse could teach an optometrist about eye surgery, just as a pharmacologist Ph.D. can teach an optometrist about pharmacology. However, no one would want an optometrist to perform surgery with an education based only on lectures and theoretical familiarity with the subject. The prescribing and using of drugs, just like the performance of surgery, must be founded on a broad-based curriculum involving many hours of supervised clinical experience using drugs. To allow any health care provider to practice with only limited classroom experience and testing violates the legislative duty to protect the public from risk of incompetency from lack of clinical experience.⁴³

As a second step, the legislature can require continuing education for those practitioners who have already completed broad formal training upon which additional, up-dated information may be rationally correlated. This type of post-graduate instruction always preumes in-depth background knowledge. It is used to present newly altered clinical concepts or additional practical experience (e.g., using operating microscopes, intraocular lens implants, vitrectomies, etc) for those practitioners with clinical experience sufficient to allow them to understand the usefulness or pitfalls, to see the advantages or clear disadvantages, to comprehend the clinical reliability or dangers of the material which the course is presenting. Crash courses which involve totally new material, presented to practitioners without that clinical judgement or experience necessary to actually grasp the real impact of the data presented, let alone the nuances, can be expected to create clinicians who will test their newly acquired knowlege in the public sphere. The hazards of such an approach are obvious. Again, such an approach does not satisfy the legislative duty to reduce public risk.

I must conclude that for the state to allow graduates of optometric schools, who are unarguably well-trained in the limited sphere of practice which optometry has exercised to date, to extend their

- a) Goal - As noted above, the frequently given objective for regulation of health care providers is the protection of the public from incompetent practitioners.³¹

This goal is stated to exist even if it deprives a citizen of a right he otherwise might enjoy in the pursuit of his profession.³²

This reasoning leads to the conclusion that the legislature has the duty to ensure that its acts and statutes do not tend to increase public exposure to health risk.³³ The stated legislative goal is increased public protection, not increased public risk. Nowhere does case law state that public protection will be qualified - i.e., that the legislature may increase the risk "a little bit", but not "a lot". No such slippery subjective terms appear. The intent is protection. The language is explicit.

- b) Means - The means by which the legislature attempts to arrive at its stated goal must be reasonable and rational.³⁴ The means which have been used by all states to regulate the professions have been noted above. The states have attempted to ensure the competency of each practitioner and then limit each to the area of practice embraced within the training which that practitioner has received.³⁵ If this means anything, it must mean that before the provider is allowed to administer to an uninformed public, (45% of the public does not know the difference between an ophthalmologist and an optometrist)⁴⁸ he must provide evidence of training sufficient to ensure the public from health care which is inadequate. Such inadequacy can range from innocuously improper diagnoses which are nonetheless economically costly, to disabling or fatal mistakes in clinical judgement - either diagnostic or the end result of therapeutics.

Insofar as it can ever be sure of the quality of professional performance, the state has two related ways to oversee clinical performance.

The state may require evidence of formal professional training which has as its foundation and primary goal, a strong commitment to an understanding and clinical application of those methods, techniques and material to which the public will be exposed and which will place it at risk. Such training must satisfactorily convince the legislature that which it certifies the practitioner, the legislative duty to prevent risk of public harm has been met.

Using the data presented in the first portion of this testimony, it is apparent that optometric training as it now exists in the State of Alaska is not directed toward a broad understanding of human pathology/physiology/pharmacology with supervised clinical experience.⁴³ Training is limited to a superficial, most theoretical, presentation of data concerning ocular dysfunction with inadequate clinical supervised experience. Not only do the data show that the instruction given the optometric student is very limited, but little or no integration of visual disease/function

clinical practice to include the application of drugs to the eye would be an irrational approach toward the protection of public health.⁴³ If the curricula of optometric schools demonstrated sufficiently integrated instruction in human anatomy/pharmacology/physiology/pathology to provide the optometric graduate with an adequate basis for making appropriate clinical decisions of diagnosis, then such a legislative extension of clinical opportunity, and responsibility would be reasonable. Crash courses are not an adequate substitute³⁸ for many hours of supervised clinical experience.⁴³

It should be repeated that the strong interest of the state in protecting the public, has traditionally and appropriately placed rigid conditions and restrictions upon the right to affect public health.³⁹ It should also be repeated that this power to restrict health care practice is recognized as proper regardless of its effect upon the economic interests of those regulated.⁴⁰

It is doubtful that an informed public would voluntarily accept a role as an on-the-job training clinical practice model so that the optometrists can gain the clinical experience needed to use drugs. The consumer public currently has expectations which include a higher standard of knowledge by the medical service provider than ever before. These expectations directly flow from the public's increased understanding that they each, as individual complex biologic units, are biochemically affected in manifold ways via the environment, foods and drugs. Any legislative change which would franchise greater administration of drugs and which simultaneously does not require firm, convincing evidence of a profound understanding of the disease to be detected, its effect on the human body, the biochemistry of the drug to be used, ignores the public right to be protected from incompetency and the public right to make decisions concerning its health care. The public has a right to understand that any practitioner, presuming to diagnosis ocular disease that usually have total body manifestations, is making diagnostic decisions based upon training which comprehends all of the above principles.

IV. AGENCY ACTION FOR ASSURANCE OF THE HIGHEST QUALITY EYE CARE FOR THE CONSUMER.

The public should be able to rely upon state certification of competency. Legislation which does not demand evidence of such competency before certification fails in its duty to provide public protection in matters of health.

Currently, states have little control over the calibre of training which optometrists acquire prior to licensure. An optometrist may have trained in an optometric school unaffiliated with any medical center, he may have obtained the minimal training necessary to qualify for graduation, but once having graduated, he can apply for and obtain a license with ease.⁴¹

The State Board of Optometry certifies the competency to use drugs of those optometrists which it approves for licensing.⁴² Two problems are immediately apparent:

- 1) The members of the Board of Optometry have little personal experience in ocular pharmacology, ocular pathology, and diagnosis. They are themselves graduate of optometry schools which have offered limited training because the board members took their training when little time was devoted to course work in pharmacology, and now have little experience with drugs. It is difficult to see how such a Board can adequately evaluate such clinical ability in optometric applicants for licensure, nor is it clear how such a Board can construct any 'refresher' course that would adequately prepare the optometrist for his broadened responsibilities. What is usually used is a 'canned' course, prepared elsewhere.
- 2) The ability of the Board to carry out its mandate to protect the public from those few individuals that would use these diagnostic drugs also as therapeutic drugs would find themselves in a frustrated position. The Board can do nothing to prevent this and the fine for practicing medicine without a medical license is only \$100.00.

The regulation of the profession by the Optometric Board will be considered appropriate so long as it is reasonable and necessary in the interest of health, safety of the people.⁴⁴ Licensing of optometrists by a Board itself lacking in the necessary qualifications to evaluate clinical performance and knowledge, is manifestly unreasonable. To grant the right to optometrists to use diagnostic drugs who are poorly qualified to do so, is not a reasonable, or an appropriate, or a necessary means of 'protecting' the public health.

The regulation of the practice of optometry is not for the benefit of the licensee, but for the state and its people.⁴⁵ Certainly, if the practice of medicine and surgery is a proper subject for careful and precise legislation, so also should be legislation which concerns eye care and those who provide it to the public.⁴⁶

V. CONCLUSION

Having looked critically at the past trend toward the expansion of optometric services into medical care, and with the present trend of more and more states defeating this kind of bill, it is proper that some statement be made regarding an appropriate role for this vision care professional.

If the optometrist will be expected to diagnose eye disease, then one of two events must occur:

- 1) optometric training must be upgraded substantially enough to provide him with clinical expertise sufficient to satisfy appropriate public expectations of high competency; or
- 2) optometrists must work in an association with ophthalmologists close enough to provide for the day-to-day transmission of diagnostic information from the M.D. to the O.D., and allow the latter to obtain practical involvement in treatment rationals and administration. This would be similar to the military, Veterans Administration and Alaska Native Service, where the optometrist use these drugs under the direct supervision of the ophthalmologists.⁴⁷

Having once recognized the above solutions two problems immediately present themselves. The first solution would require the relocation of optometric schools to permit integration with medical training and include a complete restructuring of optometric training. So much change would be needed that any difference between the ophthalmologist and optometrist would evaporate. However, if any group of practitioners presumes to medically minister to the public it must accept the rigorous training which must precede such responsibility. There is no quick and easy path to competent understanding of a subject becoming increasingly complex year-by-year. The optometrists seem to want to become doctors, but do not want to go through the extensive number of years training it requires. This is particularly true when the results of error or incompetency can be blindness.

The second solution, close day-to-day association of optometrist/ ophthalmologist, creates a psychological hurdle - perhaps an economic one as well. Optometrists would be required to visualize themselves in a supportive role. This is difficult for any professional to do, especially if he has historically been conditioned to see himself as a member of a separate group, practicing independently. So long as he can offer only limited eye care, he is in a supportive role to those who offer complete eye care. This cooperative association is currently working well in the Veteran's Administration System, the military and the Alaska Native Service. It could work well in private care.

Finally, if state legislatures believe that it is proper to expand the medical opportunities of this health-care group of practitioners via redefinition and short-course catch-up lectures without restructuring fundamental educational requirements and experience, there can be little rationale for not doing the same for all paramedical groups, e.g. naturopaths, acupuncturists, and faith healers.

Rationally, the legislature must either strictly require very high state-of-the-art medical training standards to protect its citizens or it should minimize that responsibility and lower its standards to permit each group to economically advance at the public expense. The latter practice would also reduce the educational time and

experience required to produce specialist M.D.'s- but, of course, such physicians would be recognized as marginally or totally incompetent. Should the standard be any different for optometrists who wish to medically diagnose eye disease that is so closely linked with the body as a whole functioning unit?

Thank you for your time and the opportunity to present this view indorsed by the State Ophthalmologic Association.

FOOTNOTES:

- 1 - Worthen: The Ophthalmologic-Optometric Interface. Transactions of American Academy of Ophthalmology and Otolaryngology *3:OP-155, 1977
- 2 - Representative of most ophthalmology residency programs, it is that of the University of Minnesota, Mayo Clinic Graduate School of Medicine. Following graduation from Medical school and a general or specialty internship, the resident enters a program which requires 65 hours a week of ophthalmologic instruction; of this, approximately 8 hours a week is devoted to formal, didactic lecture, the remainder is clinical or laboratory activity. This weekly schedule continues over a twelve month academic year, for three years. Some of a nine month written home study course administered by the Academy of Ophthalmology. Some programs require an additional one year of ophthalmology. Department of Ophthalmology, University of Minnesota, Mayo Clinic Resident 1974-1977.
- 3 - Curriculum, University of Minnesota College of Medicine. The basic curriculum required of any candidate for an M.D. degree includes 128 credit hours of 'medical' subjects; this does not include clinical studies which are specifically directed toward a specialty interest. Although optometrists may agree that these requirements are not appropriate for them, such an analysis ignores the fact that in expanding their role into the practice of medicine optometrists should be subjected to the same educational requirements. Unfortunately, there is no short-cut to professional competence. This is particularly true in the rapidly expanding and complex field of medicine. The public has a right to demand strict legislative requirements before practitioners are certified as competent.
- 4 - Worthen, note 1, OP-158, supra.
- 5 - Trapnell, The Impact of National Health Insurance on the Use and Spending for Sight Correction Service, 1976. (This study was underwritten by the American Optometric Association, and the Optical Manufacturers Association.) It reveals that optical device sales represent 66% of the funds expended for optometric services and 19% of funds expended for ophthalmologist services, at Table 1 of the Trapnell Study.
- 6 - This figure includes \$920 million spent for optician and \$220 spent by institutions. Those categories of service providers are not included in this discussion since they are not involved in patient care.
- 7 - This economic impact will be divided not only by optometrist and ophthalmologists, but also by opticians and lens/frame/contact lens manufacturers.

8 - Worthen, note , Op-157, supra.

9 - On Blue Shield Survey: In 1975, actuaries for Blue Shield in Connecticut requested of optometrists data necessary to project the cost of insurance covering optometric examinations. One hundred sixty six out of 266 active optometrists responded listing their age, number of years in practice, and number of eye examinations performed each year, and the cost of an eye examination, exclusive of the cost of glasses, so called service charges or visual training. Similar data was gleaned from ophthalmologists. It was concluded that the average optometrist see 23.3 patients per week. Exclusive of patients seen for medical surgical problems or for follow-up care, the average ophthalmologist, of whom there are 160 in Connecticut, sees 56 patients per week for complete eye examinations. Also, if this patients per examiner data is carried over to fit national figures for the number of practicing O.D.'s and ophthalmologists it indicates that about 60% of the primary eye care is rendered by ophthalmologists in the United States right now.

A report prepared for the Optical Manufacturers Association by a consulting actuarial firm (Trapnell Report-1975) presented data based upon national surveys conducted in 1975. The reporters estimated that approximately one-half of 50 million professional eye examinations were done by ophthalmologists and one-half by optometrists. This report dealt only with persons seeking entry into the eye services field for so-called "sight correction" services and did not count all of the services provided by ophthalmologists otherwise for persons who seek out an ophthalmologist otherwise for persons who seek out an ophthalmologist for treatment of medical and surgical problems. (Ophthalmologists obviously do 100% of significant eye surgery and treatment of major eye disease) It is remarkable to note that even though there were approximately 10,000 practicing ophthalmologists, as compared to 20,000 optometrists in the United States, that half of the 50 million so-called "routine eye exams" were performed by ophthalmologists during the year 1976.

10- Department of Commerce and Occupational Licensing

11- Obviously, where ophthalmologists are rare, optometrists see the bulk of patients. However, public education, assistance with payment of medical bills via Medicare and Medicaid, the high mobility of todays population, and the trend toward urban population clustering near ophthalmologists and other specialists certainly influence this bias toward ophthalmologists.

12- R.C.W. 18.53.005 Legislative Declaration: "The legislature finds and declares that the practice of optometry is a learned profession and affects the health, welfare and safety of the people of the this state, and should be regulated in the public interest and limited to qualified persons..." (Amendment 1975)

- 13 - Ellstad v. Swayze, 15 Wash. 2^d 281, 130 P2^d 354 (1942).
See also, Ketchum v. King Co. Medical Service Corp., 81 Wash 2^d 565, 502 P2^d 1197, 1200 (1973)
- 14 - Swayze, note 13, 353, supra.
- 15 - Kelly v. Carroll, 36 Wash 2^d 482, 219 P2^d 79, 90. (1950)
- 16 - Campbell v. State, Id., at 462
- 17 - Gellhorn has recently argued that state licensing statutes are in fact attempts by the profession or occupation involved to control competition by means of restrictive admission to practice. Even Professor Gellhorn would admit that the licensing of health professions is necessary and probably rises above such criticism. Gellhorn, The Abuse of Occupational Licensing, 44 University of Chicago L.R.6, 1976.
- 18 - Semmler v. Oregon State Dental Examiners, 294, U.S.608, 611, (1934); State v. Wilson, 11 Wn. App. 916, 528 P2^d 279 (1974)
- 19 - R.C.W. 18.53.140
- 20 - Laughney v. Maybury, 145 Wash. 146, 259 P.17 (1927)
- 21 - Ellstad v. Swayze, note 47, 353, supra, Accord. Dantzler v. Callison, 230 S.C. 75, 94 WE 2^d 177, app. dismd. 352 U.S. 939 (1955)
- 22 - Kelly v. Carroll, note 15, 85, supra.
- 23 - Art. 20, 2
- 24 - Ellstad v. Swayze, note 13, 353, supra.
- 25 - State v. Bonham, 93 Wash 489, 161 P 377, 379 (1916)
- 26 - Kelly v. Carroll, note 22, supra.
- 27 - State ex rel Fleming v. Cohn, 12 Wash 2^d 425, 121 P2^d 954 (1942)
Accord, State v Hauk, 32 Wash 2^d 68; 203 P2^d 693 (1949)
- 28 - 61 Am Jan 2^d, Physicians, Surgeons, and other Healers, 19;86 ALR 623, 624
- 29 - Ex parte Whitly, 144 Cal. 167, 77 P 879 (1904)
- 30 - "It is enough that...it might be though that the particular legislative measure was...rational..." Williamson v. Lee Optical Co., 348 U.S. 483, 488 (1955), Douglas, J., majority opinion)
- 31 - See note 15, supra.
- 32 - Campbell v. State, note 15, supra.
- 33 - "A law which reduces or prevents any increase in an ...evil tends to safeguard the public welfare..." Id. at 462. (emphasis added).
- 34 - Williamson v. Lee Optical, note 29, supra.
- 35 - State v. Houc', note 27, 700, supra.
- 36 - Worthen, note , Op-160, supra.
- 37 - "...the legislature was careful to require definite knowledge

- 38 - West Virginia Statute 30-8-5 requires those optometrists who wish to use drugs to complete those requirements which the board of optometry may see fit to establish. The board of optometry requires attendance at a pharmacology course similar to that described in note 43, infra.
- 39 - Ellstad v. Swayze, note 13, supra.
- 40 - Campbell v. State, note 15, supra.
- 41 - R.C.W. 18.54070
- 42 - R.C.W. 18.54.030 - In fact, the statute excludes from board membership any optometrist "...who has any connection with any school...of optometry..." It could be presumed that optometrists teaching at optometric schools would be best qualified to judge the qualifications of optometric candidates and possess the most currency in clinical information.
- 43 - A letter from Leon Candenberg, O.D., Director Pennsylvania College of Optometry describes the lecture outlining in pharmacology used by Kentucky, Florida, Pennsylvania and New Mexico. This course involves participation by the optometrist in six weekend sessions (Saturday and Sunday) and ends with a three hour examination covering the presented material. A letter from Sam A. McConkey, M.D. to the Honorable Charles Parr:

ON OPTOMETRISTS PRACTICING IN THE STATE OF ALASKA

According to figures obtained in February of 1978 from the Department of Commerce, Division of Licensing, there are 40 licensed optometrists in Alaska. Their educational background is as follows:

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

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

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

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

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

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

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

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

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

The maximum number of M.D.'s in even a part-time capacity on the staff of any school attended by 37 of the 40 optometrists in Alaska, is two. From a survey of the Blue Book of Optometry which was last issued in 1976, it appears that the maximum number of members of the State Board of Optometry that even have a bachelors degree from any school is two of the six board members that are listed. It would seem reasonable that there would be an ophthalmologist either in the teaching or in the clinical aspect of optometric education, but it appears from the available evidence, that the maximum number of optometrists currently practicing in Alaska that had any full or part-time instruction, either by lecture or in the clinical setting by an ophthalmologist, is zero.

44 - State v. Spino, 61 Wash 2^d 246, 377 p2^d 868, 870 (1963)

45 - Pennington v. Benelli, 15 Cal App 2^d 316, 59 P2^d 448

46 - Campbell v. State, note 15, 466, supra.

47 - The AAO Nov.-Dec. 1977. "AGREEMENT REACHED ON DEFINITION OF MILITARY OPTOMETRIST- The army, Navy and Air Force have agreed on a common definition limiting the services optometrist may render to military personnel. Prior to the new definition, the three military branches had differing definitions which the AAO mailed to all state ophthalmological societies earlier in the year. On June 15th James W. Foristel, AAO Congressional Liason, met with Robert Smith, M.D., Assistant Defense Secretary for Medicine, who was attempting to have all three of the service's Surgeons General agree on a common definition. In September, they reached agreement on the following single definition.

'The optometric clinic provides optometric patient services under medical supervision. Optometrist examine the eyes and

adnexa to include refraction and other procedures, prescribe lenses to correct refractive errors and improve vision. They refer patients to physicians for diagnosis and treatment of suspected disease. Optometrists use appropriate drugs to perform optometric procedures. When using these drugs, immediate medical care is available in the event of adverse reaction."

48 - The optical Journal and Review of Optometry, June 15, 1976
Volume 113 No. 6

TABLE A. EXAMINING ELEMENTS THAT INDICATED OPHTHALMOLOGIC
DISEASE IN 716 PATIENTS.

HISTORY	255	(35.6%)
VISUAL ACUITY	198	(27.7%)
EXTERNAL EXAMINATION BY HAND- HELD FLASHLIGHT	157	(21.9%)
REFRACTION	4	(.6%)
TONOMETRY	69	(9.6%)
SLIT LAMP	23	(3.2%)
UNDILATED FUNDUS	9	(1.3%)
DILATED FUNDUS	<u>1</u>	<u>(.1%)</u>
	716	100%

TABLE I

SYMPOSIUM ON LEGISLATION

PH. D. THESIS BY DON C. PEARSON, M. D. - APRIL 28, 1977 - WORTHEN
 THE OPHTHALMOLOGIC OPTOMETRIC INTERFACE T. A. A. O. O. 1977

Comparison of Optometry and Ophthalmology

	Optometrists	Ophthalmologists
1 - License	In all states as optometrists	In all states as Physicians and Surgeons
2 - Prerequisite	2 yrs. of college (60% of beginning students have baccalaureate degree or higher	Graduation from Medical School (M.D.) 3 - 4 years College
3 - Curriculum	School or College	Medical school internship, Postgraduate (residency)
Pharmacology	64 hours* 126 hours **	307*** (187 hrs. general with 18 months clinical and 120 hrs. ocular with 4yrs. 6mo. clinical
Pathology	20-60 hours	200 hours general with 3 years clinical and 148 hours ocular with 3 years clinical
4 - Period of training	4 yrs (34-36 months)	3-5yrs. (36-60 months)
5 - Time for education after high school	6-8yrs (54-72 months) Max. 4yr. undergrad. Max. 4yr. Opt. college	11-14yrs. (120 months)
6 - Number of active practitioners	21,900	9,322
7 - Number of students	4,985	1,914 (residents)
8 - Total number of practitioners and students	24,933	10,496
9 - Total number of eye professionals	24,800 (70% of total)	10,629 (30% of total)
* Mr. George Hall's report on Pennsylvania School of Optometry to March 1, 1978 meeting of Legislative Coalition of Health Care Professionals.		
** 126 hours - Southern College of Optometry		
*** Mayo Clinic and Iowa		

TABLE 1A

OPTOMETRIC EDUCATION DEFICIENCY DOCUMENTED FOR REDBOOK SURVEY
 As prepared by John W. Gamel, M. D.
 University of Louisville School of Medicine

EDUCATIONAL BACKGROUND REQUIRED FOR DELIVERY OF EYE CARE:
 Comparison between Optometry and Ophthalmology*

REQUIREMENT	OPTOMETRY	OPHTHALMOLOGY
Admission	2 years of college	4 years of college plus 4 years of medical school
Total Training after High School	6 years	12 years
Class and Laboratory Time	1,650 hours	3,249 hours
Supervised Practice of General Medicine (Internal Medicine, General Surgery, Obstetrics-Gynecology, Psychiatry, Primary Care)	0 hours	3,240 hours
Supervised Practice of Medicine and Surgery of the Eye	0 hours	5,240 hours
TOTAL TRAINING HOURS	1,650 hours	11,739 hours
Number of years during which training occurred	4 years	7 years
Hours per year	412½ hours	1,677 hours

*Information abstracted from:

1. Course Handbook of Indiana University, Division of Optometry, 1975-76.
2. American Association of Medical Colleges Curriculum Directory, p. 86 87 (re: University of Louisville School of Medicine.)
3. Residency Training Schedule, Department of Ophthalmology, University of Louisville.

TABLE Ib

BREAKDOWN OF HOURS SPENT IN EDUCATION OF OPHTHALMOLOGIST

1. Class & Laboratory:		
Medical School		
1st year	871	
2nd year	<u>748</u>	1,619
2. Residency:		
Lectures:		
5 hrs per wk x 150 weeks	750	
Basic Science		
40 hrs per wk x 10 weeks	400	
Home Study		
20 hrs per mo x 24 mos	<u>480</u>	1,630
TOTAL DIDACTIC TRAINING (HRS.) (1 + 2)		3,249
3. Supervised Practice of General Medicine		
54 wsk x 60 hrs. per wk (includes night calls & weekends)		3,240
4. Supervised Practice of Medicine and Surgery of the Eye		
35 hrs per wk x 150 weeks		5,250
TOTAL TIME SPENT IN SUPERVISED PRACTICE (HRS.) (3 + 4)		8,490
TOTAL TIME SPENT IN FORMAL EDUCATION OF OPHTHALMOLOGIST AT THE UNIVERSITY OF LOUISVILLE (HRS.) (1 + 2 + 3 + 4)		11,739

RESIDENCY TRAINING SCHEDULE, DEPARTMENT OF OPHTHALMOLOGY
UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINESummary of Hours of Didactic Learning
Offered During Residency:

Ongoing Lectures:

Monday, a.m.	1 hour
Tuesday, a.m.	1 hour
Thursday, a.m.	2 hours
Friday, a.m.	1 hour
TOTAL:	5 hours per week

Basic Science Courses:

40 hrs. per wk lectures/labs
Duration: 10 weeks

Home Study Course:

20 hrs per month
Duration: 24 months



TABLE 2

PH. D. THESIS BY DON C. PEARSON, M. D. - APRIL 28, 1977 - WORTHEN
 THE OPHTHALMOLOGIC OPTOMETRIC INTERFACE T. A. A. O. O. 1977

Service offered by Optometrist and Ophthalmologist

<u>Service</u>	<u>Optometrists</u>	<u>Ophthalmologists</u>
Refraction	99%	99.5%
Ophthalmoscopy	92%	99.5%
Contact Lenses	79%	58%
Visual Fields	75%	94%
Tonometry	66%	99.5%
Orthoptics	50%	53%
Low-vision aids	40%	55%
Biomicroscopy	32%	99.5%
Aniseikonic Testing	8%	9%
Treatment of eye disease	1-2%	100%
West Virginia and North Carolina		
Surgery	0%	99%

ALASKA

-  Ophthalmologists
-  Itinerant Ophthalmologists

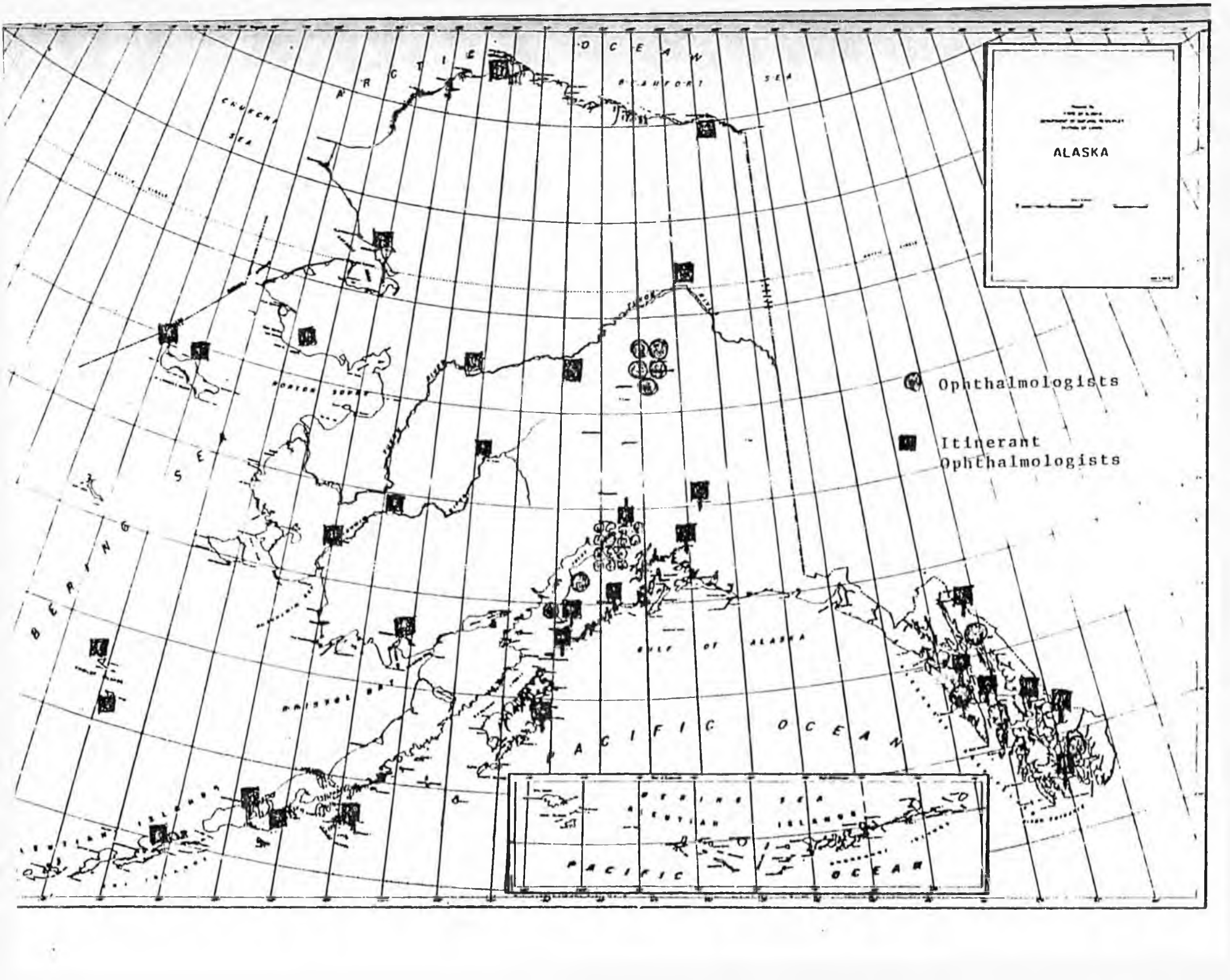


TABLE 3

CIVILIAN CONSUMER SPENDING FOR VISION CARE AND SIGHT CORRECTION
SERVICES IN 1975

<u>A. Expenditures</u>	<u>OFFICES OF OPTOMETRISTS</u>	<u>OFFICES OF OPHTHALMOLOGISTS</u>
General examinations	\$525	\$510
Medical treatment and therapy	40	500
Ophthalmic Services:		
Corrective Eye glass Lenses	865 (49.6%)	180 (14%)
Contact Lenses	285	60
Other	<u>30</u>	<u> </u>
	1,745	1,250
		No optical shops
		No surgery

How the General Practitioner Can Determine The Need for Ophthalmologic Referral

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

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

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

Method

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

Address correspondence to Dr. Campell at PO Drawer 3151, Martinsville VA 24112.

Submitted 1-12-79.

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

Results

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

Table 1 lists the means by which disease was suspected. Notice the heavy preponderance of history, visual acuity, and external examination by hand-held flashlight as the initial clues to disease. These three are, of course, different facets of the same stone and could well be combined, i.e., if a patient states that he does not see well, and if his visual acuity is indeed decreased, then the patient's history is confirmed. In 610 (85.2%) of the 716 patients with disease, this triad

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

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

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

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

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

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

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

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

Conclusions

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

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

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

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

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

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

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

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

Acknowledgment

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

WHO TEACHES OPTOMETRISTS MEDICINE?

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

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

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

Study Compiled for PEN Inc. by the EDUCATIONAL CATALOG STUDY COMMITTEE OF THE SOUTH CAROLINA OPHTHALMOLOGICAL SOCIETY
DECEMBER, 1977.

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED
AS A UNIT IN THE ORIGINAL DOCUMENT



BULLETIN

'from

COUNSEL

VOLUME XXXIV, BULLETIN NO. 62

March 8, 1976

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

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

SUBJECT: West Virginia Legislation

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

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

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

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

ENROLLED
COMMITTEE SUBSTITUTE
FOR

H. B. 1005

(By Mr. SOMMERVILLE)

(Originating in the House Committee on the Judiciary.)

[Passed February 20, 1976; In effect ninety days from passage.]

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

Be it enacted by the Legislature of West Virginia:

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

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

§30-5-1. Definitions.

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

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

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

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

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

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

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

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

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

ARTICLE 8. OPTOMETRISTS.

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

1 Any one or any combination of the following practices
2 shall constitute the practice of optometry:

3 (a) The examination of the human eye, with or without

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

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

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

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

**§30-8-4. Registration prerequisite to practice of optometry; excep-
tions.**

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

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

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

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

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

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

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

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

Enr. Com. Sub. for H. B. 1005] 6

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

7 [Enr. Com. Sub. for H. B. 1005

The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

.....
Chairman Senate Committee

.....
Chairman House Committee

Originated in the House.

Takes effect ninety days from passage.

.....
Clerk of the Senate

.....
Clerk of the House of Delegates

.....
President of the Senate

.....
Speaker House of Delegates

The within this the
day of, 1976.

.....
Governor



BULLETIN
from
OFFICE OF COUNSEL

VOLUME XXXV, BULLETIN NO. 84

June 6, 1977

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

FROM: Thomas E. Eichhorst, Counsel

SUBJECT: North Carolina Legislation

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

A copy of this bill, as enacted, is enclosed. The bill in its final form passed the Senate on May 24, 1977 by a vote of 46 to 4, and the House of Representatives on June 3, 1977 by a vote of 83 to 4. In North Carolina, the Governor has no veto power, so enactment by both houses of the legislature is final.

North Carolina is the fourteenth state to enact legislation authorizing optometrists to utilize pharmaceutical agents. Twelve other states authorize optometrists to utilize diagnostic pharmaceutical agents; the dates of the enactment of these laws are Rhode Island (July 16, 1971), Pennsylvania (March 1, 1974), Tennessee (May 8, 1975), Oregon (May 20, 1975), Maine (June 24, 1975), Louisiana (July 6, 1975), Delaware (July 10, 1975), California (July 9, 1976), Wyoming (February 17, 1977), New Mexico (March 4, 1977), Montana (April 12, 1977 at 10:10 a.m.), and Kansas (April 12, 1977 at 2:00 p.m.). On March 4, 1976, the West Virginia Legislature authorized the use of drugs for diagnostic or therapeutic purposes by optometrists who meet educational requirements set by the optometry board.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1977

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2

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

Short Title: Redefine Optometry.

(Public)

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

Referred to: Judiciary II.

April 6, 1977

1 A BILL TO BE ENTITLED

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

4 The General Assembly of North Carolina enacts:

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

8 "§ 90-114. Optometry defined.--Any one or any combination of
9 the following practices shall constitute the practice of
10 optometry:

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

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

20

21

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

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

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

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

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

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

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

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

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

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

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

1 |25.| to read as follows:

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

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

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

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

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

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PROFESSIONS AND VOCATIONS § 463.02

After such revoca-
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 subject to like
 that any such li-
 provisions of this
 circuit court in
 a certificate, un-
 annulled and that
 me and forthwith

antaries
 process: Florida's
 tive Procedure Act,
 145 (Fall 1968).

978 (See § 11.81)
 partment of Profes-
 sional Regulation.

Repealed by Laws

the diploma, license,
 license, record, or
 issued unlawfully

r than his own or

different name;
 in connection with
 in as a practition-
 authorized to prac-

suspended or re-

as provided in)

v. 76-168, § 3, eff.

and program shall

375: See § 20.30(5)
 functions that may
 Bureau of Records
 ment of Profes-
 sional Regulation.

1970 (See § 11.81)
 partment of Profes-
 sional Regulation.

462.20 Repealed by Laws 1976, c. 76-168, § 3, eff. July 1, 1978 (See § 11.81)

Laws 1965, c. 69-106, §§ 19, 36, provided for change in division of health of the department of health and rehabilitative services for state board of health.
 Change in Fla.St.1975. "[Department of Health and Rehabilitative Services]"

substituted by the division of statutory revision for "Division of health of the department of health and rehabilitative services" to reflect the abolition of the division of health by Laws 1975, c. 76-48, § 3.

462.21 Omitted in Fla.St.1967

Repeal by Laws 1967, c. 87-598, § 1. Part 1, chapter 462 was repealed. Section 3 of this act provided that: "This act shall take effect the first day of

the first month following the first regular session of the Florida legislature held subsequent to July 1, 1967."

CHAPTER 463. OPTOMETRY

Sec. 463.185 Optometric services for certain public agencies (New).

Repeal of Chapter

Laws 1976, c. 76-168, the Regulatory Reform Act of 1976, which provides for legislative review of programs and functions which regulate professions, occupations, business, industry and other endeavors in Florida; provided in section 3 of the law for repeal of this chapter on July 1, 1978. For the provisions directing the regulatory review and a listing of all statutes affected by Laws 1976, c. 76-168, see § 11.81 and notes thereunder.

463.01 "Optometry" and "optometrist" defined [Repealed by Laws 1976, c. 76-168, § 3, eff. July 1, 1978. See § 11.81]

The practice of optometry is declared a profession, and, for the purpose of this chapter, is defined as follows, viz: to be the diagnosis of the human eye and its appendages, the employment of any objective or subjective means or methods for the purpose of determining the refractive powers of the human eyes, or any visual, muscular, neurological, or anatomic anomalies of the human eyes and their appendages, and the prescribing and employment of lenses, prisms, frames, mountings, orthoptic exercises, light frequencies, and any other means or methods for the correction, remedy, or relief of any insufficiencies or abnormal conditions of the human eyes and their appendages. An optometrist is one who practices optometry in accordance with the provisions of this chapter.

Amended by Laws 1975, c. 75-239, § 1, eff. June 27, 1975.

Laws 1976, c. 76-239, amended this section without change.

Cross References
 Nonprofit optometric service corporations, see § 437.011 et seq.

1. Constitutionality
 Where this section defining optometry and optometrists, in addition to prohibiting diagnosis of human eye and its ap-

pendages by the employment of any "objective or subjective" means, described and delineated in detail activities prohibited, conduct sought to be condemned was clearly defined, and this section was not unconstitutional on ground that it was so vague and ambiguous that it deprived defendant of his constitutional rights. State v. Yanes, 231 So.2d 212 (1970).

463.02 Florida state board of optometry [Repealed by Laws 1976, c. 76-168, § 3, eff. July 1, 1978. See § 11.81]

(1) The practice of optometry and the enforcement of this law shall be under the supervision of an examining and licensing board to be known as the "Florida State Board of Optometry." There is hereby created within the division of professions of the department of professional and occupational regulation the "Florida State Board of Optometry," which board shall be composed of five (5) optometrists, each of whom shall be a resident of the state who has been engaged in the practice of optometry in the state for not less than four (4) years preceding the time of his appointment.

(2) The governor shall appoint the members of the board, with each member being appointed for a term of four (4) years or until his successor is ap-

LIST OF PHARMACEUTICAL AGENTS BY NAME (OR TYPE IF NOT NAMED) THAT
STATE LAW OR REGULATIONS SPECIFY OPTOMETRISTS ARE PERMITTED TO USE

ARIZONA: No list. Effective 1/1/82, the optometry law authorizes optometrists to utilize those diagnostic pharmaceutical agents known as topical anesthetics, cycloplegics and mydriatics.

ARKANSAS: 5. Approved Pharmaceutical Agents

The following pharmaceutical agents are hereby approved for use in the manner and strengths indicated:

<u>AGENT</u>	<u>MAXIMUM STRENGTH</u>
<u>Topical Anesthetics (For Glaucoma Screening Only)</u>	
Proparacaine Hydrochloride (Ophthaine)	.5%
Benoxinate Hydrochloride (Dorsacaine)	.4%
Fluress	-
<u>Mydriatics</u>	
Phenylephrine Hydrochloride (Neo-Synephrine)	2.5%
Hydroxyamphetamine Hydrobromide (Paredrine)	1%
<u>Cycloplegics</u>	
Tropicamide (Mydriacyl)	1% (.5%)
Cyclopentolate (Cyclogyl)	1% (.5%)
<u>Dyes</u>	
Fluorescein	-
Rose Bengal	1%
Methylene Blue	-

Additional pharmaceutical agents may be added when approved by the committee.

CALIFORNIA: Article 8 of Chapter 15, Title 16, California Administrative Code:

§1560. Definitions. As used in this Article:
(a) "Topical Pharmaceutical Agents" means:

Types of Drugs:	Maximum Concentration that may be used:
(1) Mydriatics	
(a) Phenylephrine Hydrochloride:	2.5%
(b) Hydroxyamphetamine Hydrobromide:	1%

- (2) Cycloplegics
 - (a) Tropicamide: 1%
 - (b) Cyclopentolate: 1%
 - (c) Homatropine Hydrobromide: 5%
 - (d) Atropine Sulfate: 0.5%
- (3) Topical Anesthetics
 - (a) Proparacaine Hydrochloride: 0.5%
 - (b) Benoxinate Hydrochloride: 0.4%
 - (c) Piperocaine Hydrochloride: 2%

DELAWARE:

Section 3. Use of drugs.

3.02 Licensees who have been duly authorized by the Board may, for diagnostic purposes only, make use of the following classes of topical ophthalmic drugs; (1) anesthetics, (2) mydriatics, (3) cycloplegics, and (4) myotics; provided, however, that any such authorization by the Board shall not be construed as authorizing any licensee to dispense or issue a prescription for diagnostic drugs.

FLORIDA:

No list. An optometrist may utilize pharmaceutical agents within the limits of his educational background and training.

GEORGIA:

No list. An optometrist may utilize topical pharmaceutical agents within the limits of his educational background and training.

IDAHO:

No list.

INDIANA:

No list. Every licensed O.D. is permitted to utilize any diagnostic pharmaceutical agent

IOWA:

No list. The optometry law authorizes optometrists to utilize cycloplegics, mydriatics and topical anesthetics as diagnostic agents.

KANSAS:

No list. Kansas State Board of Examiners In Optometry Rules and Regulations Sec. 65-6-30 authorizes optometrists to utilize topical pharmacological agents known generically as anesthetics, mydriatics, and cycloplegics.

KENTUCKY:

KY. AD. CODE §320.240 authorizes optometrists to administer diagnostic pharmaceutical agents limited to miotics for emergency use only, mydriatics, cycloplegics, and anesthetics applied topically only, but excluding any drug classified as a controlled substance.

LOUISIANA: No list. Optometry law authorizes optometrists to utilize topical ocular diagnostic pharmaceutical agents.

MAINE: Maine Board of Optometry Rules of Practice §90-382.

AUTHORIZED DIAGNOSTIC PHARMACEUTICAL AGENTS

Topical Anesthetics:

Proparacaine hydrochloride .5% (Ophthaine)
Benocinate hydrochloride .4% (Dorsacaine)

Mydriatics:

Hydroxyamphetamine hydrobromide
1.00% (Paradrine)
Phenylephrine hydrochloride 2.5% (Neo-synephrine)

MINNESOTA: No list.

MONTANA: Administrative Rules of Montana §40-3.70(6)-S70020.

40-3.70(6)-S70020 RULES FOR DIAGNOSTIC PHARMACEUTICAL AGENTS

(5) Upon licensure or certification the permissible drugs and their concentrations are as follows:

- (a) Mydriatics
 - (i) Phenylephrine Hydrochloride 2.5%
 - (ii) Hydroxyamphetamine Hydrobromide 1.0%
- (b) Cycloplegics
 - (i) Tropicamide 1.0%
 - (ii) Cyclopentolate 1.0%
 - (iii) Homatropine Hydrobromide .5%
 - (iv) Atropine Sulfate .5%
- (c) Topical Anesthetics
 - (i) Proparacaine Hydrochloride .5%
 - (ii) Benoxinate Hydrochloride .4%
 - (iii) Piperocaine Hydrochloride 2.0%
- (d) Miotic, only in the event of an emergency...

NEBRASKA: No list. Pharmaceutical agents mean anesthetics, cycloplegics, and mydriatics and may be used for diagnostic purposes by optometrists who are certified to use pharmaceutical agents.

NEVADA: The following topical ophthalmic pharmaceutical agents may be used in the concentrations specified for diagnostic purposes by an optometrist who has been authorized by the board to do so:

- (a) Mydriatics:
 1. Phenylephrine hydrochloride, 2.5 percent.
 2. Hydroxyamphetamine hydrobromide, 1 percent
- (b) Cycloplegics:
 1. Tropicamide, 1 percent.
 2. Cyclopentolate, 1 percent
 3. Homatropine hydrobromide, 5 percent
 4. Atropine sulfate, 0.5 percent
- (c) Topical anesthetics:
 1. Proparacaine hydrochloride, 0.5 percent.
 2. Benoxinate hydrochloride, 0.4 percent.
 3. Piperocaine hydrochloride, 2 percent.
- (d) Miotics:
 1. Pilocarpine, 1 percent in ordinary use.
 2. Pilocarpine, 3 percent for emergency use only.

NEW JERSEY: No list.

NEW MEXICO: No list. Optometry law authorizes optometrists to utilize topical ocular diagnostic pharmaceutical agents.

NORTH CAROLINA: No list. An optometrist may utilize pharmaceutical agents within the limits of his educational background and training.

NORTH DAKOTA: No list. Optometry law authorizes optometrists to utilize ocular diagnostic pharmaceutical agents.

OREGON: OR. AD. RULES §852-8-010:

Diagnostic Pharmaceutical Agents

852-80-010 Diagnostic pharmaceutical agents for topical use in the practice of optometry:

- (1) Anesthetics:
 - (a) Benoxinate 0.4%
 - (b) Proparacaine HCl 0.5%
- (2) Cycloplegics/Mydriatics:
 - (a) Cyclopentolate, not to exceed 1%
 - (b) Hydroxyamphetamine HBr 1%
 - (c) Phenylephrine HCl, not to exceed 1%
 - (d) Tropicamide, not to exceed 1%
- (3) Dyes:
 - (a) Fluorescein Na impregnated paper strips, as commonly used in the practice of optometry for some time; not to be stored in liquid form.
 - (b) Rose bengal 1%
- (4) Miotics (for emergency use only): Pilocarpine, not to exceed 4%; prior to use, consultation with a competent physician shall be held if at all possible. The Board recommends that any patient demonstrating any adverse reaction due to the instillation of any diagnostic pharmaceutical agent be referred to a competent physician as soon as practicable.

On 4/22/80 the Board proposed to amend OAR 852-80-010 by additions as follows (additions underlined):

DIAGNOSTIC PHARMACEUTICAL AGENTS

852-80-010 Diagnostic Pharmaceutical agents for topical use in the practice of optometry:

Anesthetics: Benoxinate 0.4%
Proparacaine HCl 0.5%

Cycloplegics/Mydriatics:

Cyclopentolate, not to exceed 1%
Hydroxyamphetamine HBr 1%
Phenylephrine HCl, not to exceed 10%
Tropicamide, not to exceed 1%

Dyes: Fluorescein Na impregnated paper strips, as commonly used in the practice of optometry for some time; not to be stored in liquid form.
Rose bengal 1%
Fluoresoft (Fluorexon .35%)

Combined agents:

Fluress (Fluorescein, Sodium, 0.25%, and Benoxinate HCL, 1%)

Cyclomydril (Cyclopentolate HCL, 0.2% and Phenylephrine HCL, 1%)

Any other FDA approved combination of two or more agents appearing on this list which may be used for ocular diagnostic purposes.

Miotics: (for emergency use only!)
Pilocarpine, not to exceed 4%; prior to use, consultation with a competent physician shall be held if at all possible.

PENNSYLVANIA: Optometrists who are appropriately qualified pursuant to the Act of March 1, 1974, (Act No. 29 of 1974), 63 P.S., Section 231 et. seq., shall be permitted to utilize the following drugs in their practice of Optometry, by order of the Secretary of Health, October 12, 1974, finalized April 26, 1975.

A. Local anesthetics:

Benoxinate Hydrochloride - Ophthalmic Solution (0.4%)
Proparacaine Hydrochloride - Ophthalmic Solution (0.5%)

B. Miotics:

Pilocarpine Nitrate Ophthalmic Solution U.S.P. (1%)
Pilocarpine Hydrochloride Ophthalmic Solution U.S.P. (1%)

C. Mydriatics and/or cycloplegics:

- Eucatropine Hydrochloride U.S.P. - Ophthalmic Solution (5%)
- Homatropine Hydrobromide Ophthalmic Solution U.S.P. (2%)
- Hydroxyamphetamine Hydrobromide Ophthalmic Solution U.S.P. (1/2%)
- Tropicamide Ophthalmic Solution U.S.P. (1%)
- Atropine Sulfate Ophthalmic Solution U.S.P. (1%)
Ophthalmic Ointment (1%)
- Psyclopentolate Hydrochloride - Ophthalmic Solution (1%)
- Scopolamine Hydrobromide U.S.P. - Ophthalmic Solution U.S.P. (.25%)
- Ephedrine Sulfate U.S.P. - Ophthalmic Solution (5%)
- Phenylephrine Hydrochloride - Ophthalmic Solution U.S.P. (10%)

All Potencies listed above are the maximum allowable potencies.

RHODE ISLAND: No list. Any topical anesthetic, mydriatic and miotic is allowed. Cycloplegics are not specifically mentioned but the rule of mydriatic can be applied. By Board recommendation atropine sulphate in any percentage is discouraged.

SOUTH DAKOTA: No list. Optometry law authorizes optometrists to utilize topical pharmaceutical agents for diagnostic purposes.

TENNESSEE: No list. An optometrist may utilize pharmaceutical agents, to wit, miotics, mydriatics, cycloplegics, and anesthetics, within the limits of his educational background and training.

UTAH: (e) Topically applied diagnostic agents as used herein shall be defined as the following:

(i) Commercially prepared topical anaesthetics as follows: proparacaine HCL 0.5%, benoxinate HCL 0.4%, piperocaine 2%, and tetracaine 0.5%;

(ii) Tropicamide in strength of not greater than 1%, cyclopentolate in strength of not greater than 1%, and atropine sulfate in strength of not greater than 0.5%;

(iii) Penylephrine HCL in strength of not greater than 2.5%, hydroxyamphetamine in strength of not greater than 1%;

(iv) Such others as may be from time to time determined by the Optometric Committee of the Utah State Business Regulations Division in consultation with a licensed physician specializing in diseases and surgery of the eye, appointed by the Utah Medical Association, and a pharmacologist appointed by the Medical Center of the University of Utah. Any

individual who is not certified to utilize diagnostic pharmaceutical agents hereunder shall post with the Optometry Committee of the Utah State Business Regulations Division an affidavit stating that the person is not now certified nor does the person desire to certify to use diagnostic pharmaceutical agents.

WEST VIRGINIA: Topical agents for the eye and treating the anterior segments only. No oral or injectible pharmaceuticals are permitted in any form whatsoever.

WISCONSIN: (9) "Diagnostic pharmaceutical agent" means any of the topical, ocular, diagnostic, pharmaceutical agents listed below if used in accordance with the following conditions: agents may be used in strengths no greater than the strengths indicated in the list; may be used by the optometrist only and may not be dispensed by the optometrist to patients for self-administration.

(a) Mydriatics

1. Phenylephrine 2.5%
2. Hydroxyamphetamine 1%

(b) Cycloplegics

1. Tropicamide 1%
2. Cyclopentolate 1%

(c) Topical Anesthetics

1. Benoxinate 0.4%
2. Proparacaine 0.5%
3. Tetracaine 0.5%
4. Benoxinate 0.4% - Fluorescein 0.25% Combination

(d) Dyes

1. Fluorescein 0.25% - Benoxinate 0.4% Combination

WYOMING: No list. Optometry law authorizes optometrists to use diagnostic agents, topically applied, known generically as cycloplegics, mydriatics, topical anesthetics, dyes and for emergency use only miotics for immediate administration to the ultimate user.

AMERICAN OPTOMETRIC ASSOCIATION



BULLETIN

from the

COMMITTEE ON STATE AGENCIES

COMMUNITY HEALTH DIVISION

VOLUME XXXIII, BULLETIN NO. 36

May 28, 1975

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

FROM: Virgil L. Rhodes, O.D., Chairman

SUBJECT: Oregon Legislation

DIST: O, T, Dr. Pitts, Division Executive Committee Chairmen, CHD-EC,
SAC, ED, WOD, GC, C, AA, Division Directors, E, NE, Drs. Holcombe,
Lind, Rush, Reslock, Administrative Heads of Schools and Colleges

On Tuesday, May 20, 1975, Oregon Governor Robert W. Straub signed into law House Bill No. 2740.

A copy of this bill, as enacted, is attached.

The bill passed the House by a vote of 31 to 27, and the Senate by a vote of 20 to 10.

Oregon is the fourth state to enact legislation authorizing optometrists to utilize diagnostic pharmaceutical agents. The three other states and the dates of their enactment are Rhode Island (July 16, 1971), Pennsylvania (March 1, 1974) and Tennessee (May 8, 1975).

[In addition there are seven 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: Florida (old AG-), Idaho, Indiana (AG+), Minnesota, Nevada (AG+), New Jersey (AG+), Virginia (AG-).]

Enrolled
House Bill 2740

Sponsored by Representatives OTTO, GRANNELL, GWINN, WALDEN,
Senators HOWARD, JERNSTEDT

CHAPTER.....

AN ACT

Relating to the practice of optometry; amending ORS 683.010, 683.040,
683.060 and 683.270.

Be It Enacted by the People of the State of Oregon:

Section 1. ORS 683.010 is amended to read:

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

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

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

(3) "Trial frames" or "test lenses" means any frame or lens used in testing the eye which is not sold and not for sale.

Section 2. ORS 683.040 is amended to read:

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

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

Section 3. ORS 683.060 is amended to read:

683.060. (1) Any person who has signified to the board his desire to be examined by it and who has filed proof that he is qualified under this chapter and the rules of the board to take such examination shall appear before the board at such time and place as the board may designate, and before beginning the examination the applicant shall pay \$50 to the secretary of the board. At the examinations the board shall examine applicants in the anatomy of the eye, in the use of diagnostic agents as used topically, in normal and abnormal refractive and accommodative and muscular conditions and coordination of the eye, in subjective and objective

optometry, including the fitting of glasses, the principles of lens grinding and frame adjusting, and in such other subjects as pertain to the science and practice of optometry, such subjects to be enumerated in a publication by the board.

(2) The board may, in its discretion, accept the certificate of successful examination of the National Board of Examiners in Optometry in one or more areas of the examination in lieu of its written examination in such areas.

(3) If an applicant shall fail to pass a second examination, the board may permit additional examinations upon compliance by the applicant with the law and the rules of the board.

Section 4. ORS 683.270 is amended to read:

683.270. The powers and duties of the board are as follows:

(1) To organize and elect from its membership a president and secretary of the board, each of whom shall hold office for one year, or until the election and qualification of a successor.

(2) To adopt and use a common seal.

(3) To employ agents, attorneys and inspectors to secure evidence of, report on, and prosecute all violations of this chapter and to employ other necessary assistance in the carrying out of the provisions of this chapter, and to pay the same from the funds provided in this chapter.

(4) To hold regular meetings at least once a year at which an examination of applicants for certificates of registration shall be held at such places as the board shall from time to time designate, and special meetings upon request of a majority of the members of the board or upon the call of the president.

(5) To keep an accurate record of all proceedings of the board and of all of its meetings, of all prosecutions for violations of this chapter, and of all examinations held for applicants for certificates of registration, with the names and addresses of all persons taking examinations and their success or failure to pass such examinations. All the records of the board shall be public and shall be kept in the office of the board.

(6) To keep an accurate inventory of all property of the board and of the state in the possession of the board and to obtain a receipt therefor from its successor.

(7) To keep a register of optometrists which shall contain the names and addresses of all persons to whom certificates of registration have been issued in the State of Oregon, together with the date of the issuance of such certificate and the place or places of business in which each optometrist is engaged, and all renewals, revocations and suspensions thereof.

(8) To grant or refuse to grant certificates of registration as provided in this chapter and to revoke the certificate of registration of any optometrists for any of the causes specified in ORS 683.140.

(9) To designate diagnostic pharmaceutical agents for topical use in the practice of optometry from among the generic categories enumerated within subsection (2) of ORS 683.010. Said designation shall take place not later than January 1, 1976, and shall be with the advice and guidance of the Board of Medical Examiners for the State of Oregon.

[(9)] (10) To administer oaths and take testimony upon granting and revoking or suspending any certificate of registration.

[(10)] (11) To make rules not inconsistent with the laws of this state as are deemed necessary or proper to carry out the lawful powers and duties of the board, as may be necessary or proper to determine the qualifications of applicants for a certificate to practice optometry in this state, and to establish educational, moral and professional standards for such applicants, subject to the laws of this state. If an applicant fails to pass a second examination the board may adopt rules which may provide the required courses of study before further examination.

Date: January 28, 1981

File Ref:

To:

Sen. Thompson

From: Ann J. Haney, Secretary
Department of Regulation and Licensing

Subject: Report on Diagnostic Pharmaceutical Agents

At my request, staff from the Bureau of Health Professions in the Department of Regulation and Licensing have submitted a preliminary report and recommendations concerning the use of DPAs by optometrists. A compilation of the statistics from May, 1979, to November, 1980, reported to the Department by DPA certified optometrists show the following:

280 optometrists are certified to use DPA's
215 certified optometrists have used DPA's on
99,226 patients
65 certified optometrists have not used DPA's
in their practice

Of the 99,226 patients to whom DPA's were administered, 4,359 patients were referred to appropriate medical specialists for a variety of medical problems.

Twelve certified optometrists reported that 20 patients had mild to moderate adverse drug reactions (eye stinging, allergy). Some of these patients were referred to medical specialists and other patients reactions were cleared up within a short period of time (10-15 minutes).

Based on the statistics reported it appears that many patients benefited by the use of DPA's. These patients were referred to appropriate medical specialists for possible medical problems that may otherwise have gone undetermined.

The only problem reported involved the above 20 patients where a reaction occurred. All of these reactions were reported a mild to moderate discomfort lasting no longer than 48 hours. While there were mild physical reactions in less than 1% of the patients, there were no reports of psychological reactions.

On the basis of the above data staff recommended that s. 449.17 (1) and (7), Stats., be repealed effective July 1, 1982.

Staff further recommended that the Department consider further statute and code revisions at a later date.

They are as follows:

1. Fees (to correspond with other certified or licensed individuals) to cover administrative and examination costs, and the establishment of a renewal date.
2. Deletion of the code provision that requires the optometrist to submit a report to the Department on use of DPA's and any adverse drug reaction. Physicians, dentists and osteopaths are not required to report adverse reactions by patients. In addition, the minimal number of adverse reactions (20) do not justify our reviewing and filing 1,000 pieces of paper over an 18 month period.

AJH:kcb
5136

FEB 2 1981

1 AN ACT to repeal 449.17 (1) and (7) of the statutes, relating to making
2 permanent the authorization for optometrists to use topical ocular
3 diagnostic pharmaceutical agents.

Analysis by the Legislative Reference Bureau

Chapter 280, laws of 1977, authorized optometrists to use topical ocular diagnostic pharmaceutical agents under certain conditions. These conditions include having an approved plan for the referral of patients who experience adverse reactions, successful completion of a pharmacology examination and specific education on the use of such agents.

The enacting law provided that the use of such agents was authorized only until July 1, 1982. On January 1, 1982, the department of regulation and licensing is required to report to the legislature on the use of such agents by optometrists, including the health benefits and problems involved in such use and whether or not any individual is known to have suffered any physical or psychological reaction to such an agent and the severity of the reaction.

Under this bill, the July 1, 1982, "sunset" provision is removed, thus authorizing optometrists to continue to use topical ocular diagnostic pharmaceutical agents subject to the same conditions currently imposed in the statutes and by administrative rules promulgated by the department of regulation and licensing.

The people of the state of Wisconsin, represented in senate and assembly,

do enact as follows:

4 SECTION 1. 449.17 (1) and (7) of the statutes are repealed.

5 SECTION 2. EFFECTIVE DATE. This act takes effect on July 1, 1982.

6 (End)

§ 32-1701 PROFESSIONS AND OCCUPATIONS

CHAPTER 16.—OPTOMETRY

Effective January 1, 1982

ARTICLE 1. GENERAL PROVISIONS

- Sec.
 32-1701. Definitions.
 32-1702. Board of optometry; appointment; qualifications; term; removal.
 32-1703. Organization of board; compensation; immunity; treatment of money received.
 32-1704. Powers and duties of the board; meetings.
 32-1705, 32-1706. Repealed.

ARTICLE 2. LICENSING

- 32-1721. Persons and acts not affected by this chapter.
 32-1722. Qualifications of applicant; applications.
 32-1723. Reciprocity.
 32-1724. Examination of applicants; time of examination.
 32-1725. Issuance of license.
 32-1726. Renewal of license; continuing of education; failure to renew.
 32-1727. Fees.

ARTICLE 3. REGULATIONS

- 32-1741. Practicing optometry without a license prohibited.

Chapter 16, consisting of Article 1, §§ 32-1701 to 32-1704, Article 2, §§ 32-1721 to 32-1727, Article 3, §§ 32-1741 to 32-1752, and Article 4, § 32-1761, was added by Laws 1980, Ch. 248, § 4, effective January 1, 1982.

For Chapter 16 as added by Laws 1980, Ch. 248, § 3, effective July 1, 1980, see Chapter 16, ante.

Former Chapter 16, consisting of Article 1, §§ 32-1701 to 32-1706, Article 2, §§ 32-1721 to 32-1726, and Article 3, §§ 32-1751 to 32-1759, was repealed by Laws 1980, Ch. 248, § 2, effective July 1, 1980.

Termination under Sunset Law

The board of optometry shall terminate on July 1, 1985, unless continued. See §§ 41-2363.01 and 41-2377.

Chapter 16 relating to optometry is repealed on January 1, 1986. See § 41-2371.01.

ARTICLE 1. GENERAL PROVISIONS

Article 1, consisting of §§ 32-1701 to 32-1704, was added by Laws 1980, Ch. 248, § 4, effective January 1, 1982.

For Article 1 as added by Laws 1980, Ch. 248, § 3, effective July 1, 1980, see Chapter 16, Article 1, ante.

Former Article 1, consisting of §§ 32-1701 to 32-1706, was repealed by Laws 1980, Ch. 248, § 2, effective July 1, 1980.

For termination under Sunset Law, see italic note, ante.

§ 32-1701. Definitions

In this chapter, unless the context otherwise requires:

1. "Board" means the state board of optometry.
2. "Cycloplegics" means one-half of one per cent tropicamide, one per cent tropicamide, or cyclogyl.

Ch. 16 effective until Jan. 1, 1982, see Ch. 16, ante

3. "License" means a license or certificate to practice the profession of optometry.

4. "Licensed optometrist" or "doctor of optometry" means a person holding a license to practice the profession of optometry in this state.

5. "Mydriatics" means one per cent pareдрine, two and one-half per cent phenylephrine HCL, or ten per cent phenylephrine HCL.

6. "Practice of the profession of optometry" means the examination or refraction of the human eye and its appendages, and the employment of any objective or subjective means or methods other than medicine or surgery, or the use of drugs, except those diagnostic pharmaceutical agents known as topical anesthetics, cycloplegics and mydriatics, to be administered only at the time and place of examination, for the purpose of determining any visual, muscular, neurological or anatomical anomalies of the eye, the use of any instrument or device to train the visual system or correct any abnormal condition of the eye or eyes and the prescribing, fitting or employment of any lens, prism, frame or mountings for the correction or relief of or aid to the visual function. Optometrists may use such diagnostic pharmaceutical agents for diagnostic purposes only after first satisfactorily completing a course in clinical pharmacology as required in § 32-1722.

7. "Topical anesthetics" means one-half of one per cent pontocaine or one-half of one per cent proparacaine.

8. "Unprofessional conduct" means:

(a) Willful betrayal of a professional secret or willful violation of a privileged communication except as otherwise required by law.

(b) Final judgment of conviction for an offense involving moral turpitude, in which case the record of such conviction is conclusive evidence.

(c) Giving or receiving rebates.

(d) Addiction to, or illegal use of, narcotic drugs or use of intoxicating beverages to excess or practicing or attempting to practice the profession of optometry while under the influence of intoxicating beverages or narcotic drugs.

(e) Impersonation of another licensed optometrist.

(f) Knowingly having professional connection with or lending one's name to an illegal practitioner.

(g) Gross malpractice or repeated acts constituting malpractice.

(h) Any conduct or practice, including incompetency, which constitutes a danger to the health, welfare or safety of patients or the public.

(i) Prescribing, dispensing or pretending to use any secret means, methods, device or instrumentality.

(j) Refusing to divulge to the board upon demand the means, methods, device or instrumentality used for optometric examination or therapy.

(k) Representing that a manifestly not correctable condition can be permanently corrected or that a correctable condition can be corrected within a stated time if such is not accurate.

(l) Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of the profession of optometry. Added Laws 1980, Ch. 248, § 4, eff. Jan. 1, 1982.

Effective January 1, 1982.

Laws 1980, Ch. 248, § 13, subsec. B, effective July 1, 1980, provides:

"B. The provisions of § 4 of this act are effective on January 1, 1982."

For legislative intent regarding Laws 1980, Ch. 248, see note following § 32-1701 in Chapter 16 effective until January 1, 1982, ante.

Former § 32-1701, as amended by Laws 1979, Ch. 60, § 1, eff. April 17, 1979, was repealed by Laws 1980, Ch. 248, § 2, effective July 1, 1980.

For disposition of the subject matter of repealed and expiring sections and derivation of the subject matter of added sections, see Tables preceding § 32-

Ch. 16 effective until Jan. 1, 1982, see Ch. 16, ante.

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§ 32-1701 PROFESSIONS AND OCCUPATIONS

1701 in Chapter 16 effective until January 1, 1982, ante.

1980 Reviser's Notes:

Pursuant to authority of section 41-1304.02, in paragraph 3, "license" was substituted for "licensed" to correct a manifest clerical error.

In adding chapter 16, Laws 1980, Ch. 248, sec. 4 incorrectly referred to its addition to title 43.

Pursuant to authority of section 41-1304.02, in paragraph 4 following "doctor" the word "of" was substituted for "or" as a correction of a manifest clerical error.

Library References

Physicians and Surgeons \Leftrightarrow 2.

C.J.S. Physicians and Surgeons § 3 et seq.

§ 32-1702. Board of optometry; appointment; qualifications; term; removal

A. There is established a state board of optometry which consists of six members appointed by the governor. Terms of office are for four years expiring on July 1 of the respective year. Four members shall have been licensed and engaged in the active practice of the profession of optometry in this state for at least three years immediately prior to appointment, one member shall be a physician licensed pursuant to chapter 13 or 17 of this title,¹ and one member shall be a lay person with no interest, direct or indirect, in the practices of optometry, opticianry or medicine.

B. The governor may remove any professional member for incompetency or unprofessional conduct or when his license has been revoked or suspended or when he has been censured or placed on probation. The governor may remove any member for neglect of duty or improper conduct. The unexcused absence of a member for more than two consecutive meetings is justification for removal. Appointment by the governor to fill a vacancy caused other than by expiration of a term is for the unexpired portion of the term.

C. A member of the board is ineligible to serve more than two consecutive full terms. The completion of the unexpired portion of a full term does not constitute a full term for purposes of this subsection. Added Laws 1980, Ch. 248, § 4, eff. Jan. 1, 1982.

¹ Sections 32-1401 et seq., 32-1801 et seq.

Effective January 1, 1982.

For applicable effective date provision of Laws 1980, Ch. 248, see note following § 32-1701.

For disposition of the subject matter of repealed and expiring sections and derivation of the subject matter of added sections, see Tables preceding § 32-1701 in Chapter 16 effective until January 1, 1982, ante.

Former § 32-1702, as amended by Laws 1979, Ch. 50, § 2, eff. April 17, 1979, was repealed by Laws 1980, Ch. 248, § 2, effective July 1, 1980.

Library References

Physicians and Surgeons \Leftrightarrow 3.

C.J.S. Physicians and Surgeons §§ 2, 6, 13.

§ 32-1703. Organization of board; compensation; immunity; treatment of money received

A. The board shall annually elect from its members a president who shall preside over all meetings of the board and such other officers as it deems appropriate and necessary to conduct its business. The board shall assign such duties as it deems appropriate to such other officers as it elects.

B. Members of the board are eligible to receive compensation as determined pursuant to § 38-011 for each day actually spent in the performance of their duties.

C. Members of the board are personally immune from suit with respect to all acts done and actions taken in good faith and in furtherance of the purposes of this chapter.

D. All monies received by the board shall be paid at least monthly to the state treasurer who shall deposit such monies in the general fund. Added Laws 1980, Ch. 248, § 4, eff. Jan. 1, 1982.

Effective January 1, 1982.

For applicable effective date provision of Laws 1980, Ch. 248, see note following § 32-1701.

For disposition of the subject matter of repealed and expiring sections and derivation of the subject matter of added sections, see Tables preceding § 32-1701.

Ch. 16 effective until Jan. 1, 1982, see Ch. 16, ante

PROFESSIONS AND OCCUPATIONS § 32-1704

ed sections, see Tables preceding § 32-1701 in Chapter 16 effective until January 1, 1982, ante.
Former § 32-1703, was repealed by Laws 1980, Ch. 248, § 2, effective July 1, 1980.

Library References
Physicians and Surgeons § 3.
C.J.S. Physicians and Surgeons §§ 2, 6, 13.

§ 32-1704. Powers and duties of the board; meetings

A. The board shall promulgate, and may amend, rules and regulations consistent with this chapter governing the practice of the profession of optometry, for the performance of its duties under this chapter and for the examination of applicants for licenses. The board shall adopt and use a seal, administer oaths and take testimony concerning any matter within its jurisdiction.

B. The board may not adopt a rule which:

- 1. Regulates fees or charges of a doctor of optometry to a patient.
- 2. Regulates the place in which a doctor of optometry may practice.
- 3. Prescribes the manner or method of accounting, billing or collection of fees.

4. Prohibits advertising by a doctor of optometry unless such advertising is inconsistent with § 44-1481.

C. The board shall meet at least six times each year at such times and places within the state as its president or the governor may designate by call. The board shall keep a record of all its acts, receipts and disbursements. The board shall keep a master copy of each examination given, together with the names and addresses of the applicants and their individual test scores. The board shall keep a record of the names of all persons to whom licenses have been issued and all renewals. All such records are public records.

D. The board may adopt and promulgate administrative rules providing for criteria for approving programs of continuing education for doctors of optometry. Programs shall be designed to assist doctors of optometry to maintain competency, to become aware of new developments in the practice of the profession of optometry and to increase management skills and administrative efficiency. The board shall approve programs meeting its adopted criteria.

E. The board may hire an executive director as an employee of the board. The executive director is responsible for the performance of the regular administrative functions of the board and such other administrative duties as the board may direct. The executive director is eligible to receive compensation in an amount as determined pursuant to § 38-611.

F. The board may hire or contract with investigators to assist in the investigation of violations of this chapter, hire other employees required to carry out this chapter and contract with other state agencies when required to carry out this chapter.

G. Not later than December 31 each year the board shall transmit to the governor a written report of its actions and proceedings. The report shall be verified by the president and shall include a detailed statement of the receipts and disbursements for the preceding year. Added Laws 1980, Ch. 248, § 4, eff. Jan. 1, 1982.

Effective January 1, 1982.

For applicable effective date provision of Laws 1980, Ch. 248, see note following § 32-1701.

For disposition of the subject matter of repealed and expiring sections and derivation of the subject matter of added sections, see Tables preceding § 32-1701 in Chapter 16 effective until January 1, 1982, ante.

Former § 32-1704 was repealed by Laws 1980, Ch. 248, § 2, effective July 1, 1980.

Library References
Physicians and Surgeons § 3.
C.J.S. Physicians and Surgeons §§ 2, 6, 13.

Ch. 16 effective until Jan. 1, 1982, see Ch. 16, ante

§ 32-1705 PROFESSIONS AND OCCUPATIONS

§§ 32-1705, 32-1706. Repealed by Laws 1980, Ch. 248, § 2, eff. July 1, 1980

Former §§ 32-1705, as amended by Laws 1979, Ch. 50, § 3, eff. April 17, 1979, and 32-1706, as amended by Laws 1977, Ch. 82, § 19, eff. May 23, 1977, were repealed by Laws 1980, Ch. 248, § 2, effective July 1, 1980.

ARTICLE 2. LICENSING

Article 2, consisting of §§ 32-1721 to 32-1727, was added by Laws 1980, Ch. 248, § 4, effective January 1, 1982.

For Article 2 as added by Laws 1980, Ch. 248, § 3, effective July 1, 1980, see Chapter 16, Article 2, ante.

Former Article 2, consisting of §§ 32-1721 to 32-1726, was repealed by Laws 1980, Ch. 248, § 2, effective July 1, 1980.

For termination under Sunset Law, see italic note preceding § 32-1701.

§ 32-1721. Persons and acts not affected by this chapter

This chapter does not apply to:

1. Physicians and surgeons duly licensed to practice medicine and surgery in this state, if they are practicing lawfully.
2. Dispensing opticians duly licensed to practice. If they are practicing lawfully in accordance with the provisions of § 32-1671.
3. The sale of complete ready-to-wear eyeglasses as merchandise from a permanently established place of business. Added Laws 1980, Ch. 248, § 4, eff. Jan. 1, 1982.

Effective January 1, 1982.

For applicable effective date provision of Laws 1980, Ch. 248, see note following § 32-1701.

For disposition of the subject matter of repealed and expiring sections and derivation of the subject matter of added sections, see Tables preceding § 32-1701 in Chapter 16 effective until January 1, 1982, ante.

For legislative intent regarding Laws 1980, Ch. 248, see note following § 32-

1701 in Chapter 16 effective until January 1, 1982, ante.

Former § 32-1721 was repealed by Laws 1980, Ch. 248, § 2, effective July 1, 1980.

Library References

Physicians and Surgeons § 5(5).
C.J.S. Physicians and Surgeons § 10, 23.

§ 32-1722. Qualifications of applicant; applications

A. A person of good moral character, desiring to engage in the practice of the profession of optometry, shall file with the board not less than thirty days prior to the date on which an examination is to be held a verified application with the required application fee, which shall show:

1. Applicant's name, age and address.
2. Graduation from a university or college teaching the profession of optometry accredited by a nationally accepted accrediting body on optometric education.
3. Satisfactory completion of a course of study in clinical pharmacology approved by a committee composed of the president of the board, the chairman of the pharmacology department of the university of Arizona college of medicine and the chairman of the department of ophthalmology of the university of Arizona college of medicine, with particular emphasis on the clinical application of diagnostic pharmaceutical agents for the purpose of examination of the human eye and the analysis of ocular functions.
4. Background information on a form prescribed by the attorney general for the purpose of conducting an investigation into the existence of prior arrests and convictions.

B. Upon receipt of an application in proper form and containing the information prescribed in subsection A, the board may have an investigation made of the applicant's character, ability and experience.

Ch. 16 effective until Jan. 1, 1982, see Ch. 16, ante

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PROFESSIONS AND OCCUPATIONS § 32-1723

C. For the purposes of such investigation, the board may subpoena wit-
nesses, administer oaths and take testimony with respect to the character of
the applicant or to any matter affecting the application at a hearing held
after sufficient notice has been given.

D. If the board finds that the applicant has passed the examination pro-
vided for under § 32-1723 or 32-1724, and that the applicant's character, abili-
ty and experience are satisfactory, the board shall issue a license.

E. Every application shall be approved or denied within ninety days from
the filing date or, if a hearing is held, within thirty days from the close of
hearing. Added Laws 1980, Ch. 248, § 4, eff. Jan. 1, 1982.

Effective January 1, 1982.

For applicable effective date provision
of Laws 1980, Ch. 248, see note following
§ 32-1701.

For disposition of the subject matter
of repealed and expiring sections and
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ed sections, see Tables preceding § 32-
1701 in Chapter 16 effective until Janu-
ary 1, 1982, ante.

Former § 32-1722, as amended by
Laws 1979, Ch. 50, § 4, eff. April 17,

1979, was repealed by Laws 1980, Ch.
248, § 2, effective July 1, 1980.

1980 Reviser's Note:

Pursuant to authority of section 41-
1304.02, in subsection A, paragraph 3 the
spelling of "ophthalmology" was correct-
ed as a manifest clerical error.

Library References

Physicians and Surgeons § 4.

C.J.S. Corporations § 956.

C.J.S. Physicians and Surgeons § 12.

§ 32-1723. Reciprocity

A. A person who presents to the board a certified copy of or a license in
good standing which was issued after examination by a board of registration
in the profession of optometry in any other state where the requirements for
licensure are, in the opinion of the board, equivalent to those of this state
shall be licensed in this state without a written examination but shall be given
a practical and oral examination subject to all of the following:

1. That such state accords like privileges to holders of licenses issued in
this state.

2. The license of the applicant shall not have been suspended or revoked
by such other state for any cause which is a basis of suspension or revocation
of a license under this chapter.

3. The applicant has not previously failed to pass the examination in this
state subsequent to his admission to practice in such other state.

4. The applicant has been engaged in the practice of the profession of op-
tometry continuously in such state for not less than four of the five years im-
mediately preceding his application.

5. The applicant intends to reside and practice the profession of optomet y
in this state.

6. The applicant offers proof of satisfactory completion of a course of study
in clinical pharmacology approved by a committee composed of the president
of the board, the chairman of the pharmacology department of the university
of Arizona college of medicine and the chairman of the department of ophthal-
mology of the university of Arizona college of medicine, with particular em-
phasis on the clinical application of diagnostic pharmaceutical agents for the
purpose of examination of the human eye and the analysis of ocular functions.

7. The applicant meets the requirements of § 32-1722 concerning good,
moral character.

B. Subsection A applies only to those persons coming into this state to open
a permanent office within one hundred eighty days from the date a license is
issued. Added Laws 1980, Ch. 248, § 4, eff. Jan. 1, 1982.

Effective January 1, 1982.

For applicable effective date provision
of Laws 1980, Ch. 248, see note following
§ 32-1701.

For disposition of the subject matter
of repealed and expiring sections and
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Ch. 16 effective until Jan. 1, 1982, see Ch. 16, ante

**PLEASE NOTE: THE PRECEDING PAGES WERE TREATED
AS A UNIT IN THE ORIGINAL DOCUMENT.**

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED
AS A UNIT IN THE ORIGINAL DOCUMENT

In reviewing House Bill #75 and Senate Bill #79, Section 2, Subsection 08.72.305 - Use of Drugs for Diagnosis, included in the list of drugs proposed to be used is a class of drugs called miotics. This group of drugs is only therapeutic and has no diagnostic use. They are used for treating chronic glaucoma and acute angle closure glaucoma. What is a therapeutic drug doing in a "diagnostic" bill?

Mr. George Hall's and Mr. Sternberg's (both Anchorage optometrists) response to this question at the March 1, 1978 meeting of the Legislative Coalition of Health Care Professionals in Anchorage and at the 1978 hearings on a similar bill introduced and defeated last year respectively was: "To take care of angle closure." "To use this as a first aid measure." This is treatment.

Treating angle closure glaucoma is very difficult and requires more than just putting a miotic eye drop in the eye. Treatment of this condition requires surgery in all cases. To break the angle closure attack before surgery, hospitalization, Diamox and intravenous Manitol is necessary in many cases. If angle closure glaucoma goes untreated, blindness results. All cycloplegics and mydriatics (dilating drops) can cause angle closure glaucoma.

It has been suggested to you by the optometrists that the incidence of angle closure glaucoma is only 1 in 18,400 cases. What they do not tell you is that a unique situation exists with the native Alaskan. The incidence of angle closure is 1 in 1,900 cases and even higher if dilating drops are used. This problem usually takes several hours to develop, long after the optometrist would have left the village. If we were to allow the optometrists to use dilating drops, this would result in many more unnecessary surgical emergencies and possible blindness. In view of this well known fact, ophthalmologists are hesitant to use mydriatics and cycloplegics in the Alaska native, especially in the bush areas.

Miotics are a therapeutic class of drugs and are listed incorrectly in the proposed bills as diagnostic drugs. Either the optometrists do not have a thorough understanding of the eye medications, or they are asking the legislators to allow them to treat glaucoma and other eye conditions. The proposed bill lists only broad general categories of the desired eye medications, no specific drug names and concentrations. The classes of drugs include such potent substances as Cocaine, Atropine, Scopolamine, Phenylephrine and Phospholine Iodide. All these drugs when applied to the eye are readily absorbed into the bloodstream and are capable of producing a wide range of total effects.

Cocaine, a topical anesthetic and mydriatic (dilator of the pupil) is a Class II narcotic controlled substance which is subject to wide spread abuse by addicts and requires a controlled substance registration certificate to dispense or use.

Optometrists are not medical doctors and cannot get a federal narcotics certificate. These drug bills are inconsistent with federal regulation on this point.

Atropine and Scopolamine are cycloplegic agents which paralyze the eye's focusing power and in sufficient doses produce irritability, hallucinations and even coma. Phenylephrin (a mydriatic) has the ability to raise the blood pressure markedly and to alter the rhythm of the heart and has been implicated in deaths in older people through strokes and in children through cardiac arrhythmias. Phospoline Iodide, a miotic which constricts the pupil, is used in the treatment of glaucoma (elevated pressure in the eye) and in certain cases of crossed eyes. The active ingredients are related to the active substance in certain insecticides and nerve gas. This medication has been shown to produce retinal detachments and cataracts.

The above are only a few examples demonstrating what potential dangers exist in the various classes of drugs listed in the proposed bills. By allowing wide spread use of these drugs by nonmedical persons, the overall risk to the general public of potentially serious side effects or untoward reactions are markedly increased.

I. EYE HEALTH CARE PROVIDERS OF THE CONSUMING PUBLIC

The American Optometric Association defines an optometrist as:

"...a health care professional who is specifically educated, highly trained and state licensed to examine, diagnose, and treat conditions of the vision system. Optometrists are highly skilled individuals who examine the eyes and related structures to determine the presence of vision problems, eye diseases and other abnormalities. They gather information on the vision system during the optometric examinations, diagnose any conditions discovered and prescribe optometric treatment such as contact lenses or vision therapy that may be required to provide the patient with clear effecient vision."¹

Although this definition is broad, the Alaska legislators have specifically narrowed the definition down considerably. According to the Alaska State Statutes, Title 8, Business and Professions Section 08.72.300, the Statutes define optometry as:

1. "Optometry" is the employment of means or methods, other than the use of drugs, for the diagnosis of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription or application of lenses, prisms or ocular exercises for the correction or relief of the human eye:
2. "practicing optometry" means the diagnosis, by means or methods other than the use of drugs, of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription of lenses, prisms or ocular exercises for the correction or relief of the human eye, or the holding of oneself out as being able to do so.

The optometrists will or have suggested to you that they are legally bound to diagnose eye diseases and that they are in a dilemma in that they cannot diagnose eye diseases without the use of drugs. They are only in a dilemma if the broader sense of the definition is used as set forth recently by the American Optometric Association. However, the Alaska State Legislators have ingeniously removed that dilemma for the optometrists by limiting them to the diagnosis of visual anomalies, muscular anomalies, optical deficiency or deformities and not eye diseases.

Furthermore, this construed dilemma is removed by a landmark decision by Judge James M. Fitzgerald, United States District Judge for Alaska in the Timothy Steele case in Fairbanks, Alaska. This is the case where an optometrist in Fairbanks used a dilating drop and noted an abnormality and did not refer the child to a medical doctor. The following is a direct and full quote of the Judge's conclusion:

"I conclude that competent optometric practice required that Timothy's parents be notified and that the child be referred. The failure to inform and refer was not a 'judgment call' but a violation of the governing principles of professional standards.

Optometrists are trained to recognize symptoms of many diseases which may be discovered by eye examination. They are not permitted under recognized optometric standards to undertake a definite diagnosis but recognize this as the responsibility of a medical doctor. Obviously, it is foreseeable that failure to refer to a qualified medical practitioner, when required to do so, will result in delay of diagnosis and the institution of treatment; so it proved to be in Timothy's case. At the time the referral was finally made to an ophthalmologist, it was too late. Time had run out, and the only thing that could be done was to remove the eye.

I conclude that the plaintiff is entitled to recover in this action from the United States for the loss of Timothy's right eye.

DATED at Anchorage, Alaska, this 20th day of October, 1978."

ss: James M. Fitzgerald
United States District Judge

If these bills passed, the statutory law would be inconsistent with common law or court decisions. Let us examine the optometrist's construed dilemma a bit closer. In an article "How the General Practitioner Can Determine the Need for Ophthalmologic Referral", it has been shown that the initial clues to eye disease are determined by history, visual acuity and external examination by handheld flashlight. Only .1% of eye disease is initially determined by using dilating drops. See Table A.

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

Most importantly, do not dilate the pupil. Routine tonometry according to established standards and viewing the fundus oculi through the undilated pupil are the additional needed methods. The use of mydriatic drugs to dilate the pupil risks precipitating acute narrow angle glaucoma by a 9:1 ratio over uncovering any hidden disease process. Thus it is obvious that there is no dilemma at all. This dilemma was construed by the optometrist for legislative purposes.

By now you have heard from the optometrists that there is another law suit filed against an Anchorage optometrist. They also state that if they could dilate the pupil to look in that the law suit would not have been filed. Well, the optometrist dilated Timothy Steele's pupil and still a law suit was filed and was won by Timothy Steele. The fallacy of this statement by the optometrists is clear in light of Judge Fitzgerald's decision and the article on what people need ophthalmologic referral.

The ophthalmologist is a medical doctor who has completed a 3-5 year residency program after one year internship preceded by 4 years of college and 4 years of medical school. He is trained in the diagnosis and treatment of ocular dysfunction and disease and in the use of all techniques of treatment including drugs, surgery, laser photocoagulation, radiation, etc. Because he has been trained as a general physician first, his perspective of the eye is broader than the optometrist. He views the eye and its diseases within the context of the whole body physiology and pathology. Further, referral to the ophthalmologist is viewed as only one necessary step in a differential diagnosis of the patient's complaint. Table 1 demonstrates the overall education and numbers of optometrists and ophthalmologists. From Table 1 it is evident that the ophthalmologists have much more training in pharmacology and pathology than the optometrists. Still the optometrists continue to compare their curriculum hours to dental school hours. They continue to say that if the dentists can use medications, why can't we. This is like comparing apples to oranges. They are not asking to use the drugs dentists use or to diagnose oral pathology. They are asking to do what the ophthalmologist does.

Therefore, it is more appropriate to compare ophthalmologists curriculum hours to optometric curriculum hours. (Please read Ref.#43, which explains this point in detail for the State of Alaska.) It is immediately obvious that the ophthalmologist has many more hours of classroom or book learning and many more years of clinical experience. The optometrists indicate that they can also take courses, but where do they get the years of clinical experience of putting drugs into the eyes of patients under close supervision of the clinical medical professors who are medical doctors. Optometrists simply do not get this type of training. Book learning is one thing, but clinical experience is most important.

Table 2⁴ gives a comparison of consumer services offered by ophthalmologists and optometrists. It is quite apparent that there is considerable overlap. This is most apparent with respect to refractions. The optometrist obviously can do some of the things the ophthalmologist can do; the ophthalmologist can do all of the things the optometrist can do, has the education to better interpret the data acquired, and provide medical/surgical treatment. The ophthalmologist is trained to provide complete eye care and to evaluate ocular dysfunction in the context of total body physiology and pathology. The ophthalmologist is a complete eye care provider. Although the overlap of professional services is greatest for refractions, this is a source of considerable consumer spending in both professions.

ECONOMICS (AND PRACTICE)?

Table 3⁵ shows the substantial number of public dollars which are expended for eye care. A total of approximately \$4,135 million dollars were spent in 1975 for vision care services.⁶ The national consumer spending for ophthalmic surgery is not listed. This would make the total ophthalmologic dollar spent on eye care far greater than the optometric dollar. If optometrists are allowed to expand the scope of their practice through the use of diagnostic drugs, the price of the basic eye examination would undoubtedly rise. Proposed national health care legislation can be expected to impact heavily upon these figures. For example, if the Kennedy-Mills National Health Insurance proposal were to include coverage of sight correction services, total spending for these services would rise by 21% or \$866 million dollars per year. It is obvious that there will be considerable effort by optometrists to ensure their fullest possible participation in this program. The economic stakes are very high.⁷ This makes it very clear why optometry has put on an aggressive nationally organized push to legislate themselves into a better position to compete for this consumer dollar. Even though

the optometrists in the State of Alaska suggest that this is not a "money bill"-- it is. It is merely the first step toward the national optometric goal to attempt to become primary eye care providers.

This image change is being sold to the public by a sophisticated national advertising campaign. This multi-million dollar campaign is funded by the national optometric organization through dues and special assessments. They are trying to sell themselves as "your family doctor of optometry...the one to see and keep seeing". Calling themselves family doctors in the opinion of the ophthalmologists is misleading since they are not medical doctors as are the family practitioner or family doctor. These ads are occurring on national T.V., radio and magazine; such as, The Ladies Home Journal, Better Homes and Gardens, etc. Ads that show stethoscopes hanging around the neck of the optometrist is also misleading, as the general public associates the medical doctor with the stethoscope. One article in the Anchorage Times even referred to a group of optometrists as physicians and the word ophthalmologist was used. (See supporting documents)

We should expect that in the future the Alaskan optometrists will follow the attempt of other state optometric associations to next try for the privilege to use these same diagnostic drugs as therapeutic agents. An attempt was made in West Virginia to legislate the privilege of eye surgery, but this was defeated.

The optometrists have claimed at their bill hearings in the lower 48 that they see 70% of the eye consumers and therefore are the point of first entry into the eye care system. Looking first at the source of this claim and national statistics, the fallacy of this claim is demonstrated. They have erroneously assumed that the average number of eye consumers seen by each practitioner is the same. Thus the source of the fallacy: that since they compose 70% of the national work force they see 70% of the eye consumers.

Table 1 indicated the total number of practitioners in each group.⁸ The median number of patients seen per week by optometrists was 43.2; the median seen by ophthalmologists was 102.9. The ophthalmologist sees more than twice as many patients as the optometrist while he comprises only 30% of the work force. It is therefore, clear that the ophthalmologists care for half the patients, while the optometrists, comprising 70% of the national work force, care for the other half. The statistics in Alaska show that there is a total of 40 optometrists¹⁰ and 25 ophthalmologists¹⁰. Thus the ophthalmologists make up 39% of the state work force

people in all sections of the state and in many small communities through the itinerant program.

In the states where optometric drug laws are in effect, optometrists who wish to use drugs much take short slide and lecture courses on pharmacology. This has or will create two classes of optometrists, which can only lead to additional consumer confusion about a profession already shrouded in confusion. In addition, the use of drugs by optometrists could falsely lead patients to believe diagnostic expertise is available from optometrists.

It is misleading to the consumer and legislature to imply that any drug is purely diagnostic. Each of the classes of drugs asked for by optometry have therapeutic uses. Will the optometrists resist the temptation to use these drugs to treat conditions beyond their knowledge and skill?

It has been said by the optometrists that they would like to use dilating eye drops also in the their bush clinics when they see Alaska natives. A unique situation exists within the native population of Alaska. The incidence of angle closure glaucoma is 1 in 1,800, not 1 in 20,000 as in caucasians. To allow the optometrist to use these dilating eye drops would result in many more cases of acute angle closure glaucoma, for which they are not trained to treat, and which requires quick and effective treatment to prevent blindness. Sometimes angle closure glaucoma requires administration of intravenous Diamox, Maritol or urea. This would result in further expenditure of health care dollars.

III. LEGISLATIVE DUTY FOR THE EYE CARE CONSUMER:

As practitioners of an occupation which deals with the integrity of eyesight, optometrists have been recognized by the Washington Legislators as members of a "learned profession".¹² Professionals who deliver health care may be regulated by the state via its

and the optometrists 61%. Applying the same national ratio of eye consumers seen by optometrists and ophthalmologists, it is evident that the ophthalmologists see 56% of the eye care consumer, but makes up 39% of the state work force. The accuracy of the ratio of two to one was checked in the city of Anchorage by comparing the number of eye consumers seen by the most active ophthalmologist in town - 40-50 eye consumers, as compared to the most active optometrists in town - 20-25 eye consumers seen in one day. The average ophthalmologist in Anchorage sees 30 people per day. The average optometrist sees 15 people per day. These figures would seem to indicate that although ophthalmologists are a smaller group than optometrists, the public will seek out their services given a free market choice.¹¹ On this point, the eye consumer in the state of Alaska has ready access to the ophthalmologic eye care providers. Some of the states in the lower 48 are mainly rural and ophthalmologists are congregated in the metropolitan areas and the optometrists are distributed over the rural areas. However, much of Alaska is "bush country", so that the ophthalmologists and optometrists are both congregated in Anchorage, Fairbanks, Kenai Peninsula and the southeast. There are only two areas (Kodiak and Bethel) that have a full time optometrist and no full time ophthalmologist, Table-Map 5,6. However, there are other medical doctors in these communities with "medical know how" and there are airports for evacuation in the case of eye emergencies. Furthermore, Kodiak and Bethel are visited on a regular basis by itinerant ophthalmologists. In fact, most areas in Alaska are served by itinerant ophthalmologists both by Alaska Native Service and by private practicing ophthalmologists, Table-Map⁶. In the 14 other states where a similar bill was passed, these states were mainly rural with a maldistribution of ophthalmologists. In these states, this was the main reason for passing the legislation. Therefore, this argument for passing House Bill 74 or Senate Bill 75 does not apply to the State of Alaska, because the distribution of ophthalmologists is essentially identical to that of the optometrists. Thus, the health services of ophthalmologists are readily available to

police powers to oversee those activities which are involved with health, education and welfare.¹³ The healing arts particularly have been the subject of regulatory legislation which specifies strict requirements for the practice of such professions.¹⁴ The intent of such restrictive legislation is avowedly the protection of the public against injuries it may suffer from the conduct of such business or calling.¹⁵ The state may reasonably impose any condition precedent to the grant of its consent to practice a healing art, which has a real and rational relation to that objective.¹⁶

The usual means taken by the state in applying these conditions as quality standards has been by imposing licensing requirements and by carefully defining the particular professions involved.¹⁷ Constitutional challenges to this power of the state have been universally defeated when that power has been reasonably exercised.¹⁸

Licensing requirements usually specify minimum standards of professional competence for the profession covered and frequently the definition of the profession gives broad areas of practice which will be considered appropriate for the practitioner seeking licensure. Additional restrictions upon the practice can be found in state statutes which define unprofessional or unethical conduct.¹⁹

The above state powers are broad and greatly influence the scope, and freedom of practice by the health care provider. Although the right to follow a profession is recognized as a valuable property right which is constitutionally protected,²⁰ such a right is not absolute; there is no natural or vested right to practice within the healing professions. Any such right is a conditional use.²¹

The justification for such regulations lies in a perceived right and duty of the legislature to protect the citizens of the state from incompetents and fraudulent health practitioners.²² The Washington Constitution specifically vests exclusive authority in the legislature to:

"...regulate the practice of medicine and surgery and the sale of drugs and medicines."²³ From this, courts have construed legislative authority to regulate, by means of separate statutory licensing requirements, all of the various professions and occupations engaged in health care delivery. This includes many professions which are not obviously included in "...the practice of medicine..."²⁴ Further, the state has the power to define what constitutes the practice of any profession and may then confine practitioners of various health disciplines to the particular system of practice in which they have been educated.²⁵

This is a logical stance for the legislature to take. If the legislature has an avowed interest in protecting the public,²⁶ it must make some attempt at defining the scope of appropriate practice which each class may safely employ and to license those within each class to practice upon the public only those skills for which they have demonstrated competent training. That includes courses, testing and most important of all, clinical experience under supervision. This is the legislative intent in enacting licensing statutes.²⁷ This reasoning is followed with consistency in cases involving almost every viewpoint and aspect of health care.²⁸

Great latitude is given by the courts to the legislature in defining its public health goals. However, the goal is universally stated to be the protection of public health. Health legislation is not passed to promote the personal ends of individuals or to enhance the status or prestige of any given class of practitioners.²⁹ Although the legislature may enact such regulatory legislation as it may consider necessary, there must be a rational basis upon which the legislative determination rests.³⁰ This cannot be interpreted as meaning anything less than that such legislation must appear to be rationally directed toward the achievement of the stated legislative goal and to be reasonably rational in the means which it seeks to achieve that goal.

is made with 'whole body' disease/function. The eye is studied in isolation as an optical instrument. To use an analogy, an operating room nurse could teach an optometrist about eye surgery, just as a pharmacologist Ph.D. can teach an optometrist about pharmacology. However, no one would want an optometrist to perform surgery with an education based only on lectures and theoretical familiarity with the subject. The prescribing and using of drugs, just like the performance of surgery, must be founded on a broad-based curriculum involving many hours of supervised clinical experience using drugs. To allow any health care provider to practice with only limited classroom experience and testing violates the legislative duty to protect the public from risk of incompetency from lack of clinical experience.⁴³

As a second step, the legislature can require continuing education for those practitioners who have already completed broad formal training upon which additional, up-dated information may be rationally correlated. This type of post-graduate instruction always preumes in-depth background knowledge. It is used to present newly altered clinical concepts or additional practical experience (e.g., using operating microscopes, intraocular lens implants, vitrectomies, etc) for those practitioners with clinical experience sufficient to allow them to understand the usefulness or pitfalls, to see the advantages or clear disadvantages, to comprehend the clinical reliability or dangers of the material which the course is presenting. Crash courses which involve totally new material, presented to practitioners without that clinical judgement or experience necessary to actually grasp the real impact of the data presented, let alone the nuances, can be expected to create clinicians who will test their newly acquired knowlege in the public sphere. The hazards of such an approach are obvious. Again, such an approach does not satisfy the legislative duty to reduce public risk.

I must conclude that for the state to allow graduates of optometric schools, who are unarguably well-trained in the limited sphere of practice which optometry has exercised to date, to extend their

- a) Goal - As noted above, the frequently given objective for regulation of health care providers is the protection of the public from incompetent practitioners.³¹

This goal is stated to exist even if it deprives a citizen of a right he otherwise might enjoy in the pursuit of his profession.³²

This reasoning leads to the conclusion that the legislature has the duty to ensure that its acts and statutes do not tend to increase public exposure to health risk.³³ The stated legislative goal is increased public protection, not increased public risk. Nowhere does case law state that public protection will be qualified - i.e., that the legislature may increase the risk "a little bit", but not "a lot". No such slippery subjective terms appear. The intent is protection. The language is explicit.

- b) Means - The means by which the legislature attempts to arrive at its stated goal must be reasonable and rational.³⁴ The means which have been used by all states to regulate the professions have been noted above. The states have attempted to ensure the competency of each practitioner and then limit each to the area of practice embraced within the training which that practitioner has received.³⁵ If this means anything, it must mean that before the provider is allowed to administer to an uninformed public, (45% of the public does not know the difference between an ophthalmologist and an optometrist)⁴⁸ he must provide evidence of training sufficient to ensure the public from health care which is inadequate. Such inadequacy can range from innocuously improper diagnoses which are nonetheless economically costly, to disabling or fatal mistakes in clinical judgement - either diagnostic or the end result of therapeutics.

Insofar as it can ever be sure of the quality of professional performance, the state has two related ways to oversee clinical performance.

The state may require evidence of formal professional training which has as its foundation and primary goal, a strong commitment to an understanding and clinical application of those methods, techniques and material to which the public will be exposed and which will place it at risk. Such training must satisfactorily convince the legislature that which it certifies the practitioner, the legislative duty to prevent risk of public harm has been met.

Using the data presented in the first portion of this testimony, it is apparent that optometric training as it now exists in the State of Alaska is not directed toward a broad understanding of human pathology/physiology/pharmacology with supervised clinical experience.⁴³ Training is limited to a superficial, most theoretical, presentation of data concerning ocular dysfunction with inadequate clinical supervised experience. Not only do the data show that the instruction given the optometric student is very limited, but little or no integration of visual disease/function

clinical practice to include the application of drugs to the eye would be an irrational approach toward the protection of public health.⁴³ If the curricula of optometric schools demonstrated sufficiently integrated instruction in human anatomy/pharmacology/physiology/pathology to provide the optometric graduate with an adequate basis for making appropriate clinical decisions of diagnosis, then such a legislative extension of clinical opportunity, and responsibility would be reasonable. Crash courses are not an adequate substitute³⁸ for many hours of supervised clinical experience.⁴³

It should be repeated that the strong interest of the state in protecting the public, has traditionally and appropriately placed rigid conditions and restrictions upon the right to affect public health.³⁹ It should also be repeated that this power to restrict health care practice is recognized as proper regardless of its effect upon the economic interests of those regulated.⁴⁰

It is doubtful that an informed public would voluntarily accept a role as an on-the-job training clinical practice model so that the optometrists can gain the clinical experience needed to use drugs. The consumer public currently has expectations which include a higher standard of knowledge by the medical service provider than ever before. These expectations directly flow from the public's increased understanding that they each, as individual complex biologic units, are biochemically affected in manifold ways via the environment, foods and drugs. Any legislative change which would franchise greater administration of drugs and which simultaneously does not require firm, convincing evidence of a profound understanding of the disease to be detected, its effect on the human body, the biochemistry of the drug to be used, ignores the public right to be protected from incompetency and the public right to make decisions concerning its health care. The public has a right to understand that any practitioner, presuming to diagnosis ocular disease that usually have total body manifestations, is making diagnostic decisions based upon training which comprehends all of the above principles.

IV. AGENCY ACTION FOR ASSURANCE OF THE HIGHEST QUALITY EYE CARE FOR THE CONSUMER.

The public should be able to rely upon state certification of competency. Legislation which does not demand evidence of such competency before certification fails in its duty to provide public protection in matters of health.

Currently, states have little control over the calibre of training which optometrists acquire prior to licensure. An optometrist may have trained in an optometric school unaffiliated with any medical center, he may have obtained the minimal training necessary to qualify for graduation, but once having graduated, he can apply for and obtain a license with ease.⁴¹

The State Board of Optometry certifies the competency to use drugs of those optometrists which it approves for licensing.⁴² Two problems are immediately apparent:

- 1) The members of the Board of Optometry have little personal experience in ocular pharmacology, ocular pathology, and diagnosis. They are themselves graduate of optometry schools which have offered limited training because the board members took their training when little time was devoted to course work in pharmacology, and now have little experience with drugs. It is difficult to see how such a Board can adequately evaluate such clinical ability in optometric applicants for licensure, nor is it clear how such a Board can construct any 'refresher' course that would adequately prepare the optometrist for his broadened responsibilities. What is usually used is a 'canned' course, prepared elsewhere.
- 2) The ability of the Board to carry out its mandate to protect the public from those few individuals that would use these diagnostic drugs also as therapeutic drugs would find themselves in a frustrated position. The Board can do nothing to prevent this and the fine for practicing medicine without a medical license is only \$100.00.

The regulation of the profession by the Optometric Board will be considered appropriate so long as it is reasonable and necessary in the interest of health, safety of the people.⁴⁴ Licensing of optometrists by a Board itself lacking in the necessary qualifications to evaluate clinical performance and knowledge, is manifestly unreasonable. To grant the right to optometrists to use diagnostic drugs who are poorly qualified to do so, is not a reasonable, or an appropriate, or a necessary means of 'protecting' the public health.

The regulation of the practice of optometry is not for the benefit of the licensee, but for the state and its people.⁴⁵ Certainly, if the practice of medicine and surgery is a proper subject for careful and precise legislation, so also should be legislation which concerns eye care and those who provide it to the public.⁴⁶

V. CONCLUSION

Having looked critically at the past trend toward the expansion of optometric services into medical care, and with the present trend of more and more states defeating this kind of bill, it is proper that some statement be made regarding an appropriate role for this vision care professional.

If the optometrist will be expected to diagnose eye disease, then one of two events must occur:

- 1) optometric training must be upgraded substantially enough to provide him with clinical expertise sufficient to satisfy appropriate public expectations of high competency; or
- 2) optometrists must work in an association with ophthalmologists close enough to provide for the day-to-day transmission of diagnostic information from the M.D. to the O.D., and allow the latter to obtain practical involvement in treatment rationals and administration. This would be similar to the military, Veterans Administration and Alaska Native Service, where the optometrist use these drugs under the direct supervision of the ophthalmologists.⁴⁷

Having once recognized the above solutions two problems immediately present themselves. The first solution would require the relocation of optometric schools to permit integration with medical training and include a complete restructuring of optometric training. So much change would be needed that any difference between the ophthalmologist and optometrist would evaporate. However, if any group of practitioners presumes to medically minister to the public it must accept the rigorous training which must precede such responsibility. There is no quick and easy path to competent understanding of a subject becoming increasingly complex year-by-year. The optometrists seem to want to become doctors, but do not want to go through the extensive number of years training it requires. This is particularly true when the results of error or incompetency can be blindness.

The second solution, close day-to-day association of optometrist/ophthalmologist, creates a psychological hurdle - perhaps an economic one as well. Optometrists would be required to visualize themselves in a supportive role. This is difficult for any professional to do, especially if he has historically been conditioned to see himself as a member of a separate group, practicing independently. So long as he can offer only limited eye care, he is in a supportive role to those who offer complete eye care. This cooperative association is currently working well in the Veteran's Administration System, the military and the Alaska Native Service. It could work well in private care.

Finally, if state legislatures believe that it is proper to expand the medical opportunities of this health-care group of practitioners via redefinition and short-course catch-up lectures without restructuring fundamental educational requirements and experience, there can be little rationale for not doing the same for all paramedical groups, e.g. naturopaths, acupuncturists, and faith healers.

Rationally, the legislature must either strictly require very high state-of-the-art medical training standards to protect its citizens or it should minimize that responsibility and lower its standards to permit each group to economically advance at the public expense. The latter practice would also reduce the educational time and

experience required to produce specialist M.D.'s- but, of course, such physicians would be recognized as marginally or totally incompetent. Should the standard be any different for optometrists who wish to medically diagnose eye disease that is so closely linked with the body as a whole functioning unit?

Thank you for your time and the opportunity to present this view indorsed by the State Ophthalmologic Association.

FOOTNOTES:

- 1 - Worthen: The Ophthalmologic-Optometric Interface. Transactions of American Academy of Ophthalmology and Otolaryngology *3:OP-155, 1977
- 2 - Representative of most ophthalmology residency programs, it is that of the University of Minnesota, Mayo Clinic Graduate School of Medicine. Following graduation from Medical school and a general or specialty internship, the resident enters a program which requires 65 hours a week of ophthalmologic instruction; of this, approximately 8 hours a week is devoted to formal, didactic lecture, the remainder is clinical or laboratory activity. This weekly schedule continues over a twelve month academic year, for three years. Some of a nine month written home study course administered by the Academy of Ophthalmology. Some programs require an additional one year of ophthalmology. Department of Ophthalmology, University of Minnesota, Mayo Clinic Resident 1974-1977.
- 3 - Curriculum, University of Minnesota College of Medicine. The basic curriculum required of any candidate for an M.D. degree includes 128 credit hours of 'medical' subjects; this does not include clinical studies which are specifically directed toward a specialty interest. Although optometrists may agree that these requirements are not appropriate for them, such an analysis ignores the fact that in expanding their role into the practice of medicine optometrists should be subjected to the same educational requirements. Unfortunately, there is no short-cut to professional competence. This is particularly true in the rapidly expanding and complex field of medicine. The public has a right to demand strict legislative requirements before practitioners are certified as competent.
- 4 - Worthen, note 1, OP-158, supra.
- 5 - Trapnell, The Impact of National Health Insurance on the Use and Spending for Sight Correction Service, 1976. (This study was underwritten by the American Optometric Association, and the Optical Manufacturers Association.) It reveals that optical device sales represent 66% of the funds expended for optometric services and 19% of funds expended for ophthalmologist services, at Table 1 of the Trapnell Study.
- 6 - This figure includes \$920 million spent for optician and \$220 spent by institutions. Those categories of service providers are not included in this discussion since they are not involved in patient care.
- 7 - This economic impact will be divided not only by optometrist and ophthalmologists, but also by opticians and lens/frames/contact lens manufacturers.

- 8 - Worthen, note , Op-157, supra.
- 9 - On Blue Shield Survey: In 1975, actuaries for Blue Shield in Connecticut requested of optometrists data necessary to project the cost of insurance covering optometric examinations. One hundred sixty six out of 266 active optometrists responded listing their age, number of years in practice, and number of eye examinations performed each year, and the cost of an eye examination, exclusive of the cost of glasses, so called service charges or visual training. Similar data was gleaned from ophthalmologists. It was concluded that the average optometrist see 23.3 patients per week. Exclusive of patients seen for medical surgical problems or for follow-up care, the average ophthalmologist, of whom there are 160 in Connecticut, sees 56 patients per week for complete eye examinations. Also, if this patients per examiner data is carried over to fit national figures for the number of practicing O.D.'s and ophthalmologists it indicates that about 60% of the primary eye care is rendered by ophthalmologists in the United States right now.

A report prepared for the Optical Manufacturers Association by a consulting actuarial firm (Trapnell Report-1975) presented data based upon national surveys conducted in 1975. The reporters estimated that approximately one-half of 50 million professional eye examinations were done by ophthalmologists and one-half by optometrists. This report dealt only with persons seeking entry into the eye services field for so-called "sight correction" services and did not count all of the services provided by ophthalmologists otherwise for persons who seek out an ophthalmologist otherwise for persons who seek out an ophthalmologist for treatment of medical and surgical problems. (Ophthalmologists obviously do 100% of significant eye surgery and treatment of major eye disease) It is remarkable to note that even though there were approximately 10,000 practicing ophthalmologists, as compared to 20,000 optometrists in the United States, that half of the 50 million so-called "routine eye exams" were performed by ophthalmologists during the year 1976.

- 10- Department of Commerce and Occupational Licensing
- 11- Obviously, where ophthalmologists are rare, optometrists see the bulk of patients. However, public education, assistance with payment of medical bills via Medicare and Medicaid, the high mobility of todays population, and the trend toward urban population clustering near ophthalmologists and other specialists certainly influence this bias toward ophthalmologists.
- 12- R.C.W. 18.53.005 Legislative Declaration: "The legislature finds and declares that the practice of optometry is a learned profession and affects the health, welfare and safety of the people of the this state, and should be regulated in the public interest and limited to qualified persons..." (Amendment 1975)

- 13 - Ellstad v. Swayze, 15 Wash. 2^d281, 130 P2^d 354 (1942).
See also, Ketchum v. King Co. Medical Service Corp., 81 Wash 2^d 565, 502 P2^d 1197, 1200 (1973)
- 14 - Swayze, note 13, 353, supra.
- 15 - Kelly v. Carroll, 36 Wash 2^d 482, 219 P2^d 79, 90.
(1950)
- 16 - Campbell v. State, Id., at 462
- 17 - Gellhorn has recently argued that state licensing statutes are in fact attempts by the profession or occupation involved to control competition by means of restrictive admission to practice. Even Professor Gellhorn would admit that the licensing of health professions is necessary and probably rises above such criticism. Gellhorn, The Abuse of Occupational Licensing, 44 University of Chicago L.R.6, 1976.
- 18 - Semmler v. Oregon State Dental Examiners, 294, U.S.608, 611,
(1934); State v. Wilson, 11 Wn. App. 916, 528 P2^d 279 (1974)
- 19 - R.C.W. 18.53.140
- 20 - Laughney v. Maybury, 145 Wash. 146, 259 P.17 (1927)
- 21 - Ellstad v. Swayze, note 47, 353, supra, Accord. Dantzler v. Callison, 230 S.C. 75, 94 WE 2^d 177, app. dismd. 352 U.S. 939(1956)
- 22 - Kelly v. Carroll, note 15, 85, supra.
- 23 - Art. 20, 2
- 24 - Ellstad v. Swayze, note 13, 353, supra.
- 25 - State v. Bonham, 93 Wash 489, 161 P 377, 379 (1916)
- 26 - Kelly v. Carroll, note 22, supra.
- 27 - State ex rel Fleming v. Cohn, 12 Wash 2^d 425, 121 P2^d 954 (1942)
Accord, State v Hauk, 32 Wash 2^d 68; 203 P2^d 693(1949)
- 28 - 61 Am Jan 2^d, Physicians, Surgeons, and other Healers, 19;86
ALR 623, 624
- 29 - Ex narte Whitly, 144 Cal. 167, 77 P 879 (1904)
- 30 - "It is enough that...it might be though that the particular legislative measure was...rational..." Williamson v. Lee Optical Co., 348 U.S. 483, 488 (1955), Douglas, J., majority opinion)
- 31 - See note 15, supra.
- 32 - Campbell v. State, note 15, supra.
- 33 - "A law which reduces or prevents any increase in an ...evil tends to safeguard the public welfare..." Id. at 462. (emphasis added).
- 34 - Williamson v. Lee Optical, note 29, supra.
- 35 - State v. Houck, note 27, 700, supra.
- 36 - Worthen, note , Op-160, supra.
- 37 - "...the legislature was careful to require definite knowledge

- 38 - West Virginia Statute 30-8-5 requires those optometrists who wish to use drugs to complete those requirements which the board of optometry may see fit to establish. The board of optometry requires attendance at a pharmacology course similar to that described in note 43, infra.
- 39 - Ellstad v. Swayze, note 13, supra.
- 40 - Campbell v. State, note 15, supra.
- 41 - R.C.W. 18.54070
- 42 - R.C.W. 18.54.030 - In fact, the statute excludes from board membership any optometrist "...who has any connection with any school...of optometry..." It could be presumed that optometrists teaching at optometric schools would be best qualified to judge the qualifications of optometric candidates and possess the most currency in clinical information.
- 43 - A letter from Leon Candenberg, O.D., Director Pennsylvania College of Optometry describes the lecture outlining in pharmacology used by Kentucky, Florida, Pennsylvania and New Mexico. This course involves participation by the optometrist in six weekend sessions (Saturday and Sunday) and ends with a three hour examination covering the presented material. A letter from Sam A. McConkey, M.D. to the Honorable Charles Parr:

ON OPTOMETRISTS PRACTICING IN THE STATE OF ALASKA

According to figures obtained in February of 1978 from the Department of Commerce, Division of Licensing, there are 40 licensed optometrists in Alaska. Their educational background is as follows:

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

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

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

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

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

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

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

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

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

The maximum number of M.D.'s in even a part-time capacity on the staff of any school attended by 37 of the 40 optometrists in Alaska, is two. From a survey of the Blue Book of Optometry which was last issued in 1976, it appears that the maximum number of members of the State Board of Optometry that even have a bachelors degree from any school is two of the six board members that are listed. It would seem reasonable that there would be an ophthalmologist either in the teaching or in the clinical aspect of optometric education, but it appears from the available evidence, that the maximum number of optometrists currently practicing in Alaska that had any full or part-time instruction, either by lecture or in the clinical setting by an ophthalmologist is zero.

44 - State v. Spino, 61 Wash 2^d 246, 377 p2^d 868, 870 (1963)

45 - Pennington v. Benelli, 15 Cal App 2^d 316, 59 P2^d 443

46 - Campbell v. State, note 15, 466, supra.

47 - The AAO Nov.-Dec. 1977. "AGREEMENT REACHED ON DEFINITION OF MILITARY OPTOMETRIST- The army, Navy and Air Force have agreed on a common definition limiting the services optometrist may render to military personnel. Prior to the new definition, the three military branches had differing definitions which the AAO mailed to all state ophthalmological societies earlier in the year. On June 15th James W. Foristel, AAO Congressional Liason, met with Robert Smith, M.D., Assistant Defense Secretary for Medicine, who was attempting to have all three of the service's Surgeons General agree on a common definition. In September, they reached agreement on the following single definition.

'The optometric clinic provides optometric patient services under medical supervision. Optometrist examine the eyes and

adnexa to include refraction and other procedures, prescribe lenses to correct refractive errors and improve vision. They refer patients to physicians for diagnosis and treatment of suspected disease. Optometrists use appropriate drugs to perform optometric procedures. When using these drugs, immediate medical care is available in the event of adverse reaction."

48 - The optical Journal and Review of Optometry, June 15, 1976
Volume 113 No. 6

TABLE A. EXAMINING ELEMENTS THAT INDICATED OPHTHALMOLOGIC
DISEASE IN 716 PATIENTS.

HISTORY	255	(35.6%)
VISUAL ACUITY	198	(27.7%)
EXTERNAL EXAMINATION BY HAND- HELD FLASHLIGHT	157	(21.9%)
REFRACTION	4	(.6%)
TONOMETRY	69	(9.6%)
SLIT LAMP	23	(3.2%)
UNDILATED FUNDUS	9	(1.3%)
DILATED FUNDUS	<u>1</u>	<u>(.1%)</u>
	716	100%

TABLE I

SYMPOSIUM ON LEGISLATION

PH. D. THESIS BY DON C. PEARSON, M. D. - APRIL 28, 1977 - WORTHEN
 THE OPHTHALMOLOGIC OPTOMETRIC INTERFACE T. A. A. O. O. 1977

 Comparison of Optometry and Ophthalmology

	Optometrists	Ophthalmologists
1 - License	In all states as optometrists	In all states as Physicians and Surgeons
2 - Prerequisite	2 yrs. of college (60% of beginning students have baccalaureate degree or higher)	Graduation from Medical School (M.D.) 3 - 4 years College
3 - Curriculum	School or College	Medical school internship, Postgraduate (residency)
Pharmacology	64 hours* 126 hours **	307*** (187 hrs. general with 18 months clinical and 120 hrs. ocular with 4yrs. 6mo. clinical)
Pathology	20-60 hours	200 hours general with 3 years clinical and 148 hours ocular with 3 years clinical
4 - Period of training	4 yrs (34-36 months)	3-5yrs. (36-60 months)
5 - Time for education after high school	6-8yrs (54-72 months) Max. 4yr. undergrad. Max. 4yr. Opt. college	11-14yrs. (120 months)
6 - Number of active practitioners	21,900	9,322
7 - Number of students	4,985	1,914 (residents)
8 - Total number of practitioners and students	24,933	10,496
9 - Total number of eye professionals	24,800 (70% of total)	10,629 (30% of total)
* Mr. George Hall's report on Pennsylvania School of Optometry to March 1, 1978 meeting of Legislative Coalition of Health Care Professionals.		
** 126 hours - Southern College of Optometry		
*** Mayo Clinic and Iowa		

TABLE 1A

OPTOMETRIC EDUCATION DEFICIENCY DOCUMENTED FOR REDBOOK SURVEY
 As prepared by John W. Gamel, M. D.
 University of Louisville School of Medicine

EDUCATIONAL BACKGROUND REQUIRED FOR DELIVERY OF EYE CARE:
 Comparison between Optometry and Ophthalmology*

REQUIREMENT	OPTOMETRY	OPHTHALMOLOGY
Admission	2 years of college	4 years of college plus 4 years of medical school
Total Training after High School	6 years	12 years
Class and Laboratory Time	1,650 hours	3,249 hours
Supervised Practice of General Medicine (Internal Medicine, General Surgery, Obstetrics-Gynecology, Psychiatry, Primary Care)	0 hours	3,240 hours
Supervised Practice of Medicine and Surgery of the Eye	0 hours	5,240 hours
TOTAL TRAINING HOURS	1,650 hours	11,739 hours
Number of years during which training occurred	4 years	7 years
Hours per year	412½ hours	1,677 hours

*Information abstracted from:

1. Course Handbook of Indiana University, Division of Optometry, 1975-76.
2. American Association of Medical Colleges Curriculum Directory, p. 86 87 (re: University of Louisville School of Medicine.)
3. Residency Training Schedule, Department of Ophthalmology, University of Louisville.

TABLE 1b

BREAKDOWN OF HOURS SPENT IN EDUCATION OF OPHTHALMOLOGIST

1. Class & Laboratory:			
Medical School			
1st year	871		
2nd year	<u>748</u>		
			1,519
2. Residency:			
Lectures:			
5 hrs per wk x 150 weeks	750		
Basic Science			
40 hrs per wk x 10 weeks	400		
Home Study			
20 hrs per mo x 24 mos	<u>480</u>		
			1,630
TOTAL DIDACTIC TRAINING (HRS.) (1 + 2)			3,249
3. Supervised Practice of General Medicine			
54 wsk x 60 hrs. per wk (includes night calls & weekends)			3,240
4. Supervised Practice of Medicine and Surgery of the Eye			
35 hrs per wk x 150 weeks			5,250
TOTAL TIME SPENT IN SUPERVISED PRACTICE (HRS.) (3 + 4)			8,490
TOTAL TIME SPENT IN FORMAL EDUCATION OF OPHTHALMOLOGIST AT THE UNIVERSITY OF LOUISVILLE (HRS.) (1 + 2 + 3 + 4)			11,739

RESIDENCY TRAINING SCHEDULE, DEPARTMENT OF OPHTHALMOLOGY
UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINESummary of Hours of Didactic Learning
Offered During Residency:

Ongoing Lectures:

Monday, a.m.	1 hour
Tuesday, a.m.	1 hour
Thursday, a.m.	2 hours
Friday, a.m.	1 hour
TOTAL:	5 hours per week

Basic Science Courses:

40 hrs. per wk lectures/labs
Duration: 10 weeks

Home Study Course:

20 hrs per month
Duration: 24 months

TABLE 2

PH. D. THESIS BY DON C. PEARSON, M. D. - APRIL 28, 1977 - WORTHEN
 THE OPHTHALMOLOGIC OPTOMETRIC INTERFACE T. A. A. O. O. 1977

Service offered by Optometrist and Ophthalmologist

<u>Service</u>	<u>Optometrists</u>	<u>Ophthalmologists</u>
Refraction	99%	99.5%
Ophthalmoscopy	92%	99.5%
Contact Lenses	79%	58%
Visual Fields	75%	94%
Tonometry	66%	99.5%
Orthoptics	50%	53%
Low-vision aids	40%	55%
Biomicroscopy	32%	99.5%
Aniseikonic Testing	8%	9%
Treatment of eye disease	1-2%	100%
West Virginia and North Carolina		
Surgery	0%	99%

TABLE 3

CIVILIAN CONSUMER SPENDING FOR VISION CARE AND SIGHT CORRECTION
SERVICES IN 1975

<u>A. Expenditures</u>	<u>OFFICES OF OPTOMETRISTS</u>	<u>OFFICES OF OPHTHALMOLOGISTS</u>
General examinations	\$525	\$510
Medical treatment and therapy	40	500
Ophthalmic Services:		
Corrective Eye glass Lenses	865(49.6%)	180(14%)
Contact Lenses	285	60
Other	<u>30</u>	<u> </u>
	1,745	1,250
		No optical shops No surgery

How the General Practitioner Can Determine The Need for Ophthalmologic Referral

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

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

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

Method

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

Address correspondence to Dr. Campell at PO Drawer 3151, Martinsville VA 24112.

Submitted 1-12-79.

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

Results

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

Table 1 lists the means by which disease was suspected. Notice the heavy preponderance of history, visual acuity, and external examination by hand-held flashlight as the initial clues to disease. These three are, of course, different facets of the same stone and could well be combined, i.e., if a patient states that he does not see well, and if his visual acuity is indeed decreased, then the patient's history is confirmed. In 610 (85.2%) of the 716 patients with disease, this triad

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

History	235	(35.6%)
Visual Acuity	198	(27.7%)
External Examination by Hand-Held Flashlight	157	(21.9%)
Refraction	4	(.6%)
Tonometry	69	(9.6%)
Slit Lamp	23	(3.2%)
Undilated Fundus	9	(1.3%)
Dilated Fundus	1	(.1%)
	716	100%

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

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

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

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

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

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

Conclusions

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

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

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

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

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

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

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

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

Acknowledgment

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

WHO TEACHES OPTOMETRISTS MEDICINE?

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

MEDICAL COLLEGES	Total # of Students	Total # of Faculty	Faculty Student Ratio	Total # of M.D. Professors (Full or Part Time)	Full Time Clinical* Teaching M.D. Specialists	OPHTHALMOLOGISTS (M.D. Eye Specialists)			PHARMACOLOGY DEPARTMENT		O.D.s	O.D./Ph.D.	Other Ph.D., M.S. or B.S.	COMMENTS
						Full Time	Part Time	M.D. Residents	M.D.s - M.D./Ph.D.	Ph.D., M.S. or B.S.				
Medical University of South Carolina College of Medicine	660	1,281	1.9	651	201	3	23	9**	6	25	0	0	630	* CLINICAL — Refers to working with patients in hospitals or out-patient clinics ** Ophthalmology Residents spend 3 months during their 3-year residency in an intense basic science course taught by nationally prominent Ophthalmologists at Colby College, Waterville, Maine
Duke University College of Medicine	489	1,102	2.3	632	483	8	10	16	2	7	0	0	470	
Medical College of Georgia	720	944	1.3	495	246	3	10	8**	2	10	0	0	449	
DENTAL COLLEGES														
Medical University of South Carolina College of Dentistry	160	312	2.0	74	0	0	0	0	6	25	0	0	123	84 D.D.S. teaching mostly Clinical 9 are D.D.S., Ph.D.
Medical College of Virginia College of Dentistry	439	353	.80	33	0	0	0	0	8	20	0	0	127	126 D.D.S. teaching mostly Clinical 20 are D.D.S., Ph.D.
COLLEGES OF OPTOMETRY														
Southern College of Optometry	504	49	.08	2 PART TIME	0	0	0	0	0	0	37	2	7	The 2 part time M.D.s are classroom lecturers in Pathology.
Illinois College of Optometry	600	56	.09	1 PART TIME	0	0	0	0	0	1	47	1	6	The only M.D. is a part time Lecturer in Pathology.
Pennsylvania College of Optometry	552	89	.16	5 PART TIME	0	0	2	0	0	1	55	4	17	
Southern California College of Optometry	384	83	.22	5 PART TIME	0	0	2	0	0	2	65	5	8	
Pacific University College of Optometry	340	23	.07	1 PART TIME	0	0	0	0	0	0	12	1	8	The only M.D. is a Professor of Physics and Optics, part time.
New England College of Optometry	332	66	.20	4 PART TIME	0	0	2	0	0	1	52	5	4	
University of Houston College of Optometry	284	64	.23	2 PART TIME	0	0	0	0	0	0	47	4	7	The 2 part time M.D.s are Classroom Lecturers in Pathology.
Indiana University College of Optometry	276	38	.14	0	0	0	0	0	0	0	21	4	11	No M.D.s on Staff.
Ohio State College of Optometry	228	63	.28	1 PART TIME	0	0	1	0	0	0	46	4	12	The only M.D. is part time. He lives 100 miles away in Cincinnati.
University of Alabama College of Optometry	140	48	.30	3 PART TIME	0	0	0	0	1	0	22	9	12	All M.D.s are part time classroom lecturers. One M.D./Ph.D. lectures in Pharmacology.
State University of New York College of Optometry	160	122	.76	9 PART TIME	0	0	6	0	0	0	87	3	22	
University of California Berkeley College of Optometry	256	77	.30	9 PART TIME	0	0	6	0	0	0	43	11	12	One part time M.D. teaches in Public Health, one in Engineering and one in Physiological Optics
Ferris State College of Optometry	100	31	.31	0	0	0	0	0	0	3	1	0	29	All but 2 of these 29 also teach in the Biology and Chemistry departments of the Undergraduate College.

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

Study Compiled for PEN Inc. by the EDUCATIONAL CATALOG STUDY COMMITTEE OF THE SOUTH CAROLINA OPHTHALMOLOGICAL SOCIETY
DECEMBER, 1977.

**PLEASE NOTE: THE PRECEDING PAGES WERE TREATED
AS A UNIT IN THE ORIGINAL DOCUMENT.**

STATE OF ALASKA
FISCAL NOTE

Revision Date 4/12, 1983

I. REQUEST

Bill/Resolution No.: SB 189
Title: "Optometrist - Use of Drugs"
Sponsor: Josephson
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 Phone: 465-2535
Division: Occupational Licensing Date: 4/12/83
Approved by Commissioner: Richard A. Lyon Date: 4/13/83
Department: Commerce & Economic Development

Distribution:

Original to Legislative Finance
Copy to Office of Management and Budget (for Legislature introduced bills)
Copy to Department (for Governor introduced bills)
Copy to Sponsor
Copy to Requestor (if different from Sponsor)

3/8/83

SB 139 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 \$31,502.00

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

(c) An endorsement under (b) of this section shall expire with the license to which it attaches and may be renewed upon evidence of satisfactory completion of a continuing education program specified and approved by the board for holders of this type of endorsement under (a) of this section.

(d) The board shall adopt regulations concerning the use or prescription of legend drugs and may revoke or suspend a license endorsement for their use and prescription for violation of the regulations.

(e) The board shall furnish to the board of pharmacy the names of all holders of endorsements issued under this section.

* Sec. 3. 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, of inflammations, infections, and injuries of the ^{anterior segment 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. 4. 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

* Sec. 5. 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.~~

* Sec. 6. AS 08.64.360 is amended to read:

Sec. 08.64.360. PENALTY FOR PRACTICING WITHOUT A LICENSE OR IN VIOLATION OF CHAPTER. Except for a physician assistant, an optometrist, 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.

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED
AS A UNIT IN THE ORIGINAL DOCUMENT

OPTOMETRISTS
AND EXPLANATIONS

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

May 1, 1983

The Hon. Joe Josephson
Chairman, Health, Education and
Social Services Committee
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Sen. Josephson:

re: SB 189

The attached list of drugs comprising an addition to the proposed committee substitute for SB 189 previously submitted to you needs some explanation:

These drugs will allow us to do an effective job of primary eye care. The most important of these drug groups are (1) the anti-infectives, which combat bacterial infections and will allow us to treat "pink eye" (conjunctivitis) and prevent infection secondary to contact lens overwear abrasions; (2) the anti-inflammatories (steroid eye drops) that reduce inflammation and promote more orderly healing in non-infective inflammations such as severe allergic reactions from exogenous sources; and (3) the anti-glaucomals, which we would use primarily in the emergency treatment of acute glaucoma (elevated fluid pressure within the eye), which cannot wait for referral to an ophthalmologist. For phenylephrine, a 2.5% strength has been specified; it also comes in a 10% concentration. While the latter gives better pupil dilation, it is contraindicated in persons with heart disease.

Here are some other salient background items: mydriatics/cycloplegics dilate the pupil (mydriasis), block the near focus of the eye (cycloplegia), or both. Mydriasis permits better examination of the peripheral retina, particularly when the pupil is small or there is a developing central cataract. Cycloplegia sometimes aids in refractive testing of farsighted individuals. Topical anesthetics allow the most accurate measurement of the fluid pressure within the eye (tonometry). They also enable an injured eye to be examined, and permit removal of superficially embedded foreign bodies.

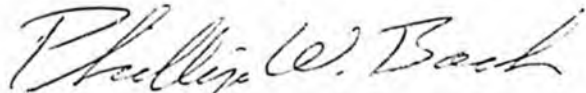
This drug list is based on the attached formulary prepared by Dr. Louis J. Catania, a faculty member of the Pennsylvania College of Optometry and an instructor in the postgraduate therapeutics course most Alaskan ODs took from that institution last year.

A drawback of listing drugs in statute is that new legislation is required every time a new drug comes out. A better law, in my opinion, is the West Virginia statute, on which West Virginia's

Sen. Josephson
May 1, 1983
p. 2

excellent track record is based. A copy of the West Virginia statute is attached. It limits drugs to those which are topically applied (drops or ointments, as opposed to oral or injectible drugs), but allows the board of examiners in optometry to approve or disallow specific drugs within that category.

Very truly yours,



Phillip W. Bach, O.D., Ph.D.
Legislative Committee
Alaska Optometric Association

* 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) Fluomethalone
- (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 (CSSB 161) is enacted.

Prepared by - Louis J. Catania, O.D.

CATEGORY	GENERIC NAME	BRAND NAME	CONCENTRATION(S)
Anesthetics	Bencxinate	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%
	Tetracycline	Achromycin	1%
	Erythromycin	Ilotycin	5 mg/3.5g
	Zinc sulfate	Zincfrin	0.25%
-(Combinations)	Sulfacetamide/Prednisolone	Blephamide	10%/0.2%
	Polymyxin B/Bacitracin	Polysporin	10000/500 units
- Antivirals	IDU	Stoxil	0.5%
	Vidarabine	Vira A	3%
	Trifluridine	Viroptic	1%
- Antifungals	Natamycin	Natacyn	5%
Artificial Tears	Mucomimetics Ointments	Hypotears 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 Fluorescein	Barnes Hind Sterile Strips	0.6 mg.
	Rose Bengal	" " "	1%
Hyperosmotics	Sodium Chloride " " Oint.	Adsorbonac Muro #128	2, 5% 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%

imposed 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.

18.54.130 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-B-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-B-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 an 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, orthotics, 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-B-3. BOARD OF OPTOMETRY, DUTIES.

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

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

30-B-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 certificate 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-B-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 pre-medical 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-B-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 CERTIFICATE; 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 juris-

diction 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 mercantile 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-

By O. PROMETRIS

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)

Summary of changes in the substitute bill

HOUSE BILL NO. 225

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 prescription drugs by optometrists."

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

* Section 1. AS 08.64.170(a) is amended by adding a new paragraph to read:

(4) a person licensed under AS 08.72 may use and prescribe legend drugs, as defined in AS 08.72.300, if the person's license is endorsed by the board of examiners in optometry as provided in AS 08.72.

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

Sec. 08.72.277. USE OR PRESCRIPTION OF LEGEND DRUGS. (a) To be eligible to use or prescribe legend drugs, a licensee shall submit proof acceptable to the board that he has completed not less than 100 transcript grade hours of education, training and clinical experience in ocular therapeutics, and passed a written and practical examination in the subject matter. The course or courses shall include the following subjects:

- (1) General and ocular pharmacology
- (2) Review of ocular pathology and differential diagnosis
- (3) Treatment protocols and procedures

This training shall be given by an institution of learning accredited by the Council on Post-Secondary Accreditation or the United States Department of Education, or by a hospital, clinic or other health care facility formally affiliated with such an institution.

(c) An endorsement under (b) of this section shall expire with the license to which it attaches and may be renewed upon evidence of satisfactory completion of a continuing education program specified and approved by the board for holders of this type of endorsement under (a) of this section.

(d) The board shall adopt regulations concerning the use or prescription of legend drugs and may revoke or suspend a license endorsement for their use and prescription for violation of the regulations.

(e) The board shall furnish to the board of pharmacy the names of all holders of endorsements issued under this section.

* Sec. 3. 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, of inflammations, infections, and injuries of the ^{anterior segment 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. 4. 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

* Sec. 5. 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.~~

* Sec. 6. AS 08.64.360 is amended to read:

Sec. 08.64.360. PENALTY FOR PRACTICING WITHOUT A LICENSE OR IN VIOLATION OF CHAPTER. Except for a physician assistant, an optometrist, 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.

**PLEASE NOTE: THE PRECEDING PAGES WERE TREATED
AS A UNIT IN THE ORIGINAL DOCUMENT.**

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)

1 IN THE HOUSE

BY HURLBERT

2 HOUSE BILL NO. 225

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 THIRTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to the practice of optometry and
7 authorizing the use of prescription drugs by optome-
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Sec. 08.72.277. USE OR PRESCRIPTION OF LEGEND DRUGS. (a) To be eligible to
use or prescribe legend drugs, a licensee shall submit proof acceptable to the
board that he has completed not less than 100 transcript grade hours of education,
training and clinical experience in ocular therapeutics, and passed a written and
practical examination in the subject matter. The course or courses shall include
the following subjects:

- (1) General and ocular pharmacology
- (2) Review of ocular pathology and differential diagnosis
- (3) Treatment protocols and procedures

This training shall be given by an institution of learning accredited by the
Council on Post-Secondary Accreditation or the United States Department of
Education, or by a hospital, clinic or other health care facility formally
affiliated with such an institution.

1 (c) An endorsement under (b) of this section shall expire with
2 the license to which it attaches and may be renewed upon evidence of
3 satisfactory completion of a continuing education program specified
4 and approved by the board for holders of this type of endorsement
5 under (a) of this section.

6 (d) The board shall adopt regulations concerning the use or
7 prescription of legend drugs and may revoke or suspend a license
8 endorsement for their use and prescription for violation of the regu-
9 lations.

10 (e) The board shall furnish to the board of pharmacy the names
11 of all holders of endorsements issued under this section.

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13 (2) "optometry" is the examination [, OTHER THAN BY THE USE
14 OF DRUGS,] of the human eyes and the visual system for the purpose of
15 ascertaining a departure from the normal, ascertaining the status of
16 the human visual system, including refractive and functional abili-
17 ties, or ascertaining the presence of ocular disease and any other
18 departure from the normal which requires referral to other health care
19 practitioners; or the diagnosis of an optical deficiency or deformity,
20 visual or muscular anomaly of the human eye; or the diagnosis and
21 treatment, including the use of drugs, of inflammations, infections.
22 and injuries of the ^{anterior segment of the} eyes and eyelids; [,] or the prescription or
23 application of lenses, prisms or ocular exercises for the correction
24 or relief of the human eye;

25 * Sec. 4. AS 08.72.300(3) is amended to read:

26 (3) "practicing optometry" is an examination [, OTHER THAN
27 BY THE USE OF DRUGS,] of the human eyes and visual system for the
28 purpose of ascertaining a departure from the normal, ascertaining the
29 status of the human visual system, including refractive and functional

1 abilities, or ascertaining the presence of ocular disease and any
2 other departure from the normal which requires referral to other
3 health care practitioners; or the diagnosis of an optical deficiency
4 or deformity, visual or muscular anomaly of the human eye; or the
5 diagnosis and treatment, including the use of drugs, of inflammations,
6 infections and injuries of the ^{anterior segment of the} eyes and eyelids; [,] or the prescrip-
7 tion or application of lenses, prisms or ocular exercises for the
8 correction or relief of the human eye; [,] or the holding of oneself
9 out as being able to do so;

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

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

(8) "anterior segment" means that portion of the eye extending from the anterior surface of the cornea to the posterior end of the ciliary processes.

18 ~~any person practicing and holding an appropriate license is guilty of~~
19 a misdemeanor and upon conviction is punishable by a fine of not less
20 than \$50 nor more than \$100, or by imprisonment for not less than 10
21 days nor more than 90 days, or by both. Evidence that the defendant
22 has failed to file a license with the clerk of the court is prima
23 facie evidence that the defendant is not licensed. Each day of
24 illegal practice is a separate offense.

Board of
Optometrists

Adds one board member who is a physician licensed in the state (Sec.1-2)

no change

Defines the public member as having no interest in the practice of optometry or medicine. (Sec. 2)

Regulations

Gives the Board power to adopt regulations for the use of diagnostic drugs. (Sec. 3)

Gives the Board power to adopt regulations for the use of prescription drugs. (Sec.2 (d))

Powers and
Duties

In conjunction with the State Medical Board, shall develop a list of specific diagnostic drugs and dosages to be used. (Sec.4(c)(3))

The Board shall furnish the Board of Pharmacy the names of licensed holders of endorsements (Sec.2(e)).

Continuing
Education

The Board shall provide for C.E. for optometrists desiring to use drugs.

Drug use endorsement may be renewed upon evidence of completion of Continuing Education program specified and approved by Board. (Sec.2 (c))

Use of Drugs

A licensee must submit to the Board evidence of satisfactory completion of Educational requirements. (Sec. 8 (1))

Provides that the Board will develop and administer a test to licensees desiring to use diagnostic drugs. (Sec. 8)

A licensee must submit for the Board proof of a minimum of 100 transcript hours of Education, training, and clinical experience and passed a written examination. Training must be from an institution accredited by the Council in Postsecondary Accreditation or the US Department of Education or by an affiliated Institution. (Sec.2(a))

NOTE: Sec. 2 refers to endorsements issued under (b) but this subsection is missing from draft.

Definitions	Includes use of diagnostic drugs in the definitions of "optometry" and "practicing optometry". defines "diagnostic drug".	"legend drugs" drugs whose labels prohibit dispensation without a prescription. Deletes in "optometry" and "practicing optometry" <u>other than by the use of drugs</u> , and limits diagnosis and treatment to the anterior segment of the eyes and the eyelid. "anterior segment" is the portion extending from the anterior surface of the cornea to the posterior end of the ciliary process.
Grounds for Imposition of Disciplinary Sanctions	Use of "Dr." or "Doctor" with name without the word "optometry" (Sec. 7) Failure to fulfill educational requirements is cause for <u>revocation of license validation</u> (Sec. 8 (d))	Board may revoke or suspend a license endorsement for violations of regulations. (Sec. 2 (d))
Registration	Unlawful to practice optometry in the State beyond the scope of the license issued. (Sec. 5)	
Other	Requires referral to medical specialist on discovery of a pathological condition. (Sec. 6)	Establishes a classification list of legend drugs that optometrist may employ or prescribe (<u>new</u> Sec. 6)

May 16, 1953

Joe, Pappy, Vic

Letter to Hallford
and P. Fischer
talk w/ Milo
re: Optometry

HB 270

Joe reviewed questions
discussed motion picture academy

SB 189

Dr. Rabau - Dir. Public Health, H²SS
problems are minimal w/ CS

* recommends

pg 1, line 12 - keep Board at 5 members
to eliminate deadlock
reduce optometrists to 3 members
1 public member, 1 physician
should not have an even number

likes line 37, pg 1 - medical board approval.
would force the boards to negotiate

pg 2, line 3-4 - examination - good.

* definition - except diagnostic drugs
administered in accordance
with AS

Harry Trueger, Dir. Organizational Licen
- minor fiscal impact
- term diagnostic should be supra

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

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

Key

E = In Emergency Use Only

x = Excludes Oral or Injectable Drugs

Source: American Optometric Association (1980)

April 13, 1983

SB 189

optometry

Joe, Vic, Rick, Pappy

Milo Fritz - House District 5

has practiced ophthalmology since 1936 until 1974. Practiced out of Anch into rural areas.

no obj. to practicing medicine if licensed.

self-generated criteria.

"legend" drug - ^(no sickening!) legend a noun and not an adjective.

definition of optometry is treatment of the eye without the use of drugs. So purpose of legislation to do good for the public or the optometrists? No public demand.

"diagnosis and treatment" are in the purview of the practice of medicine and not optometry.

many people w/ inflammation of the eyelid have trichoniasis - and could not be identified w/o medical training. Many diseases & conditions are first exhibited through the eyes - medical background is necessary.

optometry as practiced is find and fulfill a need.

Joe do you oppose diagnostic drugs?

Yes, some diagnostic drugs cause very severe reactions in some people with various conditions. Training has improved but they still should not practice medicine beyond their competency.

Steve Dobson - John Demoske - AK. Optometry Assoc.
support of bill.
Demoske YK

James H. Patterson - Ophthalmologist

opposed to SB 189 - Ed. and background does not qualify to practice medicine. lack medical and clinical training. Tests available for use w/o drugs are sufficient

to provide services.

Dr. Harrison

Joe What can an M.D. do to treat the eye?

Can use any drugs certified to use by narcotics administration.

Dr. Sam McKee - F.B.S. - ophthalmologist

10 yr. in a row that optometrists have attempted to pass such a bill.

No optometrist in Bd. has had any clinical training in pharmacology. How can Board w/o training in medicine judge who should use what drugs.

Recent Court case awarded money paid by Fed. govt for Fed. optometrist not referring child w/ problems who later lost an eye.

Joe any studies from states which allow diagnostic drugs.

findings by MD/lawyer that training is insufficient.

Harry Traeger - DL, Director

opposes the bill.

Description of legend drugs too broad. 88 categories of controlled substance in just class I lacks public protection.

Vic testifying on behalf of whom

Dept of Com. & Econ. Develop. - would need to get DEA numbers

line 18 - recommend in consultation with state medical board.
took neutral position on last yrs. bill. (CS)

Joe fiscal impact?

Yes - license manner for DEA info; registration purposes etc. would have to investigate school programs.

Dr. Dave Spence - H&SS

last session worked up compromise leg.
- diagnostic agents
- Collaborative drug off in drug use by Med. Board

Do not support.

- too broad of expansion into practice of medicine,
- adequacy of eye care in state should be addressed. Optometrists offer a lot but expansion ~~into~~ into diagnostic ok. Some topical antibiotics may be okay but full therapeutic use of drugs

Joe any other state laws as models?

Only 3 allow use of therapeutic drugs.
33 allow diagnostic use only.

^{thanks to}
Dr. Harrison - ophthalmologist
15 yr practice Eye disease specialist

Confusion in public in differences between optn/ophthalmologists. Causes delay in treatment. Medication to do state the

(4)

eye - 99% of the examination can be done by physical treatment & history.

John Remake

on Board.

want licensed endorsement to include an examination for ~~imp~~ approval to use drugs

challenge the 99% remark of Dr Harrison. Retinal detachments cannot be seen without dilation.

Vic were you not satisfied with Senate Hess compromise language of last year.

Didn't see it.

MEMORANDUM

TO: JOE
FROM: NANCY
RE: TODAY'S MEETING

SB 189 - OPTOMETRY

THERE ARE TWO DRAFTS IN YOUR FILE, ONE FROM THE OPTOMETRISTS AND ONE THAT I DID FOR THE COMMITTEE WITH A CHART COMPARING THE TWO BILLS. IN SHORT:

THE HESS CS PROVIDES FOR USE OF ONLY DIAGNOSTIC DRUGS

THOSE WISHING TO USE DRUGS MUST PASS A BOARD TEST AND MAINTAIN THEIR COMPETENCY THROUGH CONTINUING EDUCATION.

THERE IS A MANDATORY REFERRAL TO MEDICAL SPECIALISTS IF A PATHOLOGICAL CONDITION EXISTS IN THE PATIENT.

ADDS A LICENSED PHYSICIAN TO THE BOARD, AND PROVIDES THAT A LIST OF ALLOWABLE DRUGS WILL BE ESTABLISHED WITH THE GUIDANCE OF THE STATE MEDICAL BOARD.

PROVIDES THAT AN OPTOMETRIST MAY NOT PRACTICE BEYOND THE SCOPE OF HIS/HER LICENSE.

NOTE: HARRY TRAEGER WILL BE HERE FROM OCCUPATIONAL LICENSING TO TESTIFY. THE ADDITION OF THE TEST WILL RAISE THE FISCAL NOTE.

OPTOMETRISTS CS:

PROVIDES FOR THE USE OF PRESCRIPTION DRUGS AND PROVIDES A TWO PAGE LIST OF ALLOWABLE DRUG CLASSIFICATIONS.

LICENSE BY ENDORSEMENT (NO TEST) AND BY EDUCATIONAL REQUIREMENTS.

REQUIRES CONTINUING EDUCATION.

CHANGES MEDICAL BOARD STATUTE TO ALLOW THE PRACTICE OF MEDICINE BY OPTOMETRISTS.

DELETES LANGUAGE IN DEFINITIONS PROHIBITING THE PRACTICE OF MEDICINE BY OPTOMETRISTS.

ALLOWS DRUG USE IN ONLY THE ANTERIOR PART OF THE EYE, AND DEFINES THE TERM.

NOTE: THE DRAFT IS SOMEWHAT DIFFICULT TO READ - THE LIST OF DRUGS IS ON PAGES 3-4 OF THE HANDOUT, THE DEFINITIONS ARE ATTACHED ON THE LAST PAGE.

ALSO SECTION 2 (b) IS NOT IN THE DRAFT, I THINK IT MUST HAVE BEEN INADVERTANT, IT IS THE PART DESCRIBING HOW THEY ARE ENDORSED TO USE DRUGS.

POSITION PAPER

HB 225

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

This bill is an example of the worst kind of special interest legislation. The purpose is not to make things better for the people of Alaska but to allow optometrists to practice medicine.

Up to this time the practice of medicine, which includes the writing of prescriptions and the use of drugs among which of course are eye drops, has been properly restricted by the will of the people, through the Medical Practice Act, to those who have graduated from a class A medical school who have received a M.D. degree and who have passed an examination or been licensed by a reciprocity to practice medicine in the state of Alaska.

By permitting optometrists to use drugs, one is in effect saying that, people who wish to practice medicine including the prescribing of drugs are so dumb that they have to fulfill the above mentioned qualifications to be M.D.'s or optometrists are so smart that they don't need to comply with the regulations of the Medical Practice Act.

Up to the present time optometrists have been able to employ their services for the good of Alaskans all over the state quite satisfactorily without invading the practice of medicine. Therefore, there is no reason at all for them to be using drugs as they wish to without complying with the regulations of the Medical Practice Act.

Optometrists go out into the bush and are able to extend the services for supplying eyeglasses and contact lenses to people in remote areas without the use of drugs. There is no reason why they should be allowed to practice medicine only because they wish to and not because it is going to do any good for the people in the remote areas.

In the Bethel area there are at least two optometrists who do itinerant optometry in the very small villages. When a problem arises, for which drugs might be necessary, the optometrists in question call the M.D. in charge of their activities back at the Bethel Hospital and are then permitted to use certain medications, under the direction of the M.D supervisor who ultimately is responsible for the good or bad result of what is done.

Allowing optometrists, after a crash course in diseases of the eye, to diagnose and treat disease is like allowing a two hundred hour light plane pilot to assume the command of a 747 jet. It also may be like letting a law clerk who has more or less specialized in one aspect of the law to practice law without passing the bar

POSITION PAPER

HB 225

examinations, graduating from law school, or obtaining a Bachelor of Law degree or one more advanced.

This bill attempts to do by legislation what optometrists should be required to do by education and licensure. Such a subversive effort to circumvent the Medical Practice Act should be thwarted by the overwhelming defeat of this piece of pernicious legislation.

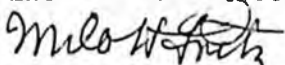
There is no indication that anybody is doing without eyeglasses or contact lenses who requires them under the present system of care either by M.D.'s or by optometrists. Therefore, there is no reason why the sphere of optometrists should be increased by allowing them to practice medicine.

An examination of the bill allows the ignorance of optometrists regarding the practice of medicine to shine through. On page 5 lines 23 through 28 they speak of being denied the use of "of inflammations" which of course is a meaningless phrase since inflammations are not induced for the cure of any eye disease, although, this was once the case 40 years ago under certain circumstances.

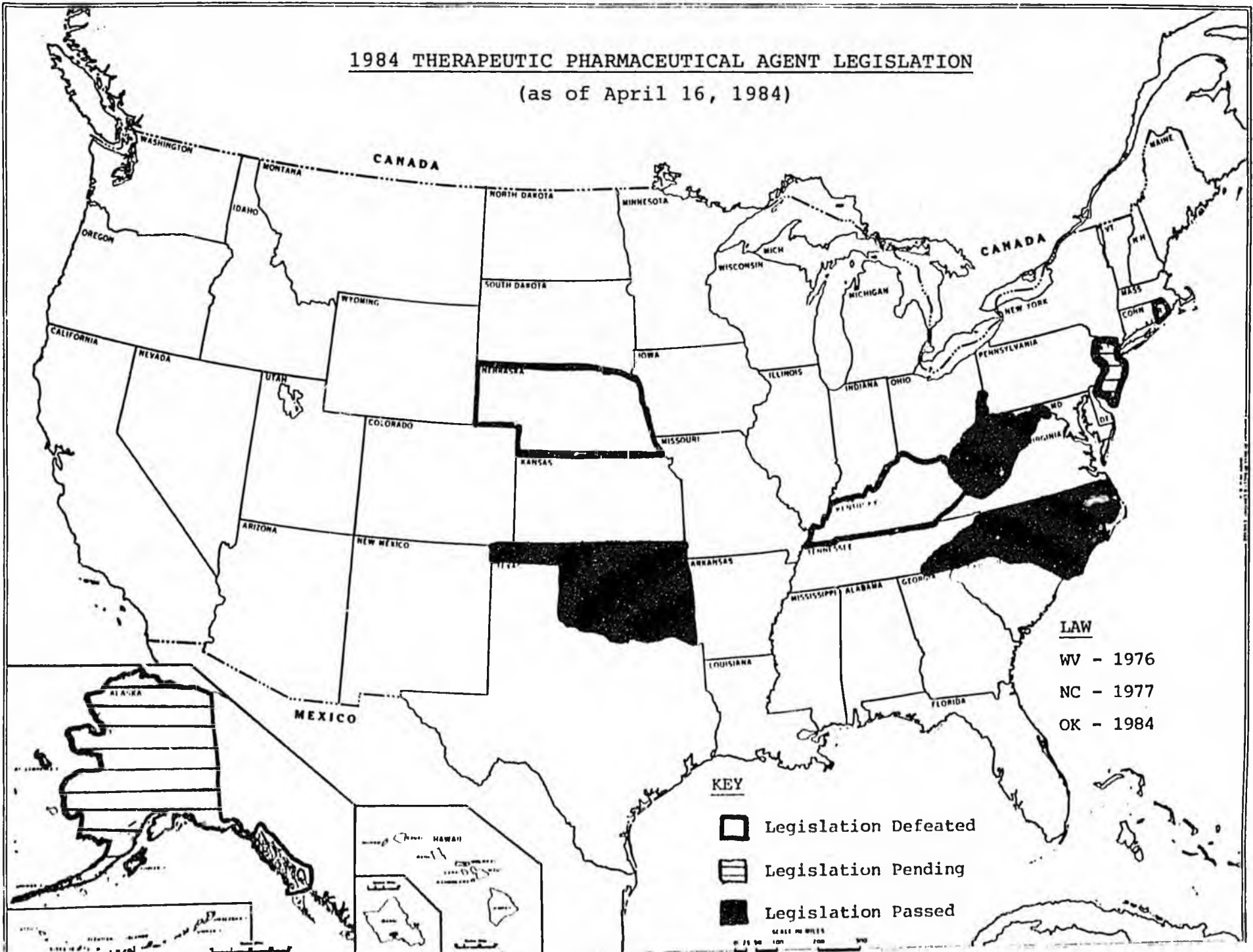
In the list of drugs on page 4 lines 1 through 10, line 3 speaks of "anti-infectives", this of course is a meaningless hyphenated word and apparently refers to a drug that would combat infections. If these people not having been to medical school are not in a position to diagnose and treat disease it seems quite obvious that they are in no position to pick out proper drugs for infections, whatever their cause. Without understanding or being skilled in the use of bacterial sensitivity tests and other means of determining what an infectious agent might be it renders any use of anti-inflammatory drugs by optometrists completely meaningless and potentially dangerous.

The use of cycloplegics on line 7 and corticosteroids on line 6 demonstrates a complete ignorance of the dangers that these drugs represent, as do certain mydriatics line 10.

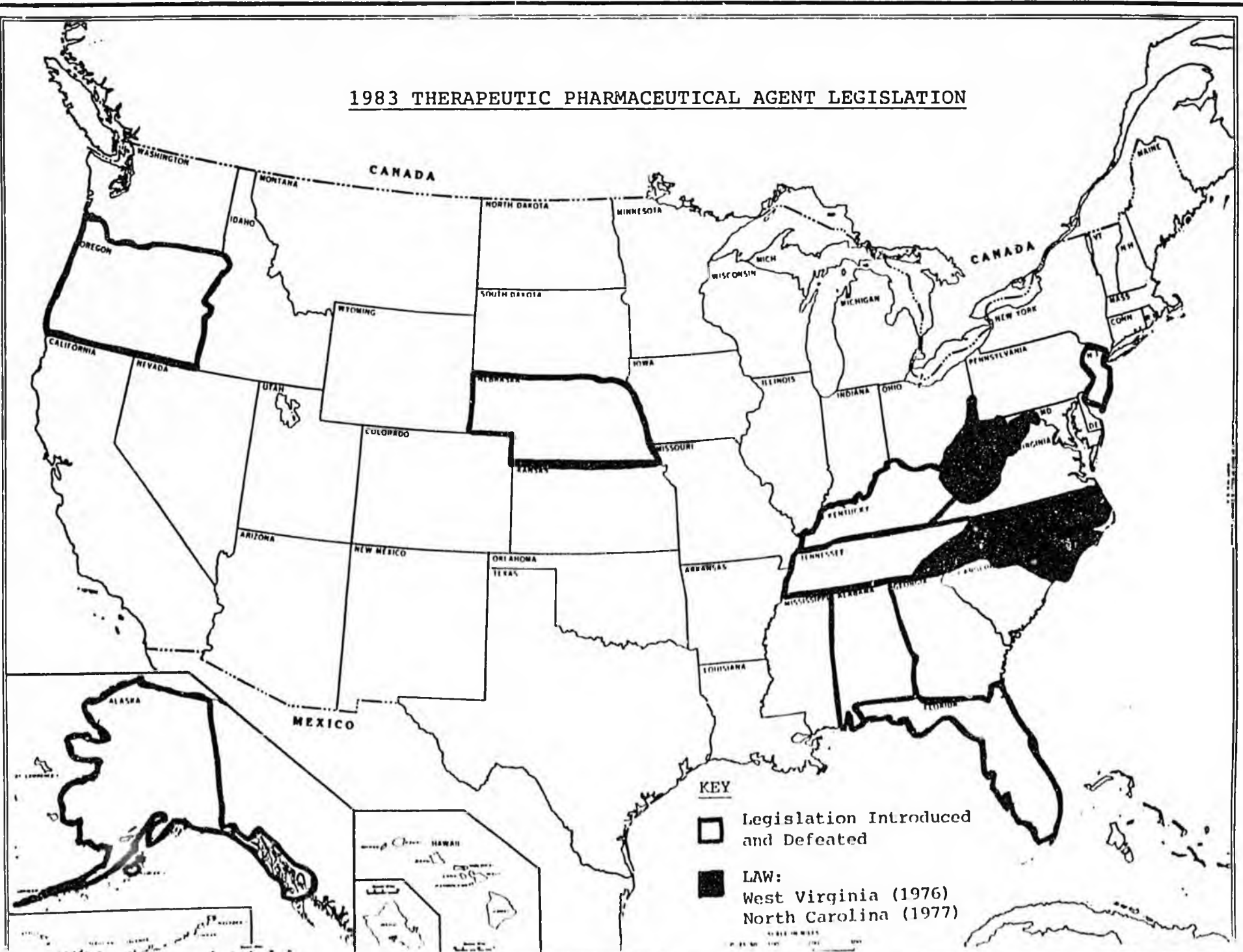
It is my feeling that this bill is completely against the public interest and should be roundly defeated.


Milo H. Fritz, O.D.

1984 THERAPEUTIC PHARMACEUTICAL AGENT LEGISLATION
(as of April 16, 1984)



1983 THERAPEUTIC PHARMACEUTICAL AGENT LEGISLATION



KEY

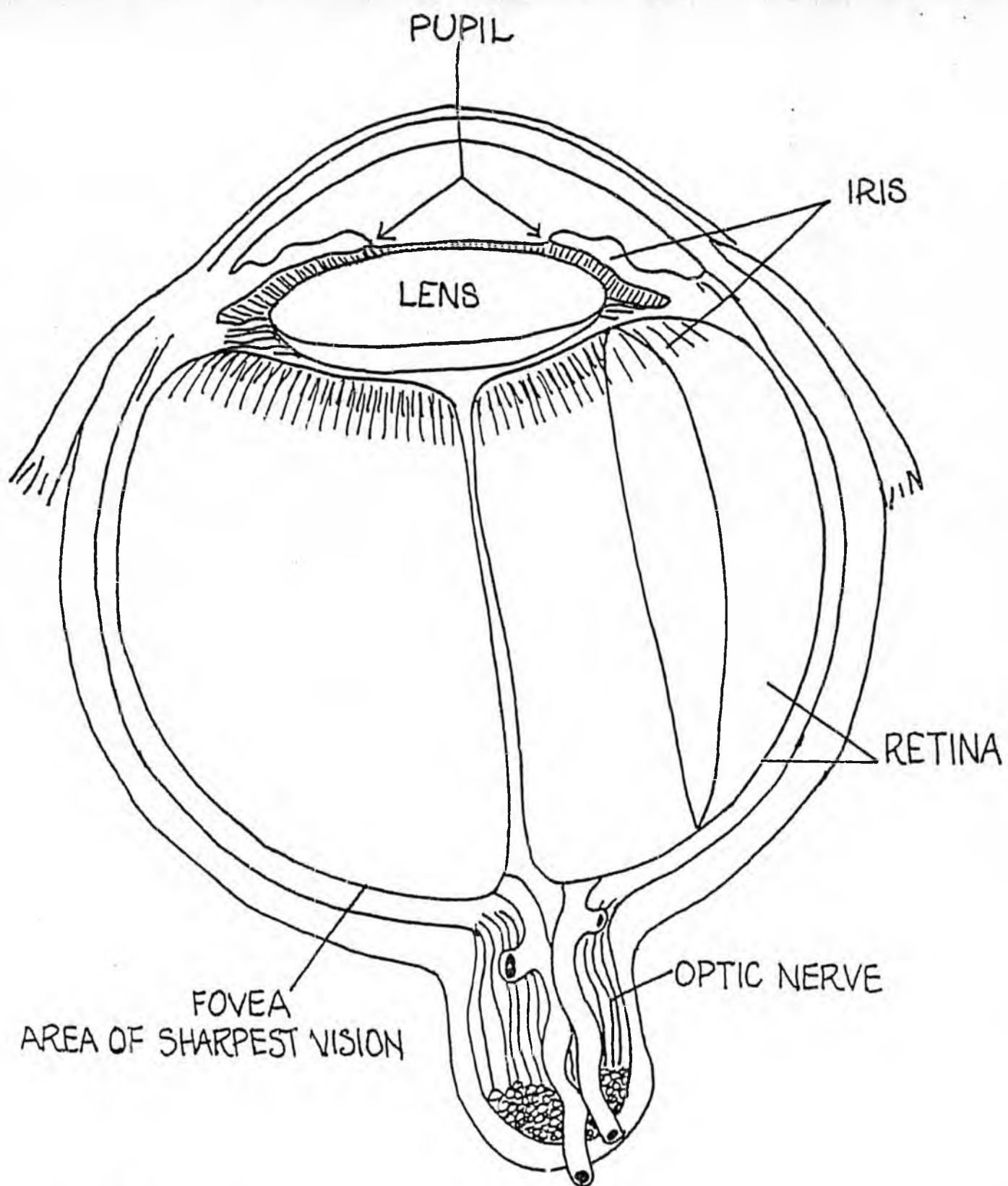
- Legislation Introduced and Defeated
- LAW:
West Virginia (1976)
North Carolina (1977)

INVESTIGATIONS - OPTOMETRY

<u>Fiscal Year</u>	<u>Allegation</u>	<u>Filed By</u>	<u>Location</u>	<u>Disposition</u>
1981	Fee Dispute	Citizen	Ketchikan	No Violation No Jurisdiction Referred to Legal Counsel
1982	Expired License Cease & Desist	Investigative Section	Anchorage	Compliance Renewed License Removed from Board
1982	No Branch Office License	Investigative Section	Homer/ Anchorage	Compliance Licensed
1982	Unauthorized Dispensing of Drugs	Citizen	Bethel	Reprimand Compliance
1984	Window Display of Glasses Violation of 12 AAC 48.070(2) Unprofessional Conduct	Optometrist	Anchorage	Normal Window w/ View of Office Interior-Declined to Prosecute Regulation Violates Anti-Trust Laws
1984	Withholding Patient Records	Citizen	Anchorage	No Violation Patient Advised of Rights Under AS 18.23.065

BOARD OF EXAMINERS IN OPTOMETRY
EXAMINATION STATISTICS

EXAMINATION DATE	NUMBER OF APPLICANTS	PASSED	FAILED
<u>JUNE 11, 1979</u>			
Patient Exam	4	3	1
Pathology	4	3	1
Ophthalmic Optics	4	2	2
Oral Exam	4	4	0
<u>JUNE 1980</u>			
Patient Exam	9	9	0
Pathology	9	6	3
Ophthalmic Optics	9	6	3
Oral Examination	8	8	0
<u>JUNE 1981</u>			
Patient Exam	6	6	0
Pathology	7	5	2
Ophthalmic Optics	6	6	0
Oral Examination	6	6	0
<u>JUNE 1982</u>			
Patient Exam	3	3	0
Pathology	3	2	1
Ophthalmic Optics	3	3	0
Oral Examination	3	3	0
<u>DECEMBER 1982</u>			
Patient Exam	4	4	0
Pathology	4	3	1
Ophthalmic Optics	4	4	0
Oral Examination	4	4	0
<u>JUNE 1983</u>			
Patient Exam	6	5	1
Pathology	7	3	4
Ophthalmic Optics	6	6	0
Oral Examination	6	6	0
<u>JANUARY 6, 1984</u>			
Patient Exam	4	4	0
Pathology	6	5	1
Ophthalmic Optics	4	4	0
Oral Examination	4	4	0



THE HUMAN EYE

(Drawing compliments of
(Nancy Deitrick - 2/26/81
(Senate HESS Committee

DEFINITIONS

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

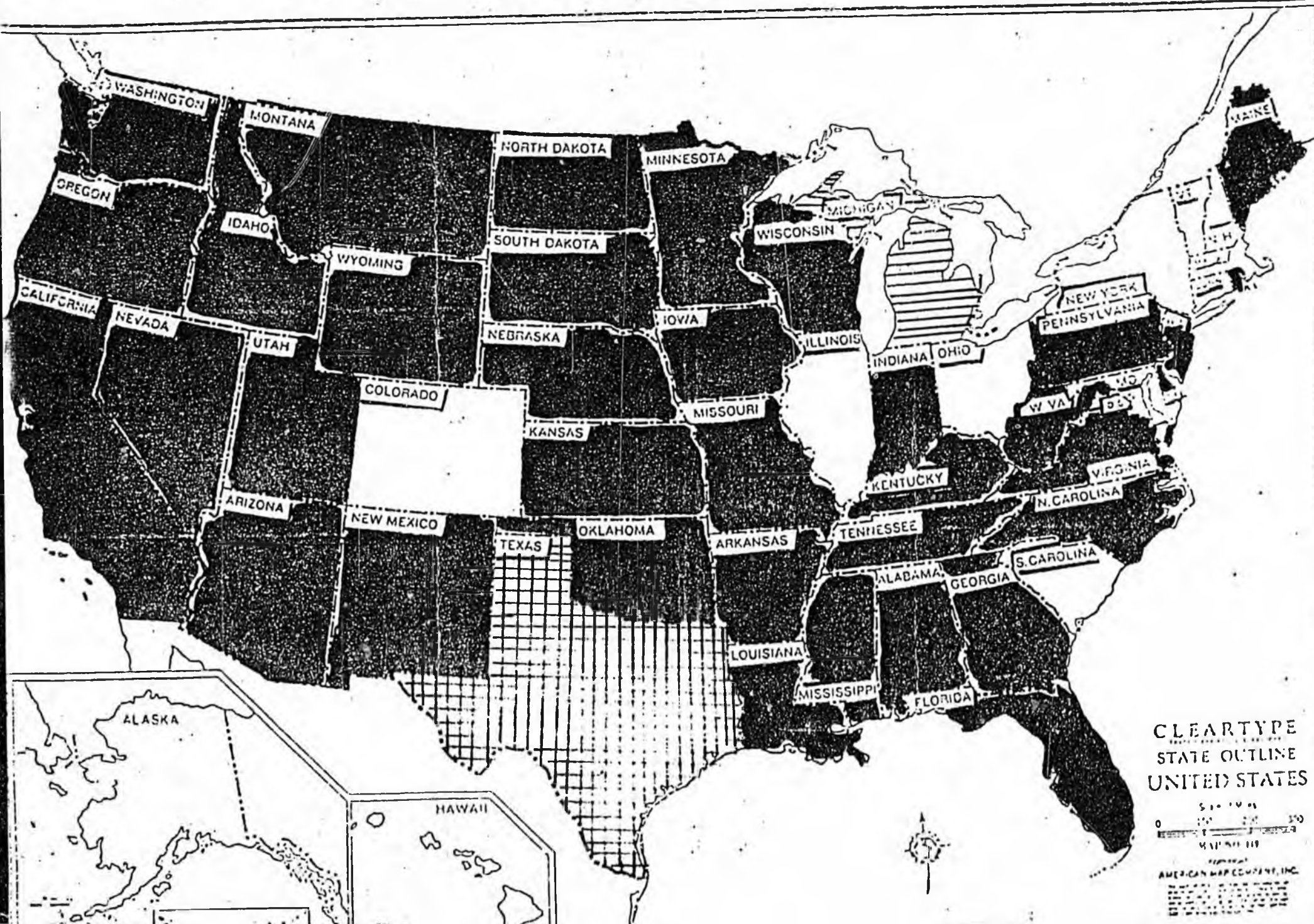
Corneal anesthetics - these temporarily remove corneal sensitivity to allow special viewing instruments to be placed in contact with the cornea.

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

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

UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

February 25, 1983



CLEARTYPE
STATE OUTLINE
UNITED STATES

Scale: 0 100 200 300
MAP NO. 111
AMERICAN MAP COMPANY, INC.

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:

<u>STATE</u>	<u>DATE OF ENACTMENT</u>
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.

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.

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

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

Key

E = In Emergency Use Only

x = Excludes Oral or Injectable Drugs

Source: American Optometric Association (1980)

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

Doctors of Optometry
Drawer 4370
Kenai, Alaska 99611

Telephone (907) 283-7575

RECEIVED

MAR 21 1983

Josephson

March 16, 1983



Joe Josephson
Pouch V
Juneau, Alaska 99811

Dear Mr. Josephson;

I am writing you to voice my endorsement of the Optometric Drug Bill and to enumerate some facts concerning Optometric and Ophthalmology as it is practiced in Alaska.

Optometrists give the state much larger coverage than does Ophthalmology. The Kenai has two Optometrists and two Ophthalmologists. As you well know, 50% of the Kenai's Ophthalmologists now practice in Juneau. The other Ophthalmologist practices 3 day per week in Soldotna, one day per week in Anchorage and one day per month in Seward.

My partner and I both practice 4 days per week in Kenai. My partner travels 1 day every two weeks to Homer and I travel 1 day every 3 weeks to Seward and 1 day per month to Seldovia. The larger bulk of the Vision Care given on the Kenai Peninsula is delivered by Optometry, this holds true for the entire state.

Optometric credentials far outweigh those of the General Practitioner concerning eye care! Every graduate of an Optometric School has an undergraduate degree, BS or BA plus 4 years studying the eye adnexa, its care and conservation!

Ophthalmologists contrary to their ballyhood claims, are in reality not as well trained in many aspects of eye care as are Optometrists.

Optometrists are as well trained as Dentists and Podiatrists and should be allowed to utilize their training!

If medicine had a jurisprudence specialty you as well as all other non-medical members, of the legislature would be considered and presented by organized medicine as lacking.

Some Alaskan Optometrists are presently using every drug considered in this bill daily. This occurs in the military as well as the public sector. Many of the drugs which would be covered by this bill are available without prescription to the general public.

To paraphrase Milo Fritz, M.D., who has been a vocal opponent of this bill in the past, "If you want to use drugs, go to Medical School." To me this translates, "Don't compete against medicine."

In summing up I would like to make these points:

- 1) Where needed, drugs help you give a much better examination.
- 2) Many of these drugs are presently available without prescription to the general public.
- 3) Optometrists are qualified to use the drugs which would be covered by the Optometric Drug Bill.
- 4) When enacted the Optometric Drug Bill will save Alaskans a lot of money.
- 5) The jury is already in! The enclosed map shows where Optometrists are allowed to use durgs. Many of these states have allowed Optometric drug use for years with positive results.

I would appreciate your support of this bill. If I can be of any further help please feel free to contact ne.

Sincerely;



Robert D. O'Connell, O.D.

DR. M.C. FALCONER
DR. J.C. FALCONER
DR. T.F. HARBOUR
DR. W.D. FAULKNER
DR. D.L. THANEPOHN
OPTOMETRISTS

ANCHORAGE EYE AND CONTACT LENS CENTER

1345 W. NINTH AVE. PHONE: (907) 272-2557

ANCHORAGE, ALASKA 99501

Mar 7

March 7, 1983

Honorable Joe Josephson
Pouch V
Juneau, Alaska 99811

RECEIVED

MAR 10 1983

Dear Joe,

Josephson,

We talked earlier this year about Optometry and the use of drugs. Please support House Bill 225 ; when it reaches the senate.

Optometry is trained and can regulate itself with respect to drug usage. The M.D.'s should regulate M.D.'s and Optometry should regulate Optometry. I feel frustrated not being able to use the full extent of my training.

Incidentally, I am licensed in Washington and Oregon where I can use drugs in my practice.

Respectfully,

Jim Falconer
Jim Falconer, O.D.

3/31/83
Rogn F. Spach
1201 Denali St, #311
Anchorage, AK 99501

Sen. Joe Josephson
Senate Health Comm.
Pouch V
Juneau, 1911 77011

Senator Joe Josephson

I strongly urge you to support
house Bill 225 Allowing use of Drugs
by OPTOMETRISTS. This will help
lower cost to Senior Citizens for Eye Care.

I am a 60 year resident & my wife
is a 30 year resident of Alaska. We would
appreciate your support.

Thank you.
Rogn F. Spach
Louise N. Spach

John W. Page II O.D.
4050 Lake Otis Suite 103
Anchorage, Alaska 99504

April 8, 1983

RECEIVED

APR 13 1983

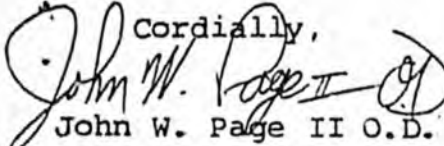
Josephson,

Senator Joe Josephson
Chairman Senate HESS Committee
Pouch V
Juneau, Alaska 99801

Dear Chairman,

I strongly urge you to support House bill 225, which would allow Doctors of Optometry to use Ophthalmic drugs in their Professional practice.

Thank you for your thoughtful consideration.

Cordially,

John W. Page II O.D.

JWP/cp

c/c Dr. Phillip W. Bach

RECEIVED

APR 13 1983

Josephson

4.6.83
WAYNE HOWE
1021 W. 12TH
ANCHORAGE, AK
99501

SENATOR JOSEPHSON;

I URGE YOUR SUPPORT OF THE
OPTOMETRIST'S DRUG BILL. IT WILL BE
REALLY HELPFUL IN AREAS WITHOUT SPECIALISTS,
WHERE THE GENERAL PRACTICE DOCTOR MUST
PROVIDE TREATMENT WITH FAR LESS EYE
TRAINING THAN THE OPTOMETRIST. WE
NEED BETTER AVAILABILITY OF EYE CARE
IN ALASKA.

Thank You
Wayne Howe

SITKA VISION CLINIC
T. B. McLAUGHLIN, O.D., P.C.
BOX 498
SITKA, ALASKA 99835
TELEPHONE 747-6644

April 8, 1983

Senator Joe Josephson
Chairman HESS
Pouch V
Juneau, Alaska

RECEIVED

APR 12 1983

Josephson,

Dear Senator Josephson;

I strongly urge your support for the bill relating to the practice of optometry, authorizing the use of drugs.

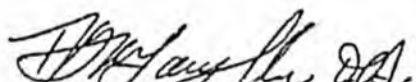
For the past ten years I have been the only resident eye care practitioner in Sitka. Presently an ophthalmologist visits Sitka, for 3-4 days, 2-3 times a year. This makes me the only specialized eye care provider for 11½ months a year, for a population of approximately 8,000 people.

I have always been proud to practice in the state where I was born and have resided for 35 years. Now I am finding myself having to cope with out-dated legislative restrictions which limit the effectiveness of my practice. Although I have received hours of training in the use of pharmaceuticals, which would allow me to be licensed to use them in all but a few states, I am unable to put this to use for the benefit of my patients.

Those Sitkans that do require treatment must travel to Seattle or Juneau, or be treated with little or no diagnostic work-up, by the general practitioner who has little specialized ocular training and none of the specialized instrumentation which I have in my office. This situation results in expensive and often inappropriate care.

Allowing optometrists to fully utilize their extensive training would be of great benefit to all Alaskans. Thank you for your support.

Sincerely,


T.B. McLaughlin, O.D.

TBM/dd

[RECEIVED]

APR 12 1983

SRA Box 1026-B
Anchorage, Alaska 99502
April 7, 1983

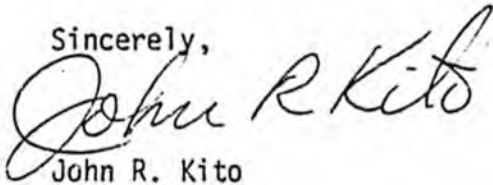
Josephson,

Senator Joe Josephson
Chairman, Senate HESS Committee
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

Please support HB 225/SB 189 allowing use of ophthalmic drugs by optometrists. This legislation is in the best interest of the people of Alaska in saving money and time, especially for "bush" residents.

Sincerely,



John R. Kito

April 8, 1983

Senator Joe Josephson
Chairman HESS
Pouch V
Gineau, AK

Dear Senator Josephson:

I am writing to ask you for
your support on allowing optometrists
to use drugs. I feel this greatly
benefit the residents of Sitka and
all Alaska.

Thanking you in advance
for your help.

Sincerely,
Karen S. Busyka

RECEIVED

APR 13 1983

Josephson

April 8, 83

Dear Senator Josephson,

I strongly urge you to support the optometry drug bill. As a concerned citizen, I feel if this bill is passed, our family optometrist could serve us more efficiently.

Thank-you.

Mr + Mrs Joseph Mack
331 Lionheart Ct.
Anchorage, Ak. 99504

RECEIVED

APR 13 1983

Josephson

RECEIVED

APR 13 1983

Joe Josephson
Senator
Pouch V
Juneau, Alaska 99811

~~Josephson~~

April 7, 1983

Dear Senator Josephson;

I am a Physicians' Assistant practicing in Alaska and am writing to you to voice my support of ~~SB 189~~ *SB 189*.

I have been a Physicians' Assistant for four years and have worked in states that have legislature allowing Optometrists to use pharmaceuticals in the diagnosis and treatment of eye disorders. I frequently refer patients to them and have been pleased with the quality of care and have had positive feedback from those patients.

I have found that the limitations placed on them by not allowing them to use pharmaceuticals in their practice a handicap.

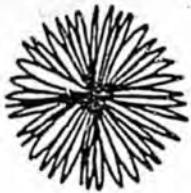
I hope that when this bill comes before you that you will support it.

Thank you very much for your consideration in this matter.

Respectfully,

Barry L. Campbell

Barry L. Campbell PA-C



PROFESSIONAL BUILDING COMPANY, INC.
529 SIXTH AVENUE • 907-452-6334 • FAIRBANKS, ALASKA 99701

April 7, 1983

RECEIVED

APR 13 1983

Senator Joe Josephson
Pouch V
Juneau, Alaska 99811

Josephson,

Dear Senator Josephson;

I would like offer support for passage of SB 189.

For many years our company has rented space to physicians, dentists and optometrists and I am familiar with their educational backgrounds. There is a great deal of it that is the same and in many instances in the same classes at the same colleges or universities.

It seems strange that with the similarities in background and training that dentists can use and prescribe many drugs while optometrists are prohibited from using any at all.

Sincerely,

Patricia L. Rosen
Manager

PLEASE REPLY BY AIRMAIL

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

RECEIVED

April 7, 1983

13 1983

Senator Joe Josephson
Pouch V
Juneau, Alaska 99811

Josephson,

Dear Senator Josephson;

I am writing to urge support and passage of SB 189, a bill related to the use of drugs by optometrists.

Legislation similar to this has been before both houses in past sessions but the medical lobby has been successful in keeping it from the floor.

I am sure you have heard many arguments on both sides of the issue and will not bore you with a re-run, I would just like to point out a couple of things I think are significant.

Legislation similar to SB 189 are now law in 35 other States, some relatively new and many of long years standing so this is nothing new. Several studies have been done and there is not one documented case of eye injury or damage caused by the use of drugs by optometrists, indeed the results have all been positive in the area of more informed and timely referrals.

Another interesting point is that malpractice insurance, which is very expensive for physicians, is relatively inexpensive for optometrists and the insurance companies charge the same premiums whether drug usage is allowed or not. Also our premiums have remained stable for many years.

Thank you for your help in this matter.

Sincerely,


Curtis M. Johnson, O.D.

RECEIVED

APR 13 1983

Josephson,

April 4, 1983

The Honorable Joseph Josephson
Alaska State Senate
Fouch V
Juneau, Alaska 99811

Dear Senator Josephson:

I would like to offer my support for HB 225 and SB 189 which would permit appropriately trained and licensed optometrists to use prescription ophthalmic drugs for diagnosis and treatment of eye problems.

I work closely with two optometrists in Bethel, John Demske, O.D., and James Taylor, O.D., who are authorized under standing orders approved by the medical staff of the Yukon Kuskokwim Delta Regional Hospital* to use certain prescription drugs for the diagnosis and treatment of eye disorders. They also work under the indirect and direct supervision of the Ophthalmology Department at the Alaska Native Medical Center in Anchorage. John Demske has been operating under these standing orders for almost five years without mishap. Both optometrists have made a substantial contribution to the increased quality of eye care in this region. The physician staff respects their knowledge and expertise and regularly consults them regarding eye problems.

The Ophthalmology Department at the Alaska Native Medical Center has recommended that the eye care program operating in this region be considered as a model for other Service Units in the Alaska Area Indian Health Service. This recommendation has been supported by the Service Unit Directors and Clinical Directors of the Alaska Area.

The backbone of the health care system in rural Alaska has been trained paramedical personnel, including Physician Assistants, Nurse Practitioners, Public Health Nurses, Community Health Aides, and in this area, the Optometrists with the YKHC Eye Care Program. They have proved themselves vital in achieving otherwise unobtainably high standards of health care in remote areas. The professional performance of the optometrists in this region has been excellent. They have provided quality eye care services otherwise unavailable to the people of the Delta. They have recognized their limitations and always referred patients when appropriate.

Based on my experience with optometrists using prescription ophthalmic medications for specified diagnostic and therapeutic purposes in this area I am inclined to agree that the major obstacle to a more extensive utilization of the optometrists' special skills and knowledge is a financial one rather than a primary concern for the quality of eye care available to the people of the state.

I strongly endorse SB189 and HB 225. If I can be of any further help, please let me know.

Sincerely,

Bill Searman MD

RECEIVED

APR 13 1983

DANIEL H. FARRAR, D.D.S.

BOX 543

KODIAK, ALASKA 99615

TELEPHONE 486-3257

Josephson,

4-8-83

Senator Joe Josephson
Chairman - Senate Health, Education + Social Services
Pouch V
Juneau, AK 99811

Dear Senator:

I would like to speak in favor of Senate Bill 189 allowing the topical application of various medications by optometrists.

The benefits to the public would be significant both in cost and convenience. By passing this bill you would allow optometrists to extend both their diagnostic and treatment services in areas of practice in which they are highly trained.

Thank you for your consideration.

Sincerely,

Dan Farrar, D.D.S.

KNOX N. CHRISTIE, D.D.S.

RECEIVED

APR 13 1983

April 7, 1983

Josephson,

Senator Joe Josephson
Chairman, Senate Health, Education & Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

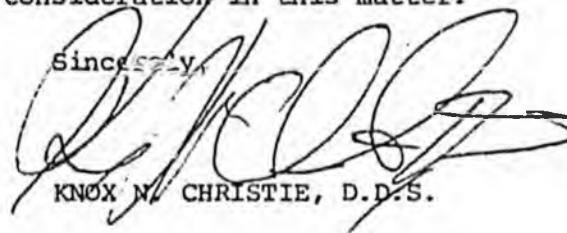
RE: Senate Bill #189, Optometric Therapeutic
Bill:

I am in favor of Senate Bill #189. Some regulation and certification relating to sufficient training in the area of topical therapeutic use should be addressed, and control administered by the state licensing board.

I believe that topical therapeutics use by optometrists would be valuable to their patients. If the competence of the administering optometrist is properly controlled, the bill would benefit the public health and the quality of the care the public receives would be enhanced.

Thank you for your consideration in this matter.

Sincerely,



KNOX N. CHRISTIE, D.D.S.

NORTH PACIFIC MEDICAL CENTER

P. O. BOX 248
KODIAK, AK 99615

TELEPHONE (907) 486-4183

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

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

April 7, 1983

RECEIVED

APR 13 1983

Senator Joe Josephson
Chairman Senate Health, Education
and Social Services

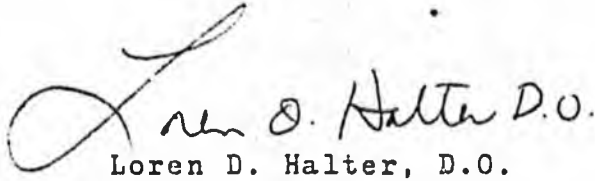
Josephson,

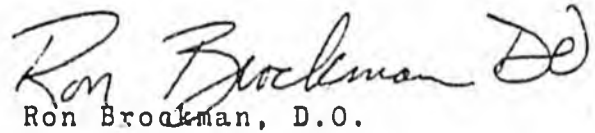
Pouch V
Juneau, Ak 99811

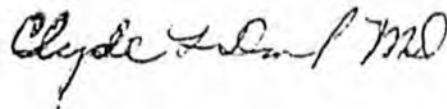
RE: Bill #189

Dear Sir:

We the undersigned support Bill #189, Optometric Therapeutics.


Loren D. Halter, D.O.

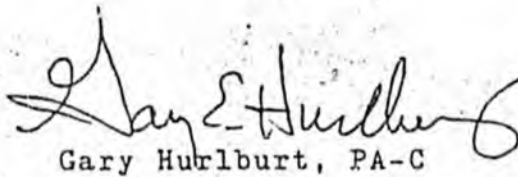

Ron Brockman, D.O.

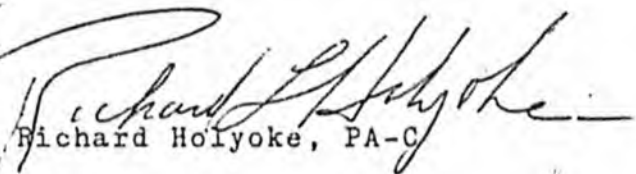


Clyde Deal, M.D



Kevin Creelman, M.D.


Gary Hurlburt, PA-C


Richard Holyoke, PA-C

April 9, 1983

Senator Joe Josephson
Chairman, Health, Education
and Social Services
Alaska State Senate
Pouch V
Juneau, Alaska 99811

RECEIVED

APR 17 1983

Dear Senator Josephson:

I wish to offer my support for Senate Bill 189 and
urge that you do likewise. I know that optometrists
are more than qualified to decide when to treat
and when not to, thusly referring those patients.
It makes no sense to me to give ophthalmologists
exclusive right to treat minor eye infection
and charge high fees when they can already
make more money in one day of surgery than
most working people make in a month.

Please support this bill. Thank you.

Very truly yours

Mrs. Michael Brandenburger
Box 216 Chicago's Loop
Eagle River, Alaska
99577

The
ALASKA OPTOMETRIC ASSOCIATION

AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

IDENT

Dennis A. Swarner, O.D.
Drawer 4370
Kenai, Alaska 99611
April 8, 1983

RECEIVED

APR 13 1983

Joe Josephson
Pouch V
Juneau, Alaska 99811

Josephson

Dear Mr. Josephson;

I am writing to ask your support for Senate Bill #189, an act relating to the practice of Optometry.

This bill would allow Optometrists to dispense drugs, as regulated by the Board of Optometry. This would put Optometrists on the same level as dentists and podiatrists as concerns the use of drugs in Alaska. The education of a Doctor of Optometry is similar to that of a dentist and podiatrist, with a background in the basic sciences and medical training.

Most of the Alaskan Optometrists have recently taken a transcript quality course in ocular therapeutics, and would like to be able to use these skills, that, if not used will deteriorate. It is in the interest of our patients and our profession that we be able to maintain the highest standards of training and practice.

Optometrists are located in more cities and towns than are Ophthalmologists. The passage of this bill that is before your committee would allow an Optometrist to provide care to a patient with an acute problem, saving that patient both time and money necessary to travel to see an Ophthalmologist.

As President of the Alaska Optometric Association, I would like to thank you for considering this bill.

Regards;



Dennis A. Swarner, O.D.

April 8, 1983

Dear Senator Josephson:

I strongly urge you to support the optometry drug bill. I feel that this will better enable my optometrist to serve the needs of my family.

Thank you,

Sara Castle

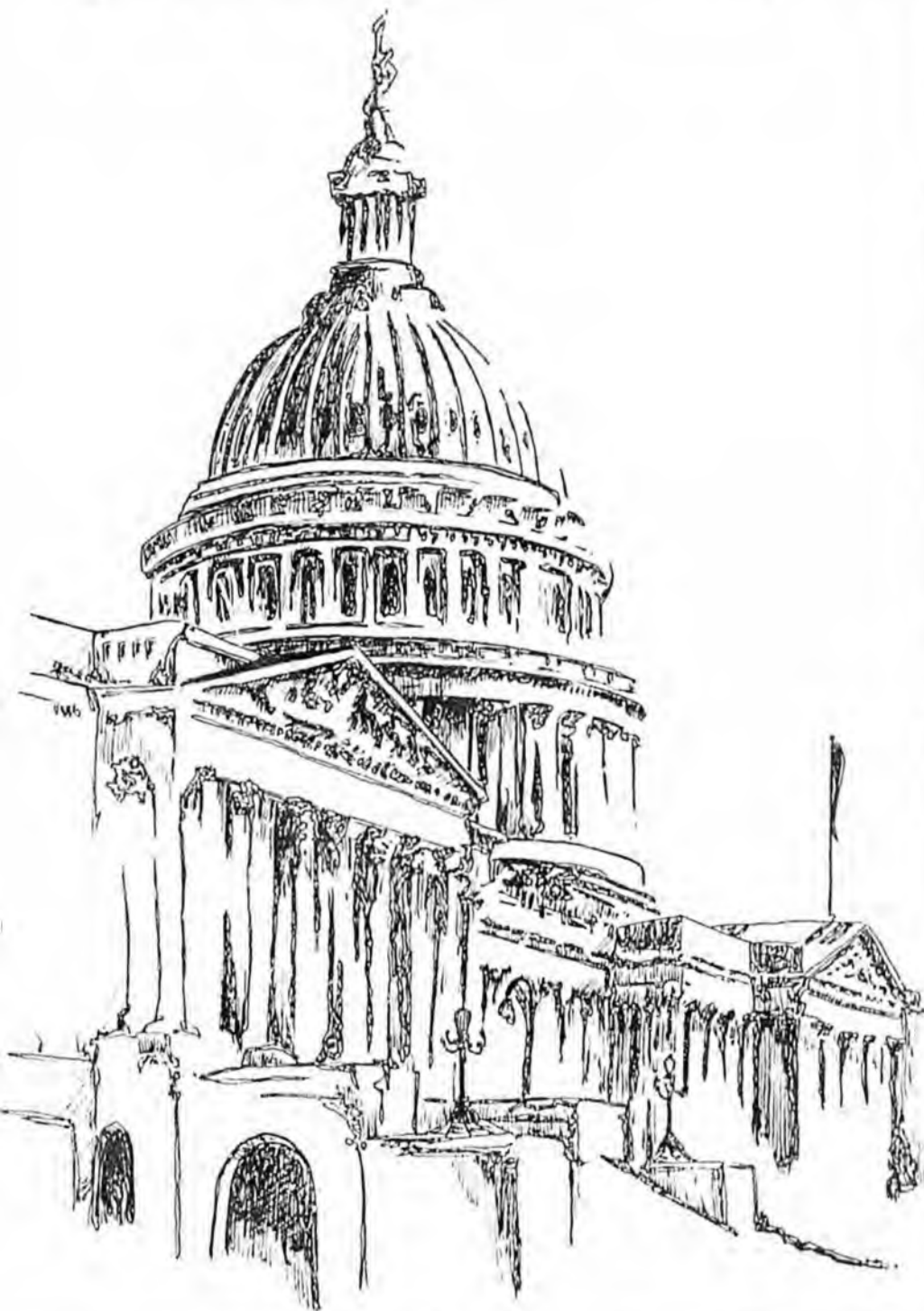
Sara Castle,

RECEIVED

APR 13 1983

Josephson,

OPHTHALMOLOGY'S VOICE IN GOVERNMENT RELATIONS



The person who says
that he is above politics
is really saying that
democracy is beneath him.

Overview

The Governmental Relations Secretariat and the Office of Governmental Relations form the American Academy of Ophthalmology's coordinating link, clearinghouse and action arm for most contacts with the federal government.

Working closely and cooperatively, these offices afford the Academy a unified approach to influence regulatory policy and affect legislation bearing on ophthalmology.

The Governmental Relations Secretariat is composed of Academy-member M.D.'s across the country: a Secretary, Robert D. Reinecke, M.D., who serves on the Academy Board, five associate secretaries and their active committees.

Associate secretaries meet quarterly with the Secretary and present their studied recommendations, which the Secretary takes to the Board for approval.

The Office of Governmental Relations, a staff of non-physicians in Washington, D.C., works to transmit the Academy's policies and opinions across to the legislative and the executive branches of government.

Toward this end, its staff monitors legislative developments in the U.S. House and Senate that may affect eye care or its providers. Similarly it tracks regulatory issues throughout departments and agencies of the bureaucracy.

The staff thus maintains contact with Senators and Representatives, Congressional committees, federal agencies, and their various staffs.

In these ways, the Office of Governmental Relations serves as an effective liaison between Academy members, the Congress, and federal government agencies.

It also assists ophthalmologists who come to Washington to testify at Congressional hearings or to contact their Senator or Representative about an issue or piece of legislation vital to eye care. It closely coordinates the Key M.D. program and the parallel Congressional Correspondent effort.

Governmental Relations Committee

Secretary

Robert D. Reinecke, M.D. Philadelphia, PA

Associate Secretaries

James V. Aquavella, M.D. Rochester, NY
Thomas A. Frey, M.D. Falls Church, VA
Michael A. Lemp, M.D. Washington, DC
Richard S. Ruiz, M.D. Houston, TX
Hunter R. Stokes, M.D. Florence, SC

Whitney G. Sampson, M.D.,
Consultant
Houston, TX

Charles B. Sonneborn
Director

Governmental Relations Committee takes a photo break during a recent meeting in Washington, D.C. Seated (L to R) Richard S. Ruiz, MD; Bruce E. Spivey, MD, Academy Executive Vice President; Robert D. Reinecke, MD, Secretary, Governmental Relations Committee; James V. Aquavella, MD. Standing (L to R) Whitney G. Sampson, MD, Academy President-elect; Hunter R. Stokes, MD; and Thomas A. Frey, MD. Not shown: Michael A. Lemp, MD.



Committee for Research and Regulatory Agencies

One of the charges to this Committee is to keep the Academy apprised of eye care issues originating in the federal regulatory agencies, such as the Food and Drug Administration (FDA), the Federal Trade Commission (FTC) and the National Eye Institute (NEI) and to furnish a commentary to the Board.

With the FDA, for example, the group supports voluntary device standards, monitors issues before the ophthalmic device panel, and provides input on a variety of drug and device related issues. At present a number of FTC issues emanating from the pending Eyeglasses II rule are being tracked.

One of the Committee's most important tasks is to formulate and organize a coordinated approach to generate Congressional support of eye research, stewarded by the National Eye Institute.

It also recommends Academy members for appointment to various federal advisory committees whose work involves ophthalmology.

Associate Secretary

Michael A. Lemp, M.D. Washington, DC

Committee Members

H. Dwight Cavanagh, M.D.	Atlanta, GA
John W. Chandler, M.D.	Seattle, WA
Oliver H. Dabeszies, Jr., M.D.	New Orleans, LA
James H. Elliott, M.D.	Nashville, TN
Arthur H. Keeney, M.D.	Louisville, KY
Walter J. Stark, M.D.	Baltimore, MD
Louis A. Wilson, M.D.	Atlanta, GA

Committee for Federal Legislation

This Committee studies federal legislation pertaining to ophthalmologists and eye care as the legislation is being created, proposed and considered.

It keeps the leadership of the Academy informed, analyzing the legislation and recommending Academy policy to the Secretariat and the Board.

The Committee also initiates legislation on behalf of the Academy and recommends the proposed legislation to federal representatives.

It calls on Congressional offices regularly, and identifies issues for the Key M.D.'s and Congressional Correspondents.

In addition, the Committee, whose membership is from the Washington Metropolitan area, is charged with contacting federal officials. It provides liaison between the Academy and governmental agencies - such as the Department of Health and Human Services and the Congress.

Associate Secretary

Thomas A. Frey, M.D. Falls Church, VA

Committee Members

David T. Casey, M.D.	Washington, DC
Richard A. Falls, M.D.	Vienna, VA
Allan D. Jensen, M.D.	Baltimore, MD
John F. Nowell, M.D.	Arlington, VA
Marshall M. Parks, M.D.	Washington, DC
A. Raymond Pilkerton, M.D.	Washington, DC
William L. Rich III, M.D.	Falls Church, VA

Committee for Health Manpower and Planning

This Committee's most enduring achievements involved preparation of the Academy's series of monographs dealing with health manpower: Ophthalmology (Eye Physician and Surgeon) Manpower Studies for the United States. The five-part series includes:

- Part I: Eye Disease Estimates, Time Requirements for Eye Disease Diagnosis, Treatment, Refractions, and Preventive Eye Care.
- Part II: Demand for Eye Care: A Public Opinion Poll Based Upon a Gallup Poll Survey.
- Part III: A Survey of Ophthalmologists' Viewpoints and Practice Characteristics.
- Part IV: Ophthalmology Manpower Distribution
- Part V: Summary and Conclusions*

* Part V should be available in early 1984. Upon completion of this charge and pending a renewed interest in Graduate Medical Education, the Committee will become inactive in 1984.

Associate Secretary

Richard S. Ruiz, M.D. Houston, TX

Committee Members

Frederick T. Fraunfelder, M.D.	Portland, OR
James P. Ganley, M.D.	Shreveport, LA
George L. Spaeth, M.D.	Philadelphia, PA
Theodore Steinberg, M.D.	Fresno, CA
Jonathan D. Trobe, M.D.	Gainesville, FL

Committee for State Affairs

As the name implies, this Committee keeps an eye on legislative affairs that affect ophthalmology in the 50 states.

Furthermore, it establishes a network between the 50 states, and between the states and the Academy, so that there is constant, up-to-date communication about the issues and concerns involving ophthalmology.

This Committee analyzes major bills that are introduced in state legislatures and likely to affect ophthalmology. It seeks to identify legislative trends and uses its clearinghouse function to alert states of such trends and related strategies. This Committee sponsors an annual conference for legislative advocates and lobbyists of state ophthalmological societies.

Planning is underway to forge a definitive working linkage between the Committee and the AAO Board of Councillors.

Associate Secretary

Hunter R. Stokes, M.D. Florence, SC

Committee Members

William C. Frayer, M.D.	Philadelphia, PA
Carl Garfinkle, M.D.	Arlington Heights, IL
Douglas A. Liddicoat, M.D.	Watson, CA
Thomas F. Moore, M.D.	Phoenix, AZ
David W. Parke, M.D.	Meriden, CT
Philip A. Shelton, M.D.	West Hartford, CT
Reginald J. Stambaugh, M.D.	West Palm Beach, FL

Committee for Health Plans

Issues affecting the financing and delivery of eye care through health plans are studied and monitored by this Committee.

The Committee for Health Plans examines and evaluates new developments and proposed vision care plans – private and governmental – analyzes each and recommends Academy policy and initiatives.

It also monitors existing programs within the Health Care Financing Administration – Medicare and Medicaid, for example, and the Public Health Service's HMO initiative, and the Department of Defense (CHAMPUS), and proposals for any federalized health insurance.

The Committee acts on reimbursement initiatives, drafting issue papers and policy statements as appropriate, for consideration by the AOA Board.

Current issues such as prospective payment by diagnostic related groupings (DRGs), preferred provider organizations (PPOs) and physician assignment are being closely monitored and addressed.

Associate Secretary

James V. Aquavella, M.D. Rochester, NY

Committee Members

S. Arthur Boruchoff, M.D. Boston, MA

Robert J. Crossen, M.D. Ann Arbor, MI

Barton L. Hodes, M.D. Hershey, PA

David J. McIntyre, M.D. Bellevue, WA

Lawrence A. Winograd, M.D. Denver, CO

Ira G. Wong, M.D. San Mateo, CA

Charles E. Jaeckle, M.D., Defiance, OH

Consultant

The Key M.D. Program

There are more than 100 U.S. Senators and Representatives who, by virtue of their committee assignments, have been designated by the Office of Governmental Relations as "key" to ophthalmology.

Key M.D.'s volunteer to keep in touch with their congressional representatives on these essential committees and to voice Academy opinions when legislation affecting ophthalmology is being considered.

They do this by writing letters to their representatives, by visiting them in their state or district offices, and by coming to Washington each spring to call on them in their Capitol Hill offices.

Key M.D.'s usually know their representatives on a first name basis. They often know the representative socially or as a patient. Ideally, the Key M.D.'s work on their representative's election campaign and make financial contributions, as well.

The Committee for Federal Legislation keeps the Key M.D.'s informed on issues and legislation of importance to ophthalmology.

A listing of these key ophthalmologists is maintained in the Office of Governmental Relations.

Congressional Correspondents

Congressional Correspondents are M.D.'s who agree to contact their representatives on legislative issues involving ophthalmology by phone, letter, or telegram.

Their representative usually holds a committee assignment less vital to ophthalmology than those of the Key M.D.'s. Nevertheless all U.S. Congressmen are important enough to be monitored and contacted.

The Office of Governmental Relations alerts Congressional Correspondents to the need to contact their representative and keeps them informed on pending legislation and related issues.

Rep. Howard C. Nielson (R-U) discusses a point at Congressional Reception held in conjunction with the 1983 Key MD program in Washington. (L to R) Robert A. Rubenstein, MD; Tom Donnelly, Special Assistant to the President for Congressional Liaison; Edward N. Brandt, MD, Assistant Secretary for Health, Dept. of Health and Human Services; Rep. Nielson; and Robert D. Reinecke, MD, Secretary, Governmental Relations Committee of AAO.





Office of Governmental Relations

Suite 300

1101 Vermont Ave., N.W.
Washington, D.C. 20005-3570

(202) 737-6662



AMERICAN ACADEMY OF OPHTHALMOLOGY

OFFICE OF STATE AND
SUBSPECIALTY RELATIONS

May 9, 1984

JOHN D. LEE
Director

HENRY L.D. EBERT
Assistant Director

Nancy Dietrick
Senator Joe P. Josephson
Pouch V
Juneau, AK 99811

Dear Nancy:

Although we've spoken several times recently, I want to take this opportunity to thank you for your letter of April 19 and the extensive material that came out of the April 18th hearings.

We would be very grateful for additional statistical information on the incidences of failures of the pathology portion of the optometric licensing exam, as well as case studies showing patient harm from the illegal use of diagnostic or therapeutic pharmaceutical agents by optometrists. To date, I realize, the problems that have been cited have arisen from optometric misdiagnosis. Even those cases could be helpful in other states, since optometrists claim they are competent to diagnose and treat eye problems.

I appreciate the information on Alaska and only regret that the more recent version does not contain photographs of the famous Skagway dance hall queen!

Sincerely,

Henry L.D. Ebert

HE:mlp

P.S. Please keep me posted on the second round of hearings on HB 225. Thanks.

JAMES H. PATTERSON, M.D.
A Professional Corporation
Subspecialty Pediatric Ophthalmology
3500 LA TOUCHE
ANCHORAGE, ALASKA 99504

April 24, 1984

RECEIVED

APR 27 1984

Josephson

Senator Joseph P. Josephson,
Pouch V,
Juneau, Alaska 99811.

Dear Senator Josephson:

As a physician, I am opposed to HB 225 which redefines the practice of optometry and allows the use of legend drugs for diagnostic purposes. I feel that this legislation does not command a wide range of public support and interest and has been conceived, lobbied and financed by organized optometry in order to further its own goals. My reasons for opposing this legislation include the lack of any true need for optometrists to use medications in performing their jobs and dramatic lack of didactic and clinical skills of optometrist in the field of medicine.

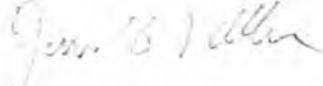
Having actively opposed this legislation since introduction, I cannot help but feel this year it has gained unwarranted and undeserved momentum. HB 225 as written lacks sufficient checks and balances to become an efficient and safe law for the people of Alaska. Amended HB 225 also contains inconsistencies, ambiguities and contradictions.

The two most glaring deficiencies are that this legislation lists legend drugs in broad categories. I feel that if drugs are to be used, they should be identified by specific name, concentration and dosage schedule. Secondly, HB 225, allows the board of optometry and this board alone to decide what legend drugs are to be used and by whom. Regardless of how noble the intentions of the board of optometry are in deciding these matters the practicality and limitations of such a policy should be self evident. In my opinion, the board of optometry should answer to and seek approval of specific drugs from the board of pharmacy and medicine. Since the amended bill lists only cyclopegics and mydriatics, section 5 as 08.7300 paragraph 5 and 6 do not apply.

Again, I am opposed to this bill and feel it should not pass in any form. If you do see fit to pass this I urge you to modify its present form significantly.

I thank you for allowime me time to testify before your committee. I hope you will review my correspondence and references that I have sent you concerning this legislation. I want to offer my services to your committee on medical matters concerning this legislation.

Sincerely,

A handwritten signature in cursive script, appearing to read "James H. Patterson".

James H. Patterson M.D.
JHP/ez

April 21, 1984

[RECEIVED]

APR 24 1984

Josephson,



STEVEN S. DOBSON, O.D.

The Honorable Joe Josephson
Alaska State Senate
Room 508 Capitol Building
Juneau, Alaska 99811

re: CS HB 225 am

Dear Senator Josephson:

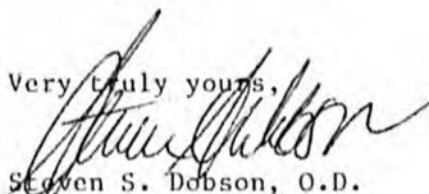
I would like to clarify a point about which there was some confusion during the HESS hearing on April 18, 1984 on HB 225.

While anyone can use an over the counter drug for treatment purposes, to charge a fee to render the treatment or recommend a drug constitutes the practice of medicine under AS 08.64.380 (2). Under existing law therefore, an optometrist must do any therapeutic procedures for free. By adding the diagnosis and treatment language to the definition of an optometrist, the bill provides the needed statutory exemption as required under AS 08.64.170 (a) (4), ("A person who is licensed or authorized under another chapter of this title may engage in a practice that is authorized under that chapter.") However this provision is of limited utility as a result of the Milo Fritz House amendment that eliminated all therapeutic drugs from the legend drug section. (Copy of CS before amendment is attached.)

It is also worth noting, in regard to Dr. Perry's comment about needing to be able to open the chest and perform heart massage, that no dentists and few physicians can competently perform this procedure.

We would like to see the therapeutic drug categories restored, as this will restore the 95% of the public benefits eliminated by the Fritz amendment.

Very truly yours,


Steven S. Dobson, O.D.
Legislative Committee
Alaska Optometric Association

cc: Senators Vic Fischer
Pappy Moss
Rick Halford
Paul Fischer

Millett Keller Company

921 West 6th Avenue
Anchorage, Alaska 99501
(907) 279-8441

April 24, 1984

RECEIVED

APR 30 1984

Josephson,

Senator Joe Josephson
Health, Education and
Social Services Committee
Pouch V, MS 3100
Juneau, AK 99811

Re: HB225

Dear Senator Josephson:

The purpose of this letter is to pass on some comments regarding HB225, particularly a personal perspective I have on this issue.

Both my father and brother are Optometrists, my father practicing in Montana and my brother in Utah. As a result of their professional background and our family relationship, I have been aware of the issue of the use of therapeutic and diagnostic drugs by Optometrists and the opposition to such practices by the Ophthalmology profession.

I am sure you have been made aware that there is no scientific or academically corroborated data which supports the contention that the use of these topical drugs by Optometrists poses a risk to the public health. It has been my perception that the major opposition is based on business practice issues rather than health or safety.

The role of competition and regulation in a free market economy is a very sensitive matter for all the professions. I believe that legislation which regulates business practices should be based on factual evidence that third party interests (namely, the public health) must be protected. Whenever legislation is based on protecting the vendors and providers, it defies the consumer and is, therefore, injurious to a free market society.

It is my understanding that HB225 has been rendered impotent by the House HESS Committee at the specific request of the Ophthalmology profession. I would urge you and your committee to examine the scientific and medical evidence as well as the business issues and use this information when crafting the appropriate language for HB225 which best serves the public interest.

Sincerely,

Millett Keller

MK/pnt

Dr. Roy A. Box
Doctor of Optometry
Professional Plaza Suite A 102
9309 Glacier Hwy
Juneau, AK 99801
Telephone (907) 789-3175

RECEIVED

APR 27 1984

Josephson,

April 24, 1984

Senator Joe P. Josephson
Pouch V
Juneau, Ak 99811

Dear Senator,

I am writing concerning House Bill 255 and would encourage you to support and vote for the original version of this bill. Four states now provide for therapeutic drug use by optometrists and somewhere around forty states allow diagnostic drug use by optometrists. The trend is obviously growing and no evidence exists to show that patients have any more problems with optometric treatment than they do with eye physician treatment. You have to know that competition in any field improves quality of service and tends to reduce cost. This is an important aspect of this legislation when you consider that physicians's fees and hospital costs are increasing faster than the rate of inflation and competition even in this limited specialty might help to reduce this trend.

This whole issue can be condensed into two basic issues, one is might and the other is right. There is no way thirty optometrists can generate as many public opinion phone and telegram messages to legislators as can several hundred or a thousand physicians, so if the only goal of legislators is re-election then might and political clout must prevail. The other issue is right! Is it right to give Alaskans freedom of choice of practitioners when training is adequate to provide good service and no evidence exists to show one discipline is better or worse than the other? There is a vast difference between rhetoric and evidence. Organized medicine with all of its might has not proven their opposition to therapeutic drug use by O.D.'s is wrong and detrimental to any thing but their bank accounts.

I would urge you to consider the fact that village health aids and P.A.'s routinely handle and dispense drugs for a wide variety of conditions from very well stocked drug supplies without much if any "medical" supervision and with little or no adverse side effects or improper diagnosis. The product description for legend drugs in the P.D.R. is over 1,500 pages. The same section in the P.D.R. for ophthalmology is 100 pages and includes descriptive information on over the counter agents and soft contact lenses. The actual drug choices are few and not difficult to become familiar with.

I would urge you to support legislation to allow doctors of optometry to use therapeutic and diagnostic agents or work against this legislation if political muscle is your important consideration in the legislation you support.

The physicians are also claiming some kind of a compromise on this legislation



Member

American Optometric Association

Dr. Roy A. Box
Doctor of Optometry
Professional Plaza Suite A 102
9309 Glacier Hwy
Juneau, AK 99801

Telephone (907) 789-3175

Page 2

in 1980 insisting I agreed to the compromise. They either have very short memories or a propensity for changing the facts to suit their purposes. The only agreement was that the physicians were going to go back to their group and the optometrists would go back to theirs and offer grounds for a compromise. The physicians were to contact us first and we never heard from them so the matter was dropped. I only agreed to discuss their concerns with my group. NOTHING ELSE! Rick Urion was the Optometric Association lobbyist at the time and can verify my recollection of the meeting.

Sincerely,


Roy A. Box, O.D.



Member

American Optometric Association

BRISTOL BAY AREA HEALTH CORPORATION

P.O. Box 10235
DILLINGHAM, ALASKA 99576

PHONE: (907) 842-5201
(907) 842-5202

April 16, 1984

RECEIVED
APR 27 1984
Josephson,

Senator Joe Josephson
Chairman; Health, Education and
Social Services Committee
Room 508, Capitol Building
Juneau, Alaska 99811

Dear Senator Josephson:

House Bill 225 has been referred to your committee for consideration. This Bill as ammended in the House has circumvented the Bill's original intent.

The original legislation was designed to authorize the use of diagnostic and therapeutic pharmiceuticals by appropriately licensed optometrists. Its scope has been significantly narrowed by ammendment in the House.

I support the original intent of the bill and ask that the Senate consider the pre-ammended legislation for passage.

Passsage of the intact House Bill 225/Senate Bill 189 will be of undeniable benefit for the citizens of our area. It will increase the availability of eye care and be very cost effective.

Thank you for your consideration of this matter.

Sincerely yours,



Robert J. Clark
Executive Director

RJC:sf

cc: Senator Vic Fisher
Senator Paul Fischer
Senator Pappy Moss
Senator Rick Halford
Dr. Jim Pickard, O.D.
Robert J. Clark's File
Reading File
File

(Part Two)

TESTIMONY IN SUPPORT OF SENATE BILL 189

Health, Education and Social Services Committee

Alaska State Senate

April 13, 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 competent 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 expertise to realize that if that were the case, then dentists and podiatrists, who are not trained as physicians, would be incompetent or only marginally competent.

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

SB 189
Senate HESS
Apr. 13, 1983
Dobson, p.3

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 subject 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

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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

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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

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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

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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 exercise the same good judgment as the other professions. And the public will be the beneficiary.

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED
AS A UNIT IN THE ORIGINAL DOCUMENT

RECEIVED

APR 15 1983

April 4, 1983

Josephson,

The Honorable Mae Tischer
Alaska State Senate
Fouch V
Juneau, Alaska 99811

APR 1 1983

Dear Representative Tischer:

I would like to offer my support for HB 225 and SB 189 which would permit appropriately trained and licensed optometrists to use prescription ophthalmic drugs for diagnosis and treatment of eye problems.

I work closely with two optometrists in Bethel, John Demske, O.D., and James Taylor, O.D., who are authorized under standing orders approved by the medical staff of the Yukon Kuskokwim Delta Regional Hospital to use certain prescription drugs for the diagnosis and treatment of eye disorders. They also work under the indirect and direct supervision of the Ophthalmology Department at the Alaska Native Medical Center in Anchorage. John Demske has been operating under these standing orders for almost five years without mishap. Both optometrists have made a substantial contribution to the increased quality of eye care in this region. The physician staff respects their knowledge and expertise and regularly consults them regarding eye problems.

The Ophthalmology Department at the Alaska Native Medical Center has recommended that the eye care program operating in this region be considered as a model for other Service Units in the Alaska Area Indian Health Service. This recommendation has been supported by the Service Unit Directors and Clinical Directors of the Alaska Area.

The backbone of the health care system in rural Alaska has been trained paramedical personnel, including Physician Assistants, Nurse Practitioners, Public Health Nurses, Community Health Aides, and in this area, the Optometrists with the YKHC Eye Care Program. They have proved themselves vital in achieving otherwise unobtainably high standards of health care in remote areas. The professional performance of the optometrists in this region has been excellent. They have provided quality eye care services otherwise unavailable to the people of the Delta. They have recognized their limitations and always referred patients when appropriate.

To: Senate HESS

From: Rep Tischer

for file on
optometry
(SB 189)

Constituent letters re: HB 225/
SB 189.

Based on my experience with optometrists using prescription ophthalmic medications for specified diagnostic and therapeutic purposes in this area I am inclined to agree that the major obstacle to a more extensive utilization of the optometrists' special skills and knowledge is a financial one rather than a primary concern for the quality of eye care available to the people of the state.

I strongly endorse SB189 and HB 225. If I can be of any further help, please let me know.

Sincerely,

John Wetherby
John Wetherby, M.D.

P.O. Box 452

Kenai, Ak

99611

APR 11 1983

Dear Ms. Tischer,

I am writing to encourage
you to vote Yes on House Bill
225.

It is my belief that bill
225 is important to the health
care of Alaskans.

Sincerely Yours,

Teresa Youngren

YUKON-KUSKOKWIM HEALTH CORPORATION

P.O. Box 528
Bethel, Alaska 99559
(907) 543-3321

April 8, 1983

APR 12 1983

The Honorable Mae Tischler
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Tischler:

I'm writing to you about HB225, relating to the use of drugs by optometrists. I support this bill and hope that it will be passed.

I work for YKHC in the eye clinic and routinely use eye drops for dilating patients. I have yet to see any undesirable effects from these drops.

Living in rural Alaska, this bill could only be beneficial. Major pathology can be detected earlier and thus save someone's eyesight.

Please support this bill.

Sincerely,
Louise A. Wilder

APR 1 1983

4. 7. 83
WAYNE HOWE
1021 W. 12TH
ANCHORAGE, AK 99501

APR 11 1983

Ms. TISCHER,

I URGE YOUR SUPPORT OF THE
OPTOMETRIST'S DRUG BILL. IT WILL BE
REALLY HELPFUL IN AREAS WITHOUT SPECIALISTS,
WHERE THE GENERAL PRACTICE DOCTOR MUST
PROVIDE TREATMENT WITH FAR LESS EYE
TRAINING THAN THE OPTOMETRIST. WE
NEED BETTER AVAILABILITY OF EYE CARE
IN ALASKA.

Thank You
Wayne R. Howe

John W. Page II O.D.
4050 Lake Otis Suite 103
Anchorage, Alaska 99504

April 8, 1983

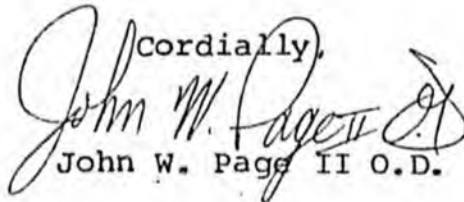
APR 11 1983

Rep. Mae Tischer
Chairperson, House HESS Committee
Pouch V
Juneau, Alaska 99801

Dear Rep. Tischer,

I strongly urge you to support House Bill 225, which would allow Doctors of Optometry to use Ophthalmic drugs in their professional practice.

Thank you for your thoughtful consideration.

Cordially,

John W. Page II O.D.

JWP/cp

c/c Dr. Phillip W. Bach

Visual Training
Contact Lenses

Ed Craig, O.D.
Doctor of Optometry
348 Main Street
Ketchikan, Alaska 99901
Telephone (907) 225-3975

April 8, 1983

APR 11 1983

Representative Mae Tischer
c/o Health, Education and Social Services
Pouch V
Juneau, Alaska 99811

Dear Rep. Tischer;

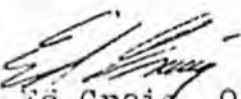
As a practicing optometrist of some 28 years in the Ketchikan area, I have many times been requested by patients to remove foreign objects embedded in their corneas and adjacent areas of the eye, treat scratches and scrapes of the eye, look after infections caused by bacterial or viral agents, etc., only to have to tell the patient that I am unable to help them - not because I do not have the knowledge, or skill - but because the law is such that it says, "NO! you may not."

Were I able to render immediate assistance to these patients, their recovery would be that much faster. Instead, I refer them to a physician's office where the patient waits his turn, perhaps for several hours, before receiving attention.

From an economic standpoint it is a waste to restrict highly, well-trained professionals from using only a part of their capabilities.

I am therefore in favor of passage of House Bill #225.

Very truly yours,


Ed Craig, O.D.
EC/vc



Member
American Optometric Association

The
ALASKA OPTOMETRIC ASSOCIATION

AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

PRESIDENT

Dennis A. Swarner, O.D.
Drawer 4370
Kenai, Alaska 99611
April 8, 1983

APR 11 1983

Mae Tischler
Pouch V
Juneau, Alaska 99811

Dear Ms. Tischler;

I am writing to urge your support of House Bill #225, an act relating to the Practice of Optometry.

It is time that Optometrists in Alaska are treated like other health professions. The educational background of Optometrists is similar to that of dentists and podiatrists, professionals who have unrestricted drug prescribing privileges, other than those imposed by their respective boards.

The statutes restricting drug use by Optometry were written when the laws were first enacted. In view of the current education of Optometrists, these laws are now outdated.

This bill is being opposed by a small group of Physicians, for what I believe to be economic reasons. If it was for the economy of the patient, there might be some merit in the opposition. But the passage of this bill will save our patients time and money, by avoiding unnecessary referrals.

As President of our Association, I would like to thank you for considering this bill, and I hope you find it prudent to allow our Board to regulate Optometry in the same manner that those who oppose it are regulated by their board.

Regards;



Dennis A. Swarner, O.D.

Mae Tischer
Representative District 11
3305 Oregon Drive
Anchorage, Alaska 99503

APR 11 1983

April 7, 1982

Dear Representative Tischer;

I am a Physicians' Assistant practicing in the State of Alaska and am writing to you to voice my support of HB 225.

I have been a Physicians' Assistant for four years and have worked in states that have legislature allowing Optometrists to use pharmaceuticals in the diagnosis and treatment of eye disorders. I frequently refer patients to them and have been pleased with the quality of care and have had positive feedback from those patients.

I have found that the limitations placed on them by not allowing them to use pharmaceuticals in their practice somewhat of a handicap.

I hope that when this bill comes before the house that you will support it.

Thank you for your kind consideration in this matter.

Respectfully,

Barry L. Campbell

Barry L. Campbell PA-C

APR 12 1983

April 9, 1983

Representative Mal Tischer
Chairman, Health, Education
and Social Services
Alaska State House of Representatives
Touch 2
Juneau, Alaska 99811

Dear Representative Tischer

I wish to offer my support for House bill #225 and urge that you do likewise. I know that optometrists are more than qualified to decide when to treat and when to refer. It makes no sense to me to give ophthalmologists exclusive right to treat minor eye infections and charge high fees when they already make more money in one day of surgery than most working people do in a month.

Please support this bill. Thank you.

Very truly yours,

Mrs. Michael Brandenburger
Box 216 Chuchagof Ip
Eagle River, Alaska
99577

April 8, 1983

APR 11 1983

Dear Ms. Tischer:

I strongly urge you to support the optometry drug bill. I feel that this will better enable my optometrist to serve the needs of my family.

Thank you,

Sara Castle

Sara Castle

3700 Arkansas #13

Arch 99503

APR 11 1983

April 4, 1983

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

Dear Representative Tischer:

I would like to offer my support for HB 225 and SB 189 which would permit appropriately trained and licensed optometrists to use prescription ophthalmic drugs for diagnosis and treatment of eye problems.

I work closely with two optometrists in Bethel, John Demske, O.D., and James Taylor, O.D., who are authorized under standing orders approved by the medical staff of the Yukon Kuskokwim Delta Regional Hospital to use certain prescription drugs for the diagnosis and treatment of eye disorders. They also work under the indirect and direct supervision of the Ophthalmology Department at the Alaska Native Medical Center in Anchorage. John Demske had been operating under these standing orders for almost five years without mishap. Both optometrists have made a substantial contribution to the increased quality of eye care in this region. The physician staff respects their knowledge and expertise and regularly consults them regarding eye problems.

The Ophthalmology Department at the Alaska Native Medical Center has recommended that the eye care program operating in this region be considered as a model for other Service Units in the Alaska Area Indian Health Service. This recommendation has been supported by the Service Unit Directors and Clinical Directors of the Alaska Area.

The backbone of the health care system in rural Alaska has been trained paramedical personnel, including Physician Assistants, Nurse Practitioners, Public Health Nurses, Community Health Aides, and in this area, the Optometrists with the YKHC Eye Care Program. They have proved themselves vital in achieving otherwise unobtainably high standards of health care in remote areas. The professional performance of the optometrists in this region has been excellent. They have provided quality eye care services otherwise unavailable to the people of the Delta. They have recognized their limitations and always referred patients when appropriate.

I strongly endorse SB189 and HB 225. Thankyou for your time.

Sincerely,

Jill Seaman

Jill Seaman, MD

*PHS Hqs
Bethel*

APR 11 1983

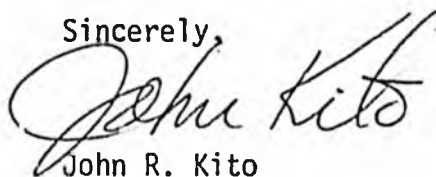
SRA Box 1026-B
Anchorage, Alaska 99502
April 7, 1983

Honorable Mae Tischer
Co-Chairman, House HESS Committee
Pouch V
Juneau, Alaska 99811

Dear Representative Tischer:

Please support HB 225/SB 189 allowing use of ophthalmic drugs by optometrists. This legislation is in the best interest of the people of Alaska in saving money and time, especially for "bush" residents.

Sincerely,



John R. Kito

APR 12 1983

April 4, 1983

The Honorable Mae Tischer
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Representative Tischer:

I would like to offer my support for HB 225 and SB 169 which would permit appropriately trained and licensed optometrists to use prescription ophthalmic drugs for diagnosis and treatment of eye problems.

I work closely with two optometrists in Bethel, John Demske, O.D., and James Taylor, O.D., who are authorized under standing orders approved by the medical staff of the Yukon Kuskokwim Delta Regional Hospital to use certain prescription drugs for the diagnosis and treatment of eye disorders. They also work under the indirect and direct supervision of the Ophthalmology Department at the Alaska Native Medical Center in Anchorage. John Demske has been operating under these standing orders for almost five years without mishap. Both optometrists have made a substantial contribution to the increased quality of eye care in this region. The physician staff respects their knowledge and expertise and regularly consults them regarding eye problems.

The Ophthalmology Department at the Alaska Native Medical Center has recommended that the eye care program operating in this region be considered as a model for other Service Units in the Alaska Area Indian Health Service. This recommendation has been supported by the Service Unit Directors and Clinical Directors of the Alaska Area.

The backbone of the health care system in rural Alaska has been trained paramedical personnel, including Physician Assistants, Nurse Practitioners, Public Health Nurses, Community Health Aides, and in this area, the Optometrists with the YKDC Eye Care Program. They have proved themselves vital in achieving otherwise unobtainably high standards of health care in remote areas. The professional performance of the optometrists in this region has been excellent. They have provided quality eye care services otherwise unavailable to the people of the Delta. They have recognized their limitations and always referred patients when appropriate.

Based on my experience with optometrists using prescription ophthalmic medications for specified diagnostic and therapeutic purposes in this area I am inclined to agree that the major obstacle to a more extensive utilization of the optometrists' special skills and knowledge is a financial one rather than a primary concern for the quality of eye care available to the people of the state.

I strongly endorse SB189 and HB 225. If I can be of any further help, please let me know.

Sincerely,

David Clement MD

**PLEASE NOTE: THE PRECEDING PAGES WERE TREATED
AS A UNIT IN THE ORIGINAL DOCUMENT.**

Testimony In Support of Senate Bill 189
Health, Education and Social Services Committee

Alaska State Senate

April 13, 1983

John Demske, O.D.

Good afternoon, My name is John Demske, and I am an optometrist employed by Yukon-Kuskokwim Health Corporation in Bethel. In this capacity, I and another optometrist provide primary eye care services at the Public Health Service Hospital in Bethel and at field clinics throughout the Yukon-Kuskokwim delta. We routinely use prescription drugs through the use of standing orders.

I would like to outline some role relationships and practitioner competencies in eye health care as they relate to the bill under consideration today. Later, my colleague, Dr. Steve Dobson, will discuss optometric and dental models of education as they relate to medical training.

I will start with four concrete examples that illustrate the kinds of knowledge and equipment needed in providing primary eye care.

First, I would like to relate a recent case from my practice. Last Sat. April 9th, I was called at home by one of the General Physicians in regard to a patient, Mr S. The Physician involved, Dr.X. has consented to my using this experience as an example in testimony as he is in support of this legislation. Mr S. Initially presented to Dr.X. on Saturday April 2nd in the emergency room. He complained that he felt something in his left eye. He also reported that he thought he might have scratched his eye the previous evening. Pertinent medical history is that Mr S. is confined to a wheelchair from rheumatoid arthritis, ankylosing spondylitis and a spinal injury. His right eye is blind from glaucoma:

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April 13, 1983

Demske, P.2

He had cataract surgery in his left eye in 1976. His current medications are methadone and a prescription for his arthritis. Dr. X diagnosed a corneal abrasion with the use of sodium fluorescein. He reassured Mr S. and told him to report to the optometry clinic on Monday the 4th if his eye didn't improve. No medications were prescribed. Mr S. returned 1 (one) week later, Saturday April 9th. He stated his eye was getting worse. When asked why he had not returned earlier, he reported that initially his eye felt better and that it didn't get worse until that morning. Dr X thought that Mr. S. may have developed a corneal ulcer and he consulted me.

My examination revealed a definite corneal ulcer and a moderate iritis, his vision was 20/25. I worked up the patient as a bacterial corneal ulcer. The laboratory studies confirmed my diagnosis. I consulted with an ophthalmologist and reported my findings, diagnoses and the laboratory results, I strongly recommended that Mr S. be admitted to the hospital. He concurred and recommended a treatment regimen. The ulcer and iritis are healing well but Mr S. remains hospitalized. As it is his only seeing eye and it is questionable if he can adequately care for himself. The plan is to keep him hospitalized until the ulcer is totally healed.

This case is a perfect example of what can happen to a corneal abrasion. Optometrists see corneal abrasions secondary to contact lenses routinely in their practices. With their expertise with a slit lamp/biomicroscope, they can determine the depth and severity of a corneal abrasion. This instrument is also necessary to diagnose iritis an inflammation of the iris. Dr X did not use a slit lamp/biomicroscope as he is unfamiliar with it.

Many mild corneal abrasions will heal spontaneously without treatment, some will progress to an ulcer. A short course of a topical antibiotic for prophylaxis will prevent an ulcer. Dr X a General Practitioner had the option to treat the abrasion. Optometrists in private practice have the option to refer to a physician for treatment Dr X referred Mr S. to a doctor of optometry.

Second, A herpes simplex infection of the cornea may resemble simply a red eye, because there is often relatively little pain. However if eyedrops containing steroids are used to reduce inflammation and whiten the eye, the sever-

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Demostre, P3

ity of the corneal infection will be dramatically increased, and can lead to a scarring stromal ulcer. In the early stages of an hermetic involvement, a biomicroscope is needed to see the characteristically branching lesion and distinguish it from other types of corneal involvement. This microscope is used routinely by optometrists and ophthalmologists but is not found in offices of general physicians.

Example number three, A lump in the eyelid resembling a styne may be a swelling of an oil producing meibomian gland. The condition is called a chalazion. The first treatment of choice is not a drug but a hot compress. However anyone providing primary eye care should not simply be ignored, but should be evaluated by a specialist for the possibility that it might be a carcinoma of the meibomian gland. The specialist can also do lancing and expression of the contents of the gland; if indicated.

A fourth example; A generalized swelling and inflammation of the eyelids without pain on movement of the eye may be a condition known as pre-septal cellulitis.

It generally requires oral antibiotics for effective treatment. However anyone providing primary eye care should know that a possible complication is extension of the inflammation past a protective septum and on into the orbit, characterized by pain on moving the eye. This is orbital cellulitis. The infection can then follow the sheath of the optic nerve and lead to meningitis, a much

more serious complication. It is unlikely that a general physician is aware of this possible sequence of events.

I have used these examples not to run down the general physician but to emphasize that there is only so much that he can know. In the busy medical school curriculum, the average medical student receives less than 25 clock hours of instruction in the eye and its treatment. This includes anatomy and physiology of the eye, examination techniques, ocular pathology, treatment and management of eye conditions. By contrast, the optometrist receives hundreds of hours in these subjects, plus specialized clinical experience. It does not matter how much kidney disease a general practitioner treats, or how many broken arms he sets or babies he delivers, if he does not know the specifics of ocular syndromes or have the proper equipment, he cannot be a good diagnostician of the eye.

The other relevant comparison is between the optometrist and ophthalmologist. The ophthalmologist considers himself to be primarily a surgical specialist, but in the course of his post-medical school surgical training, he also receives extensive exposure to diagnosis and treatment of non-surgical eye conditions. He typically sees more pathology in his hospital based residency than most optometry students see in the pathology portions of their outpatient clinics. His academic preparation, on the other hand, is less extensive than that of the optometrist, currently consisting of 6 weeks of academics at an east

or west coast university.

These role relationships can best be seen in institutional settings, where fixed salaries eliminate economic competition factors and workloads, promote professional cooperation, competition. include military hospitals, Veterans Administration hospitals, HMOs and Indian Health Service facilities. In such settings, if an ophthalmologist is on staff, eye ailments of a more serious nature are referred to him for evaluation and treatment. If an optometrist is on staff but no ophthalmologist, the optometrist receives the referral and his advice is sought. However if a drug is to be prescribed, the optometrist cannot sign the prescription, for in most states only physicians, dentists or podiatrists can sign a prescription. So the prescription is signed by the general physician or non-eye specialist, who knows less about the condition, the treatment or the drug than does the optometrist.

Thus the optometrist, both by training and in practice, occupies a position between the general practitioner and the ophthalmologist, though closer to the ophthalmologist.

This analysis leads naturally into another question: if diagnostic and treatment abilities vary among practitioners, should not the licensing system attempt to define specific areas of

competance and specify the treatments which can or cannot be performed? Traditionally the profession of medicine has enjoyed unlimited licensure under the broad statutory definition of treating the sick and injured. Professions of more limited scope such as dentistry, podiatry and optometry have statutory definitions using an organ level of specificity rather than, say, specific structures or parts of organs. In each case, it is left to the profession to decide whether a given condition should be treated by a generalist, specialist or subspecialist. This is appropriate, for reasons I will give in a minute. It is very significant that for every profession that has drug prescribing authority, there is no statutory specification as to the allowable drugs or even the classes of drugs. That is to say, each practitioner's prescribing authority is theoretically unlimited. I say theoretically, because each group tends to limit itself, on a common sense basis, to drugs which are appropriate to its field of endeavor. This allows them to be quite adept at using this narrower spectrum of drugs. A listing of drugs or procedures in statute is unnecessary and would quickly become obsolete. Where very specific restrictions are appropriate, they are imposed by the respective boards, whose members know what is going on in their field's educational system. Thus for a dentist to use general anesthetics, the dental board requires, by regulation, that he have a year of postgraduate training in this area, for general anesthesia is a very tricky procedure. Prescribing abuses by MDs and dentists tend to be in the area of controlled substances, for there is a large illicit market for controlled substances.

However, such prescribing is closely monitored by the federal Drug Enforcement Administration, and few practitioners get away with abuses for long.

I mentioned a moment ago that it is appropriate for each profession to decide how to handle different levels of treatment. Unlimited licensure needs to be preserved for two reasons: first, a practitioner in a rural area needs to have the legal freedom to treat somewhat more specialized problems when a specialist is not available in his area. He is frequently aided in this by telephone consultation with a specialist. This is exactly what I do when a case comes up that needs more specialized expertise. Secondly, no two practitioners have exactly the same knowledge or skills. If a generalist has experience in a given procedure, he may undertake it when another generalist might chose not to do so but instead send the patient to another doctor in another locale. It is this process of intercommunication and interreferral, with practitioner latitude, that makes the system work. Optometry is an integral part of this process, but with the limitations that this bill seeks to redress.

At this point, you may still be moved to ask, do broadly worded statutes provide sufficient protection for the public? In addition to the system I have just described, which incorporates licensing board and federal regulations, and the judgment of the practitioner, there are additional free market constraints upon the behavior of professionals.

Perhaps most important, malpractice considerations dictate that the individual practitioner not practice at or beyond the limits of his expertise, and in any event not deviate significantly from what are considered to be accepted procedures unless he is participating in a carefully defined research project. In addition, medical care is a quality oriented market. Much of it is covered by third party payment plans. There is an attitude that "nothing is too good for my body". The patient thus has every incentive to seek the highest quality care available. If a practitioner is doing slipshod work or not keeping up with his field, patients can sense it and word quickly gets around. It is in the interest of both the individual practitioner and the profession that prepares him to maintain the highest standards of training and practice.

If quality of optometric care can be defended, what about savings to the patient? A truly rationalized system of health care dictates that each practitioner practice at his highest and most efficient level. Under the present system, the doctor of optometry must refer his patient to the ophthalmologist, to be charged a specialist's fee for a primary care procedure. If the OD sends his patient to a general physician with recommendations, there is still a second visit fee. And whether the patient pays the fee himself or is covered by private insurance, Medicare or Medicaid, consumers of health care still ultimately pay the bill. This is why third party payors are now beginning to recommend optometric treatment for primary conditions.

One final thought. You will be asked by opponents of the bill to impose special restrictions on the optometric practice of therapeutics. While we are not dogmatically committed to the exact language of the present bill, we wish to emphasize that most restrictions in statute would set precedents that do not exist for other practicing professions and serve only to maintain a privileged status for a group that is no longer entitled to that status by virtue of exclusive education and training. If you are drawn into attempting to draft specific standards, you will be treated to the opponents' ability to obfuscate, raise red herrings and confuse. It will then be suggested that you refer the matter to a study committee. In other states where this has been tried, it has served to delay passage and increase the number of committee meetings devoted to the subject. There was also the politically charged question of how the committee would be constituted, and the recommendations of the committee have tended to reflect the political allegiances of its individual members, even those representing supposedly neutral groups.

The question this committee and the legislature as a whole must answer is basically a simple one: shall the profession of optometry be treated as a mature profession, capable of making intelligent, informed decisions? I hope that by the time our testimony is completed you will be firmly convinced that it is.

STATE OF ALASKA

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

JAY S. HAMMOND, GOVERNOR

CHARLES R. RUSH
P.O. BOX 3728
ANCHORAGE, ALASKA

99501

MARCH 9, 1983

DIVISION OF OCCUPATIONAL
LICENSING

POUCH D
JUNEAU, ALASKA
99811

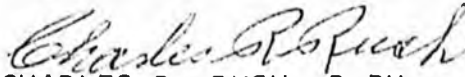
ATTN: HARRY TREAGER

PERTAINING TO HOUSE BILL #225 I WOULD OPPOSE THE BILL AS WRITTEN. FROM A PHARMACY STANDPOINT, IF OPTOMETRISTS ARE GOING TO PRESCRIBE THE SEC. 8-72-277(B) DOES NOT MAKE SENSE AS ALL PRESCRIPTION DRUGS ARE LEGEND DRUGS. POSSIBLY THEY WANTED THIS TO READ THAT THEY CANNOT PRESCRIBE CONTROLLED SUBSTANCES WHICH WOULD CERTAINLY BE A GOOD IDEA AND ALSO THAT THEY WOULD NOT HAVE DEA LICENSES.

IT IS DIFFICULT FOR PHARMACISTS TO HAVE THIS TYPE OF PRESCRIBER WHERE THEY HAVE TO REMEMBER THE PRESCRIBER CAN ONLY WRITE FOR CONDITIONS OF EYES AND EYELIDS AND IF THEY WRITE FOR SOMETHING ELSE THE PHARMACIST MUST CATCH IT AND REFUSE TO FILL. WE HAVE SOME PROBLEM WITH DENTISTS IN THIS REGARD AS THEY CAN ONLY WRITE FOR DISEASES OF THE MOUTH, GUMS ETC, HOWEVER, DENTISTS PRESCRIPTIONS ARE MORE EASILY NOTICED THAN WOULD BE AN OPTOMETRISTS.

WE ALSO HAD THIS PROBLEM WITH PHYSICIANS ASSISTANTS AND NURSE PRACTITIONERS AND WERE FORCED INTO ADVISING THE MEDICAL BOARD THAT WE COULD NOT MONITOR EACH PA'S OR NP'S INDIVIDUAL PRESCRIPTION ALLOWANCES AND THAT THIS WOULD HAVE TO BE CONTROLLED BY THE COLLABORATING PHYSICIAN TO SEE THAT THE PA OR NP ONLY WROTE FOR THE ITEMS THAT WERE AUTHORIZED.

POSSIBLY THERE COULD BE A REQUIREMENT THAT OPTOMETRISTS RX BLANKS CARRY A NOTATION "CAN ONLY PRESCRIBE FOR DISEASES OF EYES AND EYELIDS" EITHER THAT OR HAVE A COLLABORATING PHYSICIAN TO MONITOR THE ITEMS PRESCRIBED.

SINCERELY,
ALASKA BOARD OF PHARMACY

CHARLES R. RUSH, R.P.H.
MEMBER

CRR/JD

MEMORANDUM

State of Alaska

TO: Harry D. Treager
Administrator, DOL

DATE: March 14, 1983

FILE NO:

TELEPHONE NO:

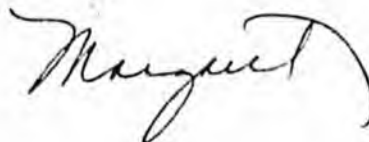
FROM: Margaret Soden
Member, Board of Pharmacy

SUBJECT: HB 225 Practice of
Optometry/Use of Drugs

I have several questions and concerns about this bill that you can perhaps have addressed when it is being discussed in the Legislature.

1. There are apparently going to be two classes of Optometrists- Those who have been approved to prescribe drugs and those who have not. In AS 08.64.170(e) it says that the names of those who can prescribe drugs will be furnished to the Board of Pharmacy. Are we then going to have to issue lists of the nature of their authority to prescribe similar to what we do for PA's and ANP's? We are having a difficult time keeping the pharmacies supplied with current lists of these folks that this will add something new for us to be falling behind on.

2. Under the provisions for the use by optometrists for prescription drugs, is this going to include all drugs or just those which are used as drops or ointments to be applied directly to the eye and which have been formulated for that use. If this is the case, and I think it needs to be spelled out, then I would favor this provision with some reservations. I would not, however, feel comfortable if they could prescribe drugs taken internally since it would definitely be a matter of interpretation as to whether a particular drug's use falls into their scope of expertise. The reason I would favor the use of ophthalmic drops or ointments being allowed is that optometrists sometimes recommend that patients buy certain non-ophthalmic ointments to be used in the eye. (We have such a case in Fairbanks and it is rather difficult to handle at times-the Dr. tells that patient to get Neosporin Ointment which says right on the label "do not use in the eye", the patient asks me if it is safe, the Dr. tells me it is, the manufacturer says it is not-liability reasons, I suppose-so that puts me right in the middle of a messy situation. Do I say go ahead? Do I say NO WAY? Or take the most sensible way out and recommend that they go back to the Dr. for a clarification of what he wants. There is an ophthalmic preparation available and it would certainly simplify matters if he were allowed to prescribe it) I would favor having only ophthalmic drops and ointments allowed in the sections dealing with the use of drugs.



March 25, 1983

Mr. Harry Treager, Director
Ms. Wanda Fleming, Licensing Examiner
Department of Commerce & Economic Development
Division of Occupational Licensing
Pouch D
Juneau, Alaska 99811

Dear Mr. Treager & Ms. Fleming:

I'm writing to you in regard to the teleconference call of March 22, 1983.

After a discussion with the legislative committee of the Alaska Optometric Association, I realized that I had erred in my recommendations in regard to HB225. I had assumed that all sections of the bill were changes in the optometry law whereas Section 08.64.360 is part of the state medical law.

I had recommended changing the first three lines of that section. Inasmuch as HB225 is amending the current medical law, Section 08.64.360, and that I am in agreement with the amendment, I am retracting the recommendation I gave during the teleconference call.

I discussed this with Doctors Falconer and O'Connell individually by phone yesterday and they agreed that a retraction is in order. Thus, our only recommendation on HB225 is that endorsement be obtained by examination.

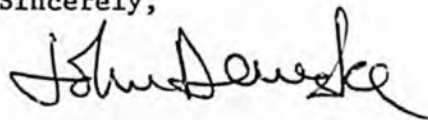
Since the teleconference, an identical bill has been introduced in the Senate as SB189. We would appreciate your submitting our recommendation to the Health, Education and Social Services committees of both the House and the Senate.

Per your request, I have contacted Tom Eichorst, counsel for the American Optometric Association in St. Louis, Missouri, in regard to registration with the Drug Enforcement Administration (DEA). He informed me that he is not aware of any problems with DEA registration in states where optometrists use therapeutic drugs. At his suggestion, I called John Robinson, O.D., Secretary for the North Carolina Optometry Board. Dr. Robinson stated that the individual optometrist applies for the federal DEA number. The DEA then verifies the doctor's credentials with the Secretary of the State Board. The DEA number is then issued and printed on the doctor's prescription blanks. Dr. Robinson added that to date, they have not had any conflicts with the DEA or their Board of Pharmacy.

Mr. Harry Treager, Director
Ms. Wanda Fleming, Licensing Examiner
March 25, 1983
Page 2

I hope that this information is helpful to you. Mr. Eichorst mentioned that you could contact him directly if you had any further questions. He can be reached at (314) 991-4100.

Sincerely,

A handwritten signature in cursive script, appearing to read "John A. Demske".

JOHN A. DEMSKE, O.D.
Secretary, Board of Optometry

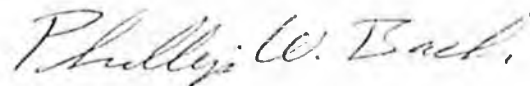
cc: Dr. Maynard Falconer
Dr. Robert O'Connell

cost free basis from an interested group such as the Alaska Optometric Association. Mr. Treager appears to display a personal antipathy toward the bill, and I expect that he will attempt to attach a fiscal note to cause the bill to be referred to the Finance Committee. The Department of Health and Social Services attached a fiscal note to a similar bill, CSSB 136, in the Twelfth Alaska Legislature. Then, as now, Sen. Don Bennett was Co-Chairman of the Finance Committee. Senator Bennett was and is employed by a medical clinic on which staff are ophthalmologists. Senator Bennett would not agree to consider the bill without revisions unacceptable to optometry. A similar situation could be expected to obtain should the bill again be referred to the Finance Committee.

3. David Spence, MD, of the Department of Health and Social Services, proposed stricter and more specific requirements for certification in drug usage than those provided for in the bill, "to insure protection of the public". While it is appropriate that his department provide input regarding health legislation, his testimony failed to indicate why such presumed safeguards are needed for optometry but not for dentistry. Dr. Spence also advocated joint promulgation of regulations by the optometry and medical boards. However any such arrangement that would give the medical board effective veto power over the regulations is considered unacceptable to optometry, because when this has been tried in other states (e.g. Montana and Texas), the medical board has either failed to act or has set standards that are inconsistent with those required for the other autonomous prescribing professions of medicine, dentistry and podiatry.

Also in regard to Dr. Spence's suggestions, I would note that the evolving body of case law contains a court decision declaring unconstitutional a provision of licensing law restricting the kinds of similar surgical operations that podiatrists are allowed to perform. Some legal authorities believe this case may be applicable to other fields, including optometry, where, for instance, exclusion from optometric use of all but a few diagnostic drugs may be impermissible in the absence of clearly demonstrated benefits to the public safety and welfare. A copy of this analysis is attached. In the same connection, I have also attached a letter dated March 3, 1981 from Dean Thomas L. Lewis, of Pennsylvania College of Optometry, outlining the classes of drugs currently taught at that institution. I also notice his use of the term, "legend drugs", on page 3.

Very truly yours,



Phillip W. Bach, O.D., Ph.D.
Legislative Committee, Alaska
Optometric Association

PWB/lr

Attachments: 2

State court stomps on licensing provision

For several years it has appeared that, even though private sector certifying agencies were legally vulnerable to antitrust attack, state licensing agencies and boards were sturdily protected. In December 1981, however, a circuit court in Montgomery, AL, struck down a state licensing scheme that set limits on the scope of practice of a health profession.

At issue in the case, captioned *Wood v. Graddick*, was a portion of the state licensing law for podiatry that prohibited podiatrists from working on the tarsals of the human foot. The law allowed them to work with all other parts of the foot, but reserved the tarsals to the jurisdiction of the medical profession.

That distinction, said the court, is malodorous. The court found no reason why podiatrists could be considered competent enough to operate on the metatarsals and phalanges, but not the tarsals. The court's opinion noted that the law effectively keeps many podiatrists out of Alabama. And, comparing podiatric education favorably to medical training, the court found:

... it appears that podiatrists are better qualified than osteopaths and MDs, by education training, and experience, to treat the tarsals, and are at least as well qualified as orthopedists, who comprise only 5 percent of the medical doctor population.

What is significant about the case is its use of a legal theory seldom applied to occupational licensure. The 14th Amendment to the U.S. Constitution—the same amendment that mandates states to provide “due process of law”—also mandates them to afford “equal protection of the laws” to everyone. Distinctions in laws or regulations that establish two classes of persons and treat them differently must be rationally related to a legitimate state purpose.

In the *Wood* case the two classes were physicians and podiatrists. The former were permitted to operate on the tarsals, while the latter were not. Because the court found that this distinction bore no rational relationship to the state's legitimate purpose of protecting the public health, the court struck down the relevant provisions of

the podiatric licensing law.

Indeed, the court went so far as to say that, not only must all licensed podiatrists be permitted to operate on the tarsals, but also many medical doctors probably should be prohibited by law from performing surgical procedures on the tarsals:

... the classification scheme adopted by the legislature as it relates to the tarsal bones of the foot is both overinclusive—by including within the preferential class many medical doctors who are unqualified—and underinclusive because it excludes podiatrists who are qualified to perform surgery to the tarsal bones.

Currently, all licensed physicians enjoy unlimited licensure, with no bounds on their scope of practice, in all states. Here, the court suggests that some bounds should be applied as a matter of law. However, the court did not draw such bounds itself, granting only enough relief to permit licensed podiatrists to handle the tarsals.

We now may assume that further litigation will develop, across the country, to strike down arbitrary scope of practice limits in state licensing laws. The result could revolutionize licensure by requiring professions that receive preferential treatment under the laws to show that they are better qualified than other professions to perform the specific functions at issue. Clinical social workers prohibited from practicing psychotherapy, nurse practitioners and physician assistants banned from prescribing common drugs, nurse-midwives effectively denied hospital privileges as a matter of law, and optometrists, pharmacists, and the bevy of other professions with reasonable gripes about licensure could be favorably affected.

A few words of caution. Alabama was the only state maintaining this bizarre prohibition on podiatry. On issues where there is a reasonable division of opinion among states, the result could be very different. Also, this is a state trial court opinion only. It lacks the force of precedent that a higher state court or a federal court could provide. But it does suggest the availability of a remedy to occupational groups that are short-shrifted by legislatures in the enactment of licensure laws.

Supplement to Commission Reports
Vol. 3, No. 3, Summer 1982

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1101 30th Street, N.W. Washington, D.C. 20007



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

Office of Academic Affairs

**Pennsylvania College
of Optometry**

March 3, 1981

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

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

Dear Doctor Bach:

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

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

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

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

- I. Topical Anesthetics
 - Example: Proparacaine
Benoxinate

- II. Mydriatics
 - A. Sympathomimetics
 - Example: Phenylephrine
 - B. Parasympatholytics
 - Example: Atropine group

- III. Cycloplegics
 - A. Parasympatholytics
 - Examples: Atropine group
Cyclopentolate

- IV. Miotics
 - A. Examples: Pilocarpine
Anticholinesterases

- V. Antimicrobials
 - A. Antibiotics
 - Examples: Tetracycline
Erythromycin
Gentamicin
Chloramphenicol
Bacitracin
Cephalosporins
 - B. Antibacterial
 - Example: Sulfonamides
 - C. Antiviral
 - Example: Idoxuridine
 - D. Antifungal
 - Example: Natamycin

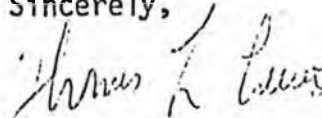
- VI. Anti-inflammatory
 - Example: Corticosteroids

- VII. Anti-glaucoma
 - A. Sympathomimetics
 - Example: Epinephrine
 - B. Sympatholytic
 - Example: Timolol Maleate
 - C. Parasympathomimetics
 - Examples: Pilocarpine
Anticholinesterases
 - D. Carbonic Anhydrase Inhibitors
 - Example: Acetazolamide

- VIII. Antihistamines
Examples: Diphenhydramine
Antazoline
- IX. Miscellaneous Legend Drugs
Example: Hyperosmotic Agents
- X. Over-the-counter Drugs
Example: Dyes
Ocular Lubricants
Decongestants

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

Sincerely,



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

TLL:dmf

WEST VIRGINIA BOARD OF OPTOMETRY

JOHN E. CASTO, O.D.

SECRETARY-TREASURER

WEST VIRGINIA BOARD OF OPTOMETRY

511 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.

The Honorable Warren R. McGraw
The Honorable Clyde M. See, Jr.
February 27, 1981
Page 2

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

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
POSITION PAPER
SB 189/HB 225

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

The above-cited legislative bills are the same in wording, intent, and subject matter.

The Department of Commerce and Economic Development opposes this legislation for the following reasons:

1. This legislation does not protect the public. There is no identified public support or hue and cry for the passage of this legislation.
2. It provides broad prescriptive authority for controlled substances (drugs) without verification of the practitioners' ability.
3. The use of the term "legend drugs" is too broad for the number of drugs that are normally used in the treatment of eye and eyelid conditions.


"Legend drugs" according to this bill are "drugs whose containers must bear a label prohibiting dispensing without a prescription." This is a useless definition.

4. The Department of Health and Social Services has testified against the bill.


This legislation is a State sanction for the use of all legend drugs by a professional group not educated in their use, or results and effects of the broad spectrum use. It does not afford the public protection necessary in prescribing and distributing control substances.

The bill, in its present form, must be opposed as being too broad in the wide use of the terms "may use and prescribe legend drugs, as defined in AS 08.72.300, if the person's license is endorsed by the Board of Examiners in Optometry as provided in AS 08.72." Section AS 08.72.300 does not sufficiently identify the drugs. The term "legend" is too broad and all encompassing.

The bill lacks public protection that should be a must when mandating the authorization of drug prescription and distribution.



Harry D. Treager, Director
Division of Occupational Licensing

 5/2/83

Richard A. Lyon, Commissioner

Whereas; permanent, irreversible damage to eyes have resulted from the inability to diagnose and recognize serious eye disorders by optometrists, the following referral guidelines are recommended:

Sec. 2 AS or 300 (2) is amended by adding a new section to read:

When an optometrist examines any person, he shall inform that person or a parent or other responsible party, prior to prescribing or providing eyeglasses or any other service, that examination by a licensed physician

is indicated whenever any of the following conditions is present. These conditions fall into the following categories:

- I. ABNORMALITIES OF VISION
- II. ABNORMALITIES OF TISSUE
- III. ABNORMALITIES OF MOTOR FUNCTION
- IV. OTHER ABNORMALITIES

ABNORMALITIES OF VISION:

- A. Failure on the part of an individual to obtain 20/20 vision in each eye, 20/40 in children under eight years of age by refractive correction by lenses unless the cause has been medically determined by a physician and is stable.
- B. A complaint by the individual of the sudden appearance of spots, flashing lights, scintillating images, transient dimming, less vision, or distortion in the shape of objects.
- C. A complaint by the individual of a temporary or permanent loss of any portion of the visual field, such as a curtain coming over the vision.
- D. History of seeing rainbows or halos around lights.
- E. Diplopia (Double Vision) of sudden onset.

ABNORMALITIES OF TISSUE:

- A. Presence of redness, swelling, masses, or ulceration of the eye or its surrounding tissue.
- B. Opacities of the cornea, lenses or vitreous.
- C. Changes in the appearance of the optic disc.
 - 1. A difference in appearance between the optic discs of each eye.
 - 2. A change in appearance of the optic discs from a previous exam.
 - 3. Suspicion of elevation of the optic nerve head.
- D. Observation of a deviation from the usual appearance of the retina or its vessels.

ABNORMALITIES OF MOTOR FUNCTION:

- A. Strabismus, a deviation of the eyes from their normal parallel position in straight ahead gaze or gaze in any direction.
- B. Difference in the size of the pupils or failure to constrict with illumination or with near vision.
- C. Ptosis or Lagophthalmos (Drooping of the eyelids).
- D. Nystagmus (Rapidly occilating eye movements).

OTHER:

- A. Continuous tearing of longer than 24 hours duration or complaints of watering eyes not associated with visual tasks.
- B. Intraocular tension of twenty-two or more, or family history of glaucoma.
- C. Any other observation of deviation from the normal appearance of the eye and related tissues, or any complaint that is not attributable to the refractive state or muscle balance or which is not amenable to lenses or prisms.
- D. Keratometry readings greater than 47.00 diopters or suggesting keratoconus.

Exception to any of the preceeding conditions would be previous evaluation by a physician and discharge from medical treatment and follow-up for that condition.

Failure to comply with the provisions of this act shall subject the offender to the revocation or suspension of his license to practice optometry.

Nothing in the provisions of this section or any other section pertaining to optometry shall apply to, nor in any way restrict the practice of medicine, or osteopathy, nor to any licensed physician, osteopath, nor any nurse, technician, medical assistant, optician, nor to any allied or auxiliary health personnel acting under their prescription, supervision or direction, nor to any eye screening, state or government eye testing program, nor to any eye teaching in any medical, osteopathic or nursing or allied health personnel school.

This act shall take effect immediately.

Over many years, ophthalmologists have seen the continued and perplexing problem of delayed or non-referral by optometrists. There are two reasons why ophthalmologists are concerned about this: 1. irreversible loss of vision can and has occurred. 2. the ophthalmologists eventually treat these people, and often we feel that some or more sight could have been preserved if earlier treatment had been instituted. The ophthalmologists feel that the optometrists are trained to recognize the symptoms of many diseases which may be discovered by history, visual acuity testing, refraction, tonometry and external examination. They are not permitted under recognized optometric standards to undertake a definitive diagnosis, but recognize this as the responsibility of the medical doctor, and to refer that person to a doctor. For these reasons, we feel that a 20/40 bill would help with the problem of delayed referral and non-referral.

In reviewing a small fraction of one ophthalmologist's files, we find 9 well documented cases of delayed or non-referral. It is our opinion that this resulted in harm or potential harm.

Case #1

This person complained of double vision to an optometrist. He was not referred to a medical doctor. Finally the patient came to an ophthalmologist where the diagnosis of myasthenia gravis was made. This disease can kill by respiratory arrest.

Case #2

This person went to an optometrist with an eye complaint and was told by the optometrist that he thought he had something bad and to come back tomorrow for a field. This patient finally went to an ophthalmologist and was determined to have a retinal detachment. It is well known by the ophthalmologists that the earlier the detachment is repaired the better the vision will be after the surgery.

Case #3

This person was a diabetic and had a cataract in the left eye. This person was told by an optometrist that it was not necessary to do anything about the eye. This person had an iritis or inflammation of the eye from leaking of lens protein. This

person finally went to an ophthalmologist and underwent immediate cataract surgery. It is well known by the ophthalmologists that this can lead to adhesion of the iris to the diseased lens and/or cornea, resulting in permanent glaucoma and irreversible loss of vision.

Case #4

This person went to the optometrist because of decreased vision. He was told that he had a cataract and to see an ophthalmologist about it. He was left with the impression that there was no hurry. This person's vision became worse and he then saw an ophthalmologist who determined that he had a retinal detachment. It is well known by ophthalmologists that early repair of retinal detachments not involving the central part of the retina most often results in 20/20 vision. But, if surgery is delayed and the central part of the retina (macula) detaches or pulls off, the visual outcome is poor.

Case #5

This child had difficulty with his school work and did not want to go to school. His parents were told by an optometrist that the child was malingering or faking. This child was seriously reprimanded by the parents. The child finally saw an ophthalmologist and was determined to have Stargart's disease. This condition is well known by the ophthalmologist to cause serious problem with vision.

Cases #6,7,8,9

All of these people were diabetics. The optometrists did not tell these people to see an ophthalmologist for their potentially serious eye manifestations of diabetes. By the time these people finally saw the ophthalmologist time had run out, serious eye problems of diabetes had already set in. It is well known by the ophthalmologist that early treatment with laser can preserve vision

Case #10

This is the well known Timothy Steele case. This child was seen by an optometrist in Fairbanks because his eyes were crossing. A dilating eye drop was used to dilate the child's eyes. The optometrist's record noted "No good reflex" in Timothy's right eye. He diagnosed Timothy's eye condition as accommodative esotropia, which is correctable by eyeglasses. He wrote a prescription for eyeglasses and made an appointment for Timothy to return to the clinic on January 29, 1974, for a checkup.

On January 29, 1974, Timothy reported to Mr Shank as requested. The optometrist wrote a different prescription for eyeglasses and instructed Mrs. Steele to make another appointment for Timothy four months after he would begin wearing the new glasses.

The testimony further reveals that in early May, Mrs. Steel noticed that Timothy frequently removed his glasses, saying sometimes he could not see well with them.

On June 10, 1974, Timothy was again examined by Mr. Shank and it was then that he discovered that the vision in Timothy's right eye was limited to light perception. At this point, Mr. Shank made an appointment for Timothy with ophthalmologist Bruce Wolf, M. D., of Fairbanks.

When Dr. Wolf, a medical doctor, examined Timothy on June 17, 1974, he found Timothy's visual acuity in the right eye limited to hand motions and capable of perceiving light. Essentially, his right eye was blind.

Recognizing the seriousness of the case, Dr. Wolf called in William Kinn, M. D., as a consultant. On July 9, 1974, Dr. Wolf and Dr. Kinn observed a retinal detachment of the right eye with a subretinal mass. Their diagnosis was possible retinoblastoma, but toxocara canis was also to be considered. Concluding that specific tests were necessary to identify the disease, Timothy was flown to Letterman Army Medical Center where he was examined on July 12, 1974.

At Letterman, it was determined that, because of the danger of retinoblastoma, a fast-spreading, life-threatening malignancy, Timothy's eye should be removed. With parental consent, the surgery

was performed by Major Bradley C. Black, M. D.

When the pathological report ruled out retinoblastoma, Timothy was returned to surgery and an implant was placed in the socket. Although recovery appeared to be good, Timothy continued to suffer from periodic socket inflammation.

In September of 1974, Timothy returned to Leterman Medical Center where a prosthesis was inserted in the socket. Testimony revealed that since the prosthesis could not be inserted immediately following the operation, it is unlikely that it will ever appear similar to a natural eye.

Dr. Black was also aware of several cases where inflammation of the eye was treated with steroids, and in isolated cases steroid treatment has decreased the inflammation, resulting in minimal scarring. But in Dr. Black's opinion, in most instances toxocara is not seen by the ophthalmologist until it has been quite destructive. However, assuming that visual acuity in Timothy's right eye was 20/30 in December of 1973 and treatment with steroids was instituted, some vision might have been salvaged.

In Dr. Wolf's opinion, if Timothy had been seen by an ophthalmologist in 1973, very possibly the eye could have been saved. Since a granulomatous inflammation is a cellular reaction to a foreign object, treatment would be taken to block the reaction. Steroids are a recognized form of treatment for granulomatous inflammation.

This case was tried by Judge James M. Fitzgerald, United States District Judge, District of Alaska. The Judges decision was:

"I conclude that competent optometric practice required that Timothy's parents be notified and that the child be referred. The failure to inform and refer was not a 'judgement call' but a violation of the governing principles of professional standards.

Optometrists are trained to recognize symptoms of many diseases which may be discovered by eye examination. They are not permitted under recognized optometric standards to undertake a definite diagnosis but recognize this as the responsibility of a medical doctor. Obviously, it is foreseeable that failure to refer to a qualified medical practitioner, when required to do so, will result in delay of diagnosis and the institution of treatment; so it proved to be in Timothy's case. At the time the referral was finally made to an ophthalmologist, it was too late. Time had run out, and the only thing that could be done was to remove the eye.

I conclude that the plaintiff is entitled to recover in this action from the United States for the loss of Timothy's right eye.
DATED at Anchorage, Alaska, this 20th day of October, 1978."

ss: James M. Fitzgerald
United States District Judge

It is thus obvious if this bill were passed then statutory law would be completely consistent with common law or court decision.

You will hear from the optometrists that they cannot get their people in to see the ophthalmologist immediately. But, what they do not tell you is that there is a city call schedule in both Fairbanks and Anchorage with an ophthalmologist available 24 hours a day to see people and all that has to be done is to call the emergency rooms to get the name of the ophthalmologist for that week, and that patient can be seen the same day. They have not told you that there are now new ophthalmologists that have started practice in the state and that more often than not they can get their people in with one of them the same day.

You will also hear from the optometrist that this bill will seriously restrict them, that this is a restraint of trade, that this bill is designed by the ophthalmologists to bring them more income. This simply is not true. The criteria of referral written into this bill are what is called the LeMoine criteria. This is what is taught in the schools of optometry as indications for referral to a competent medical doctor. This is even in their textbooks: "The Optometric Profession" by Hirsch and Wick. Why, then, are they opposed to this type of legislation when it merely reiterates in law what is considered by the textbooks of optometry as a standard of optometric practice?

The reason is economics, which is tied together very closely with a national attempt to change the standards of optometric practice, as well as public and governmental image. This is done by legislative "drug bills" and advertising. The essence of the court's decision in the Timothy Steele case was that optometrists, and schools of optometry (compared to Ophthalmology) will not be allowed to set their own standards as to what they can and cannot do. The court's decision recognized that optometrists are not sufficiently trained to make the same kinds of decisions that ophthalmologist M.D.'s can, and should make, in situations similar to that presented in Timothy's case. See Tables I, Ia, Ib

ECONOMICS AND PRACTICE?

Table 3⁵ shows the substantial number of public dollars which are expended for eye care. A total of approximately \$4,135 million dollars were spent in 1975 for vision care services.⁶ The national consumer spending for ophthalmic surgery is not listed. This would make the total ophthalmologic dollar spent on eye care far greater than the optometric dollar. If optometrists are allowed to expand the scope of their practice through the use of diagnostic drugs, the price of the basic eye examination would undoubtedly rise. Proposed national health care legislation can be expected to impact heavily upon these figures. For example, if the Kennedy-Mills National Health Insurance proposal were to include coverage of sight correction services, total spending for these services would rise by 21% or \$866 million dollars per year. It is obvious that there will be considerable effort by optometrists to ensure their fullest possible participation in this program. The economic stakes are very high.⁷ This makes it very clear why optometry has put on an aggressive nationally organized push to legislate themselves into a better position to compete for this consumer dollar. Even though optometrists in the State of Alaska suggest that this is not an "economic issue"---it is. The optometric opposition to this bill is due to continued effort toward the national optometric goal of attempting to become primary eye care providers.

This image change is being sold to the public by a sophisticated national advertising campaign. This multi-million dollar campaign is funded by the national optometric organization through dues and special assessments. They are trying to sell themselves as "your family doctor of optometry...the one to see and keep seeing". Calling themselves family doctors in the opinion of the ophthalmologists is misleading since they are not medical doctors as are the family practitioner or family doctor. These adds are occurring on national T.V., radio and magazines; such as, The Ladies Home Journal, Better Homes and Gardens, etc. Adds that show stethoscopes hanging around the neck of the optometrist is also misleading, as the general public associates the medical doctor with the stethoscope. One article in the Anchorage Times even referred to a group of optometrists as physicians and the word ophthalmologist was used. (see supporting documents)

Let us examine the basis for supporting the Lemoine criteria. In an article "How the General Practitioner can Determine The Need for Ophthalmologic Referral", it was shown that by history (listening to the patient's story), visual acuity and external examination by hand-held flashlight, most of the initial clues to eye disease are determined, 85% in fact.

Examination Elements That Indicated Ophthalmologic
Disease in 716 Patients.

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

All of the Lemoine criteria of referral are symptoms of disease and require no instrumentation except for two: looking at the optic disk through an undilated pupil and checking the "K" readings on a keratometer. No eye drops are needed, since the optic disc is in the posterior pole of the eye and simply putting the small aperture disk in place on the ophthalmoscope even the smallest pupil can be seen through. It is obvious from this article that detection of 99% of all eye disease is possible without dilation. All of these examining techniques can be done by the optometrist at this time in the State of Alaska.

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

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

By now you have heard from the optometrists that there is another law suit filed against an Anchorage optometrist. They also state that if they could dilate the pupil to look in that the law suit would not have been filed. Well, the optometrist dilated Timothy Steele's pupil and still a law suit was filed and was won by Timothy Steele. The falacy of this statement by the optometrists is clear in light of Judge Fitzgerald's decision and the article on what people need ophthalmologic referral.

If this bill were passed, it would clear up once and for all through statutory law that what is already clear through common law and optometric textbooks. Judge James M. Fitzgerald clearly states this in his decision:

"I conclude that competent optometric practice required that Timothy's parents be notified and that the child be referred. The failure to inform and refer was not a 'judgement call' but a violation of the governing principles of professional standards.

Optometrists are trained to recognize symptoms of many diseases which may be discovered by eye examination. They are not permitted under recognized optometric standards to undertake a definite diagnosis, but recognize this as the responsibility of a medical doctor. Obviously, it is foreseeable that failure to refer to a qualified medical practitioner, when required to do so, will result in delay of diagnosis and the institution of treatment; so it proved to be in Timothy's case. At the time the referral was finally made to an ophthalmologist, it was too late. Time had run out, and the only thing that could be done was to remove the eye.

I conclude that the plaintiff is entitled to recover in this action from the United States for the loss of Timothy's right eye.

DATED at Anchorage, Alaska, this 20th day of October, 1978."

ss: James M. Fitzgerald

United States District Judge

Thank you for your time and the opportunity to present the views endorsed
by the State Ophthalmologic Association.

May 4, 1983

The Honorable Joe Josephson
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson,

I am writing to you one more time in regard to SB 189, relating to the use of prescription drugs by optometrists.

I am sending a letter by Dr. John Casto of West Virginia. You may recall that West Virginia is one of the states where optometrists use therapeutic drugs. Dr. Casto's letter is an update on the Board of Optometry's post facto report to the legislature. The Board requires all doctors who use drugs (183 out of the 260 O.D.s in the state) to keep a log of: 1) Name of patient treated, 2) Disease treated, 3) Drug used 4) Side effects and 5) Number of miles saved by the patient by non-referral.

Dr. Casto mentioned by phone that there have been several allegations by physicians of misdiagnosis and mis-treatment by optometrists. The Board sent letters of inquiry by certified mail to the involved physicians. To date, none of the letters were ever answered.

I trust that you'll find this information helpful.

Dear Doctor Demske:

Thank you for your note and the copy of the letter from Dr. Casto of West Virginia. I will keep these your thoughts in mind as we proceed with our study of SB 189.

Sincerely,
John Demske, O.D.
JOHN DEMSKE, O.D.
PO Box 528
Bethel, AK.

WEST VIRGINIA BOARD OF OPTOMETRY

JOHN E. CASTO, O.D.

SECRETARY-TREASURER

WEST VIRGINIA BOARD OF OPTOMETRY

511 SIXTH AVE.

P.O. BOX 710

ST. ALBANS, W.VA. 25177

April 27, 1983



The Honorable Warren R. McFay
President, Senate of West Virginia
State Capitol Building
Charleston, West Virginia 25305

The Honorable Clyde H. 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 McFay 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 assigned 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 regulation of this law.

Recent information compiled from the one hundred eighty-three (183) West Virginia registered optometrists now certified by this Board for drug usage is as follows:

1. A total of seventy-four (74) different drugs prescribable for the human eye have been employed by those West Virginia certified optometrists since the law was enacted.

2. Over one hundred thousand (100,000) individual patients have been seen by these optometrists and conditions such as injuries or allergic conjunctivitis, corneal abrasions, and blepharitis (granular eye lids) have been treated by those certified in the completion. This does not include the use of topical anesthetics used routinely by most of these optometrists in performing tonometry (glaucoma test). It is estimated that some one and one quarter million (1,250,000) patients have been administered a topical anesthetic for this testing procedure.

WEST VIRGINIA BOARD OF OPTOMETRY

JOHN E. CASTO, O.D.

SECRETARY-TREASURER

WEST VIRGINIA BOARD OF OPTOMETRY

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The Honorable Warren R. McGraw

The Honorable Clyde M. See, Jr.

January 25, 1983

Page 2

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 appropriate medical specialties to whom they formerly were referred, would have been required to travel is nearly one million eight hundred thousand miles (1,800,000).

4. Fifty-three (53) different pathological conditions have been diagnosed and treated by these West Virginia certified optometrists.

These 183 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 unusual adverse drug reaction to patients where drugs were administered.

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. This data was compiled in a continuing effort to support the trust which has been reposed in us. 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.
Secretary-Treasurer
West Virginia Board of Optometry