

**HB**

**222**

## FISCAL NOTE

**REQUEST:**

Revision Date: \_\_\_\_\_  
 Title: An Act relating to optometrists and opticians.  
 Sponsor: House HESS Committee  
 Requestor: House HESS Committee

Agency Affected: Commerce & Economic Dev.  
 BRU: Occupational Licensing  
 Components: All

**EXPENDITURES/REVENUES:** (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	0	0	0	0	0	0
<b>CAPITAL</b>						
<b>REVENUE</b>	0	0	0	0	0	0

**FUNDING:** (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
<b>TOTAL</b>	0	0	0	0	0	0

**POSITIONS:**

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

**ANALYSIS :** (Attach a separate page if necessary)

Prepared by: Jennifer Strickler, Admin. Officer Phone: 465-2144  
 Division: Occupational Licensing Date: 2/5/90  
 Approved by Commissioner: Larry Mercurieff Date: 5 Feb 90  
 Agency: Commerce and Economic Development

Distribution (by preparer):  
 Legislative Finance  
 Legislative Sponsor  
 Requestor  
 Office of Management and Budget  
 Impacted Agency(ies)



# AMERICAN ACADEMY OF OPHTHALMOLOGY

---

OFFICE OF STATE AND  
SUBSPECIALTY RELATIONS

STEVEN D. CARTER  
*Director*

RICHARD H. PAUL  
*Manager, State Government Relations*

COLISE G. MEDVED  
*State Relations Assistant*

May 8, 1990

The Honorable Richard Eliason  
Alaska State Senate  
State Capitol  
Pouch V  
Juneau, AK 99811

Dear Senator Eliason:

At the request of Samuel A. McConkey, MD, I am taking the liberty of providing you with information concerning the proposed expansion of the optometric scope of practice, which I understand is pending in your state.

As you will notice in some of these materials, state legislatures have repeatedly turned down the requests of organized optometry to treat medical disorders. As you may know, Alaska was one of the last two states to permit ODs to use any pharmaceuticals in their practice, and now they are limited to so-called "diagnostic" drugs.

You may be interested to know that the optometrists have not been satisfied with passage of a "therapeutic" bill. In one state (Nebraska) this year, and in two states last year (North Dakota and Montana), optometrists sought to further expand their scope of practice by adding items that were excluded when they agreed to compromise bills previously. In all three instances, the legislature defeated the attempt.

It is important to note that there have been problems in states which have approved these bills. Most often, the "problems" are not from side-effects caused by the drugs, but rather are caused by a misdiagnosis by the optometrist. This, perhaps, is the most serious threat since optometric training does not include medical differential diagnosis. Enclosed are excerpts from several articles with examples.

The Honorable Richard Eliason

May 8, 1990

Page 2

As two other examples, we were made aware of a woman from North Carolina who died after being given Timoptic, a glaucoma eye drop, by an optometrist. She had asthma which is a clear contra-indication for this particular medication. It is certainly probable that somebody with a well-rounded medical training would not have prescribed this drug for a known asthmatic.

The second case involves a resident of Vermont who was in Florida for the winter. She awoke one morning with a painful, slightly red eye and sensitivity to light. The Florida optometrist "diagnosed" conjunctivitis, a mild eye infection. It actually was a serious inflammation called iritis. The antibiotic drug did nothing to solve the problem which was correctly diagnosed only after the woman went home to Vermont and called her own ophthalmologist. The point here is that some cases of "red eye" are not merely minor infections, and they are not always easily identified.

I'm sure that optometrists in your state will claim that there have been no problems in any of the other states that have passed this legislation. This argument is hard to swallow in any sense. But it becomes more understandable when you take into account the following facts:

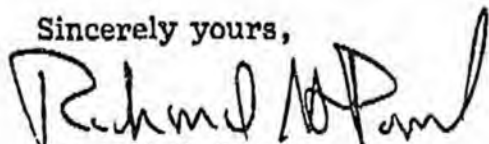
- ▶ The states that have passed "therapeutic" laws are generally the least populous, representing less than 30 percent of the U.S. population.
- ▶ Barely half of the optometrists in these states have bothered to get certified under their expanded laws to treat eye diseases.
- ▶ Of these, as reported by the Review of Optometry, only about four percent treat any disease on a regular basis.

Given this information, it would seem unlikely that there would be an avalanche of problems being reported. Plus, there is no central location where problem cases are collected, so reliable statistics and examples are not readily available.

I hope this information, along with the attachments, are useful. Please feel free to call me if you have any questions. As you can well imagine, this issue -- like many -- has numerous facets that are hard to cover in one letter.

Thank you for your interest in this issue.

Sincerely yours,



Richard H. Paul

RHP:les  
Enclosures

cc: Samuel A. McConkey, MD

## Optometric Bills Enacted & Defeated

Following is a table which shows, by state, the number of attempts optometrists have made to pass or expand a therapeutic scope of practice bill. A failed attempt is indicated by an "X." A successful try resulting in a bill being enacted is indicated with an "O." Bills currently pending are designated by a question mark.

ALABAMA	X	X	X	X	?
ALASKA	X				
ARIZONA	X	X	X	X	
ARKANSAS	O				
<hr/> CALIFORNIA					
COLORADO	O				
<hr/> CONNECTICUT					
DELAWARE	X	X			?
<hr/> D.C.					
FLORIDA	X	X	X	O	
<hr/> GEORGIA					
HAWAII					
IDAHO	O				
ILLINOIS	?				
INDIANA	*				
<hr/> IOWA					
IOWA	O	O			
KANSAS	X	O			
KENTUCKY	X	X	O		
LOUISIANA	X	X	X	X	
MAINE	O				
<hr/> MARYLAND					
MASSACHUSETTS	?				
MICHIGAN	?				
MINNESOTA	X	X			

X = Defeated

O = Enacted

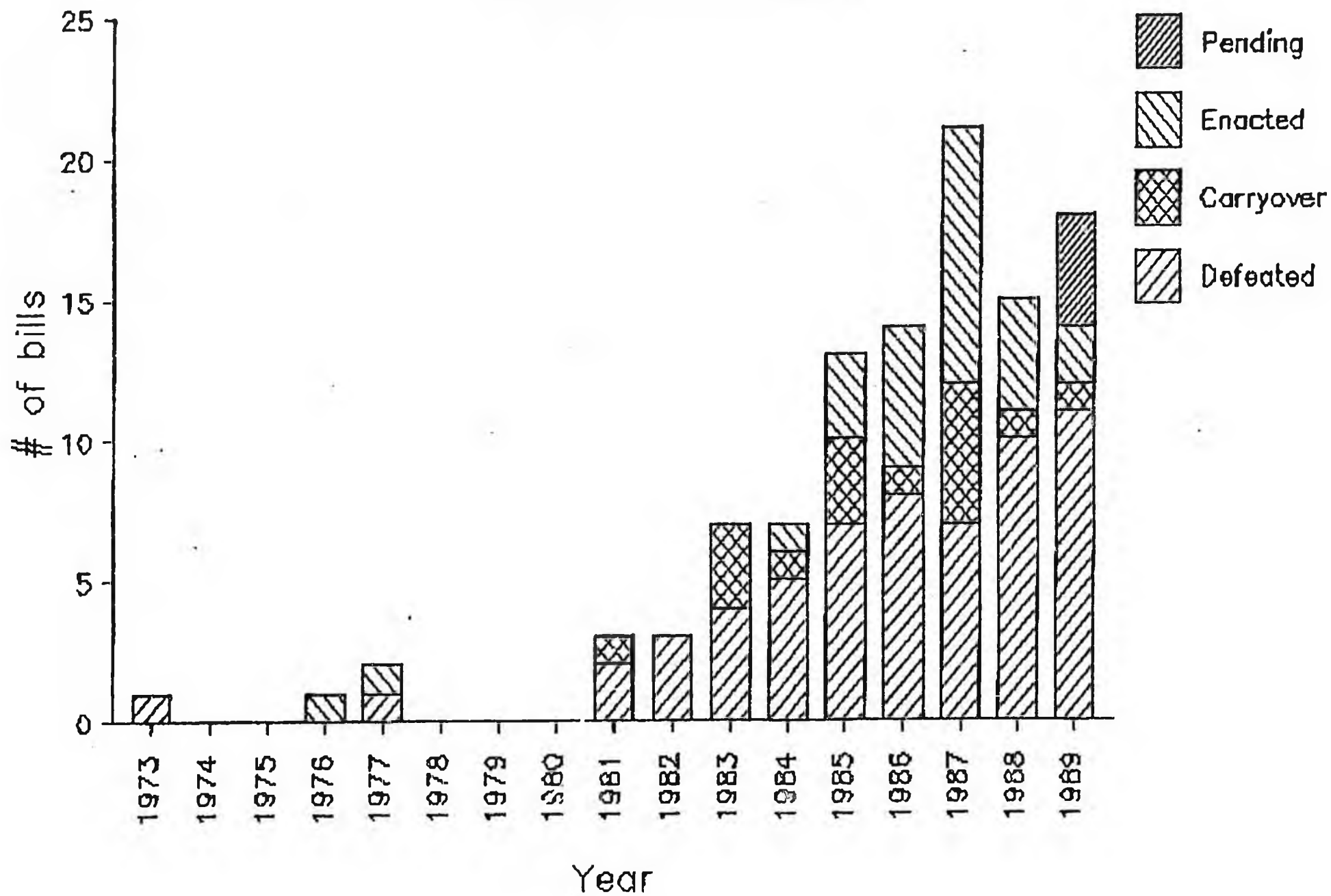
? = Pending

\* No bill proposed.  
Some ODs treat based  
on informal Attorney  
General interpretation.

MISSISSIPPI	X	X	X	X	X	X
MISSOURI	O	O				
MONTANA	O	X				
NEBRASKA	X	O	X			
NEVADA	X	X				
NEW HAMPSHIRE						
<hr/>						
NEW JERSEY	X	X	X	?		
NEW MEXICO	O					
NEW YORK	?					
NORTH CAROLINA	X	O				
NORTH DAKOTA	O	X				
<hr/>						
OHIO	?					
OKLAHOMA	O					
OREGON	X	X	X	X	X	
PENNSYLVANIA	X	X	X	?		
PUERTO RICO						
<hr/>						
RHODE ISLAND	X	O				
SOUTH CAROLINA						
SOUTH DAKOTA	X	O				
TENNESSEE	X	X	X	O		
<hr/>						
TEXAS						
UTAH	X	X	X	X		
VERMONT						
VIRGINIA	X	X	O			
<hr/>						
WASHINGTON	X	X	O			
WEST VIRGINIA	O					
WISCONSIN	X	O				
WYOMING	O					

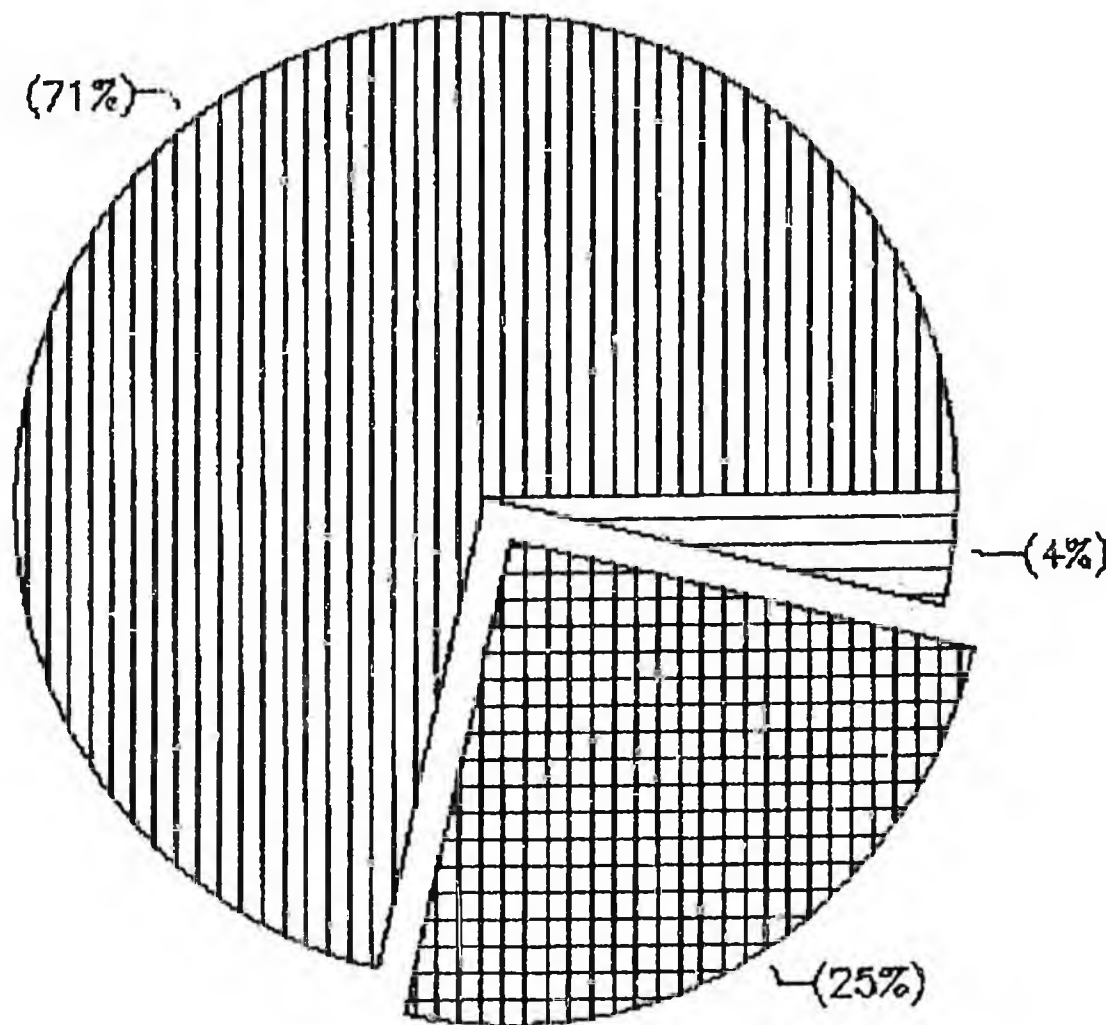
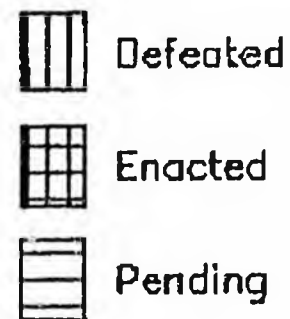
# OD Therapeutic Bills

## Defeated & Enacted



# OD Therapeutic Bills

Defeated & Enacted as of 8/15/89



Updated January 19, 1989

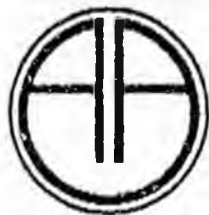
PERCENTAGE OF LICENSED OPTOMETRISTS  
CERTIFIED TO USE PHARMACEUTICAL AGENTS

Only states that have approved "TPA" bills are included in this list. Some states have not yet responded to the inquiry.

C E R T I F I C A T I O N S

	<u>Total Licensed</u>	<u>TPA</u>	<u>DPA ONLY</u>	<u>NONE</u>
Average		51.2%	12.5%	36.3%
ARKANSAS	249	59.0%	22.0%	18.9%
COLORADO*				
FLORIDA	2,322	40.3%	0%	59.7%
GEORGIA*				
IDAHO	305	38.0%	22.6%	39.4%
KANSAS	416	59.3%	21.9%	18.8%
KENTUCKY	500	56.0%	4.0%	40.0%
MAINE				
MISSOURI	759	46.2%	21.0%	32.8%
MONTANA	238	34.5%	37.3%	28.2%
NEBRASKA	228	57.9%	19.7%	22.4%
NEW MEXICO				
NORTH CAROLINA	711	86.1%	0%	13.9%
NORTH DAKOTA	145	62.8%	11.7%	25.5%
OKLAHOMA	540	76.3%	0%	23.7%
RHODE ISLAND	161	24.8%	74.6%	0.6%
SOUTH DAKOTA	124	55.6%	24.1%	20.3%
TENNESSEE	853	41.0%	29.3%	29.7%
VIRGINIA*				
WEST VIRGINIA				
WYOMING				

\* Bill passed in 1988, not implemented as yet.



# AMERICAN ACADEMY OF OPHTHALMOLOGY

## BOARD OF DIRECTORS

GEORGE E. GARCIA, MD  
President  
Boston, MA

BRUCE E. SPIVEY, MD  
Executive Vice-President  
San Francisco, CA

GEORGE W. WEINSTEIN, MD  
President-Elect  
Morgantown, WV

H. DUNBAR HOSKINS, JR., MD  
Secretary for Annual Meeting  
San Francisco, CA

DAN B. JONES, MD  
Secretary for Instruction  
Houston, TX

RONALD E. SMITH, MD  
Secretary for Continuing  
Education  
Los Angeles, CA

HUNTER R. STOKES, MD  
Secretary for Representation  
Florence, SC

RICHARD P. MILLS, MD  
Secretary for Public and  
Professional Information  
Seattle, WA

B. THOMAS HUTCHINSON, MD  
Secretary for Ophthalmic Practice  
Boston, MA

ROBERT D. REINECKE, MD  
Past President  
Philadelphia, PA

MELVIN L. RUBIN, MD  
Past President  
Gainesville, FL

ARNALL PATZ, MD  
Past President  
Baltimore, MD

PAUL R. LICHTER, MD  
Editor  
Ann Arbor, MI

FRONCIE A. GUTMAN, MD  
Director-At-Large  
Cleveland, OH

RICHARD S. RUIZ, MD  
Director-At-Large  
Houston, TX

EDWARD K. ISBEY, JR., MD  
Director-At-Large  
Asheville, NC

CLAUDE L. COWAN, JR., MD  
Director-At-Large  
Washington, DC

MARILYN T. MILLER, MD  
Director-At-Large  
Chicago, IL

THOMAS FREY, MD  
Director-At-Large  
Falls Church, VA

ALLAN D. JENSEN, MD  
Chairman, The Council  
Baltimore, MD

WILLIAM N. OFFUTT IV, MD  
Vice-Chairman, The Council  
Lexington, KY

January 12, 1990

Mr. Larry Gonzalez  
Secretary  
Department of Professional Regulation  
State of Florida  
1940 N. Monroe  
Tallahassee, FL 32399-0775

Dear Mr. Gonzalez:

Your hearing scheduled for January 19, 1990, concerning the Florida Optometric Association's request to expand the optometry drug formulary to include use of steroid medications has been brought to my attention.

On behalf of the 16,000 members of the American Academy of Ophthalmology, and the nearly 900 Academy members in Florida, I would like to go on record as strenuously opposing granting permission for optometrists to prescribe steroids for their patients. Among our reasons for this position are:

- ▶ Twenty-nine states properly recognize the risk involved in use of steroids and prohibit their use in optometry licensing statutes. Another three permit it, but only for an extremely limited period of time.
- ▶ Two states just this year rejected permission for steroid use for the second consecutive legislative session. In fact, one North Dakota state representative who was a party to the "compromise" bill enacted in 1987 which permitted optometrists to treat some eye diseases testified against adding steroids this year. She said, "The safety and welfare of patients was protected by specifically prohibiting the prescription of corticosteroids ... They can be extremely dangerous and must be monitored very closely."
- ▶ Steroids often are used as a post-operative medication, for example, following cataract surgery. Since optometrists are not licensed to provide surgical services in any state (including Florida), they would have no need for access to this medication for post-operative care.

Mr. Larry Gonzalez  
Department of Professional Regulation  
State of Florida  
January 12, 1990  
Page 2

- ▶ Misdiagnosis of medical problems is a major cause of malpractice actions. For example, the Journal of the American Optometric Association reported on a case in its December 1986 issue against a Florida optometrist who employed a topical steroid for treatment of a corneal ulcer that eventually was diagnosed as being due to a Pseudomonas infection. The jury awarded the plaintiff in this case a \$175,000 judgement.

The same Journal article reported on a number of other cases involving the apparent misuse of topical corticosteroids. Long-term use resulted in severe complications, such as cataracts and glaucoma. To quote from the article, "Topical corticosteroids were the leading source of injury (in malpractice claims)..."

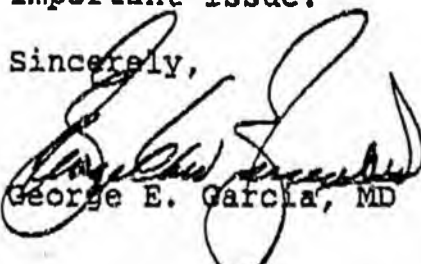
Meanwhile, the September 1989 issue documented two malpractice cases against optometrists caused by "inappropriate use of topical steroids" following apparent misdiagnosis of corneal ulcers.

- ▶ Optometrists themselves recognize the risky nature of steroid medications. In May 1980, the Journal of the American Optometric Association reported, "It is reasonable to state that the indiscriminate use of corticosteroids for any type of red eye has resulted in many cases of unnecessary corneal complications." The July 1989 Journal said, "Topical corticosteroids produce significant adverse reactions with extended use."

The proper use of steroids -- even in topical form -- requires a thorough medical background enabling the physician to make the correct diagnosis and adequately monitor dosage and length of use. Because steroids can mask symptoms, often their improper use results in a much worse condition by the time it is finally diagnosed. Consideration for the public safety and proper medical care clearly indicates that steroid use by optometrists should not be permitted.

Thank you for considering our views as you analyze this very important issue.

Sincerely,

  
George E. Garcia, MD

GEG:les

cc: William J. Knauer, MD

greatly enlarged role as diagnosticians — at the very time errors of diagnosis have been growing in importance as a cause of malpractice claims — it is remarkable that the relative cost of professional liability insurance coverage for optometrists (i.e., as a percentage of income) has remained unchanged.

Because of the increased emphasis on diagnostic errors, however, claims alleging misdiagnosis have become the leading source of large malpractice claims against optometrists.<sup>5,6,7,12</sup> Although the majority of malpractice claims — estimated to be in excess of 40% — arise from contact lens practice,<sup>13</sup> the preponderance of these claims are small. Large claims are usually due to allegations of failure to diagnose ocular disease, with three diseases being of particular importance: open-angle glaucoma, retinal detachments, and tumors. Before the era of diagnostic drug use by optometrists, the ability of clinicians to examine for these diseases was limited. Today, optometrists can expect to be held to a medical standard of care with respect to the examination of patients to rule out the presence of these and other diseases.<sup>14</sup>

### An analysis of 50 claims

Over the past 12 years I have served as a consultant in 50 professional liability claims. This series of cases may not be typical of the experience of the profession as a whole since virtually all of the cases involved claims for substantial damages. For this reason, perhaps, claims involving ophthalmic materials — contact lenses and spectacles — did not constitute the largest category, being limited to 11 of the 50 cases. Rather, misdiagnosis was the most significant category of claims, with 31 of the 50 cases arising directly from allegations of failure to properly diagnose various diseases. Another three cases alleging errors of diagnosis involved contact lens wearers

**Table 1: Malpractice claims against optometrists, 1977-1989**

<b>Misdiagnosis of ocular disease</b>	<b>31 claims</b>
Retinal detachment	10 claims
Open-angle glaucoma	8 claims
Tumors	
Ocular tumors	3 claims
Brain tumors	5 claims
Ocular foreign bodies	3 claims
Diabetic retinopathy	1 claim
Histoplasmosis	1 claim
<b>Ophthalmic materials</b>	<b>11 claims</b>
Contact lenses	
Failure to manage the complications of corneal abrasions	5 claims
Failure to diagnose corneal disease	2 claims
Failure to diagnose intraocular disease	1 claim
Spectacles	
Failure to prescribe polycarbonate plastic	3 claims
<b>Ophthalmic drugs</b>	<b>6 claims</b>
Adverse effects of diagnostic agents	2 claims
Failure to prescribe the appropriate therapeutic agent	4 claims
<b>Binocular vision</b>	<b>2 claims</b>
Failure to treat amblyopia	2 claims

and an additional four claims were based upon alleged misuse of therapeutic drugs. Therefore, a total of 38 of the 50 cases in this series involved misdiagnosis (Table 1).

*Misdiagnosis.* The great majority of claims alleged failure to diagnose open-angle glaucoma, retinal detachment, and tumors. Although open-angle glaucoma was the single largest cause of claims in a previous report on this series,<sup>15</sup> in recent years it has been surpassed by retinal detachment. There are three probable explanations for this change: Optometrists have employed tonometry as a routine procedure for all age brackets and thus fewer cases of open-angle glaucoma go undetected; the emphasis upon primary care by optometry has caused more patients with acute problems such as retinal detachment to seek optometric care, thereby increasing the likelihood of such a claim; and optometrists have found, just as ophthalmologists have,<sup>16,17</sup> that ret-

inal detachment can be an extremely difficult diagnosis to make.

Failure to diagnose tumors was alleged as frequently as failure to detect open-angle glaucoma. It is interesting to note that, of the eight claims involving tumors, only two of them actually concerned an intraocular tumor (malignant melanoma). Another claim involved a lid tumor (basal cell carcinoma), while the majority of claims were caused by failure to diagnose brain tumors with ocular signs or symptoms (i.e., papilledema, diplopia, reduced visual acuity, headaches). Again, it seems reasonable to postulate that the patient population of optometrists has changed and that more patients are seeking eye health services, as compared to refractive services, from optometrists.

Two claims involved ocular manifestations of systemic disease, alleging failure to refer for treatment the complications of diabetes mellitus and histoplasmosis. Three

claims alleged misdiagnosis and failure to refer for ocular foreign bodies, but two of these claims were dropped and the third arose because the optometrist used an ocular therapeutic agent that was outside the scope of practice, rather than because of mismanagement of the foreign body.

**Ophthalmic materials.** Forty years ago most malpractice claims against optometrists were caused by injuries from spectacle lenses or frames,<sup>18</sup> but many of these claims were for minor injuries and would not be brought today for economic reasons. It is interesting to note that, of the 50 claims in this series, only three claims alleged injury due to spectacles, each citing the same cause of injury: failure to prescribe polycarbonate plastic in lieu of glass as the lens material.

Eight claims involved contact lens patients, with five of the claims caused by complications evolving from corneal abrasions. Significantly, perhaps, three of the five cases occurred in extended wear soft lens patients, and in all five claims it was alleged that the optometrist failed to manage the corneal compromise in a timely manner, thereby allowing the injury to worsen significantly before appropriate therapeutic measures could be taken. The other three claims alleged failure to diagnose ocular disease (herpes simplex in two cases and pigmentary glaucoma in the other) affecting contact lens patients.

**Ophthalmic drugs.** There were six claims alleging misuse of ophthalmic drugs, with four of the claims being due to use of the inappropriate therapeutic agent and the two other claims arising from the complications of diagnostic drug use. This result is interesting, given the greater toxicity of diagnostic drugs, and although no definite conclusions can be drawn from such a small number of cases, it is possible that therapeutic agents may become a greater source of liability than diagnostic agents, as has been the case in ophthalmology.<sup>17</sup>

With respect to ophthalmic drug use, it is arguable that failure to use a diagnostic agent represents the greatest liability risk of all. In 21 of the 25 cases in this series in which it was alleged that the examining optometrist failed to detect open-angle glaucoma, retinal detachments, ocular tumors, or ocular manifestations of brain tumors, dilation of the pupil was not employed. Of the four cases in which a dilated fundus examination was performed, three resulted in vindication for the optometrist or the payment of a nominal amount. In only one case were substantial damages awarded, and the basis for the award was failure to warn of potential complications rather than failure to detect pathology (discussed later in the section on retinal detachment). Therefore, it can be concluded that failure to perform a dilated fundus examination was the key omission in cases where liability claims alleged failure to diagnose ocular disease.

Similarly, in the four claims involving the use of therapeutic drugs, it was the failure to make the correct diagnosis, not the adverse effects of these drugs, that caused the claims to be brought. The delay in appropriate treatment led to the worsening of the patient's injury, which was caused by herpes simplex, *pseudomonas aeruginosa*, or fungus.

**Binocular vision.** There were two claims that alleged failure to treat amblyopia in children who were still within the "critical period."<sup>19</sup> In both cases the optometrist recognized that amblyopia was present but did not undertake to treat it, thereby reducing the best visual acuity that could ultimately be obtained in the affected eye.

These 50 cases are representative of the most significant liability risks faced by contemporary practitioners of optometry and describe the standards of care that will be expected of optometric clinicians. To minimize the risk of litigation, optometrists must understand the standard of care that will be applied

in a particular case, institute procedures intended to ensure that the standard of care is met, and document the care rendered to establish that the appropriate measures were in fact taken.

Case reports from this series will be used to illustrate the clinical and legal steps that may be taken to conform to the standard of care.

### Misdiagnosis

There is a single thread weaving together liability for misdiagnosis of open-angle glaucoma, retinal detachments, and tumors: failure to perform a dilated fundus examination.

### Open-angle glaucoma

All eight claims of failure to diagnose open-angle glaucoma were caused by failure to use the full panoply of techniques available to detect the disease (i.e., tonometry, ophthalmoscopy, visual fields).

For more than a decade, eye care practitioners have been obliged to perform tonometry as a routine procedure. The legal basis for this obligation may be found in a well-publicized case<sup>20,21</sup> which held that the duty to test for open-angle glaucoma existed irrespective of the age of the patient. Although the likelihood of finding open-angle glaucoma in young patients is remote, failure to perform tonometry — if it leads to a delay in the diagnosis of the disease — can be the cause of a liability claim.

A woman in her early 20s sought the services of an optometrist for the purpose of being fitted with contact lenses. While observing trial lenses on the patient's eye through a slit lamp, the optometrist noticed pigment on the corneal endothelium. He planned to perform further testing to determine the significance of this finding at a progress check after dispensing the lenses, but the patient failed to return as scheduled. Be-

**Table 2: 12 recommendations to reduce the risk of malpractice**

1. Misdiagnosis is the most likely cause of malpractice. Do not permit reduced acuity, diplopia, acute onset flashes or floaters, or other signs or symptoms of disease to go unexplained.
2. Perform tonometry on all patients upon whom the test can be administered.
3. If a reasonable practitioner would perform a dilated fundus examination, the test must be administered to conform to the standard of care. Remember, a reasonable practitioner may include a physician.
4. Warn all patients with reduced or impaired vision—including those whose pupils have been dilated—of the risks of operating a motor vehicle, working with machinery, or other tasks that may present an opportunity for injury.
5. When making a referral, it is preferable to schedule the appointment with a specific doctor at a specific date and time before the patient has left the office. Referrals should always be documented in the patient's record.
6. Document all recall appointments, patient cancellations or "no-shows," and efforts to contact patients to determine why recalls were not kept.
7. Be prepared to manage corneal compromise in contact lens patients, either by providing the appropriate medical therapy or by promptly referring patients for therapy. In treating an abrasion or other corneal insult, schedule the patient in a timely manner for a definite follow-up appointment.
8. Do not neglect periodic health assessments in contact lens patients or in any patients receiving specialized services.
9. Prescribe polycarbonate plastic when protection is a key clinical consideration and warn patients of the reduced impact resistance of alternative lens materials. If protective spectacles are to be provided by a third party, include "polycarbonate only" on the prescription.
10. Supervise employees adequately and do not permit them to perform duties that they are not qualified to perform.
11. Routinely inspect equipment and premises to ensure that they are not hazardous to patients and personnel.
12. Maintain clear, accurate contemporaneous patient records at all times.

nal and external disease and must contend with the difficult issue of patient noncompliance.

There are several clinical steps that, if observed by optometrists, will reduce the risk of malpractice. These recommendations are summarized in Table 2. All clinicians should obtain adequate professional liability insurance to provide for indemnification in the event they are the victims of a claim.<sup>6,7</sup>

School of Optometry/  
The Medical Center

University of Alabama  
at Birmingham  
Birmingham, AL 35294

**Footnotes**

- a. For example, Kansas Statutes Annotated 65-1501(3)(b) states "An optometrist certified to use topical pharmaceutical drugs as provided herein shall be held to a standard of care in the use of such agents in diagnosis and treatment commensurate to that of a person licensed to practice medicine and surgery, who exercises that degree of skill and proficiency commonly exercised by an ordinary, skillful, careful and prudent person licensed to practice medicine and surgery."
- b. For example, Section 463.0135(1), Florida Statutes, states that an optometrist

"shall provide that degree of care that conforms to that level of care provided by medical practitioners in the same or similar communities."

- c. The \$430 average cost of malpractice coverage is based upon a 1986 survey of premiums paid by optometrists that was reported by Poe and Associates of Tampa, FL. The Poe findings were based upon a 7-year study of the underwriting results for three major insurance carriers.
- d. The 1987 Economic Survey conducted by the American Optometric Association reported a mean net income of \$57,190 for optometrists.
- e. A 1987 survey of malpractice insurance costs for ophthalmologists found that premium costs averaged \$7,630. *Med Econ* 1987; 64(23):190-1.
- f. For a state-by-state listing of professional liability insurance costs for optometrists, see *Classé JG. Legal aspects of optometry.* Boston: Butterworths, 1989: 261.
- g. The study of medical malpractice published by the U.S. government's Malpractice Commission in 1970 reported that diagnostic errors accounted for 14% of claims. By comparison, the massive study published by the National Association of Insurance Commissioners in 1980 determined that 27% of all claims were caused by errors of diagnosis.
- h. The clinician assessed the anterior chamber angle, selected the appropriate ophthalmic drug, and warned the patient of the effects of mydriasis. When the clinician was informed that the patient was experiencing headache and nausea 4-5 hours after the examination, he asked the patient to return to the clinic, but the patient delayed returning until the next morning. The diagnosis of acute angle closure was made and the patient was immediately referred for treatment. The case was filed because the plaintiff's attorney believed there was some ambiguity in the state law concerning the use of diagnostic drugs by optometrists.

**References**

1. From the "Definition of an Optometrist," adopted by the Board of Trustees of the American Optometric Association in March 1989, and published in the *AOA News*, April 1, 1989.
2. *Classé JG. Liability and the primary care optometrist.* *J Am Optom Assoc* 1986; 57:926-8.
3. *Fairchild v. Brian*, 354 So.2d 675 (La. App. 1977).
4. *Steele v. United States*, 463 F.Supp. 321 (D.C. Ala. 1978).
5. *Bowers SA. Precedent-setting professional liability claims involving optometrists.* *J Am Optom Assoc* 1986; 57:397-401.
6. *Classé JG. A review of professional liability cases affecting the practice of optometry.* *J Am Optom Assoc* 1986; 57:66-71.
7. *Scholles JR. A review of professional liability claims in optometry.* *J Am Optom Assoc* 1986; 57:764-6.



## Liability and the primary care optometrist

John G. Classé, O.D., J.D.

The key element of primary care is increased clinical responsibility for optometrists. Therefore, it is not surprising to find that primary care has brought about increased legal responsibilities as well. In fact, it has become apparent that the legacy of primary care will be a medical standard of care for optometrists.

This development is evident in the opinions of courts asked to review malpractice judgments against optometrists. These decisions reflect the perception of the courts that optometry is a health care profession and that optometrists are responsible for the detection of medical conditions affecting vision — even conditions that are rare. Let us review several recent cases that illustrate the reasoning of the courts in applying a medical standard for optometrists.

In a 1977 Louisiana case,<sup>1</sup> an optometrist was alleged to have been negligent for failing to diagnose a retinal detachment. The optometrist's examination had revealed decreased acuity in the affected eye, but he had attributed this finding to cataract, which was diagnosed without the use of dilation since the use of mydriatic drugs by optometrists was not permitted under state law at the time. About two months later the patient was found to have a retinal detachment secondary to von Hippel-Lindau disease, and despite two surgeries, she was unable to regain normal vision. She sued the optometrist, alleging

that he was negligent in failing to diagnose the retinal detachment, and the trial court awarded a judgment in his favor.<sup>4</sup> This decision was appealed, and the appellate court reversed, awarding \$25,000 as damages. The court's rationale for reversal was, among other things, that the optometrist had undertaken the diagnosis of a *medical* condition — cataract — and that consequently he should be held to a *medical* standard of care, which required dilation in order to confirm the diagnosis. The failure to refer for dilation — to not only diagnose cataract but also to rule out the presence of a retinal detachment — constituted negligence, in the court's opinion, and justified the awarding of damages to the patient.

A 1978 Alaska case<sup>2</sup> was based upon allegations that a military optometrist failed to recognize retinal pathology in a four-year-old. At the optometrist's first examination he diagnosed accommodative esotropia, prescribed glasses, and scheduled a follow-up examination for 5 weeks later. At this second visit the optometrist found 20/30 acuities in each eye but noted "no good reflex" in one, which a dilated fundus examination revealed to have a dark vitreous hemorrhage. However, the optometrist did not refer the patient, since he believed the hemorrhage to be old or inactive. The youngster was scheduled to return in 4 months, at which time the acuity in the eye was limited to light perception only. The patient was referred to an ophthalmologist, who

consulted a pediatrician and another ophthalmologist, before the diagnosis of retinal detachment was made. Because there was uncertainty as to the cause of the detachment, the youngster was sent to San Francisco for examination by a team of physicians, but despite their efforts, the eye ultimately had to be enucleated. The optometrist subsequently was sued for negligence, and was held to be liable for failure to diagnose the detachment — which the trial court found was due to *Toxocara canis* — and to refer the patient promptly for treatment. The trial judge specifically rejected testimony that an optometric standard of care did not require referral and based his decision upon the opinion of ophthalmologists. The youngster was awarded \$200,000 as damages.

In a 1984 Alabama case<sup>3</sup> an optometrist was charged with negligence for failing to diagnose papilledema in a patient who was subsequently found to have a brain tumor. Because the patient was already under the care of a physician (for hypertension), the optometrist defended the claim by arguing that he had no duty to refer, but the state supreme court, relying in part upon the testimony of an ophthalmologist, rejected this defense, stating, "it is clear that the duties and responsibilities of an optometrist would not be relieved under these circumstances."<sup>4</sup>

It should be mentioned that insurance companies are also recognizing the responsibility of optometrists for the diagnosis of ocular

Jeff Gonnesson OD

HB 222

## The old "Compromise" story

- Early 1987: We wanted to re-introduce a comprehensive Therapeutic Drug Bill. Sen. Fischer wanted the ophthalmologists + optometrists (MD's + OD's) to meet and compromise. We told him they would never compromise on any therapeutics.
- We met anyway to discuss it w/ MD's. Rick Urion ~~remotely~~ (our lobbyist at one time past) promised a compromise bill would fly through the legislature in 2 weeks.
- After Dr. McCorkay from Fairbanks left the meeting, the OD's + MD's shook hands on a bill for diagnostic drugs and some limited therapeutic drugs for when an ophthalmologist wasn't available.
- 2 Hours later, Dr. Korshin, MD leader, called back and broke the deal, saying we had to add "after consultation w/ an ophthalmologist". Faced with no bill at all, Dr. Coon, OD leader, agreed, but said "no more changes".
- 3 Days later, Korshin MD said he had to remove all therapeutics from the bill, and if ~~we~~ we held him to the deal, he would be replaced as chair by the MD's.

→ Coon OD, took the broken deal for diagnostics only, since it was promised to fly through & be supported by both groups, and only Alaska & Maryland were left in the nation without diagnostic drugs for OD's.

→ After Senate passage, Korshin MD said they would withdraw support because they disliked an advertisement run by Falconer OD on Medicare.

→ McConkey MD and others actively fought against our bill, and it got amended once or twice, sent to sub-committee, and we had to hire a second lobbyist and struggle ~~both~~ both years of the 15<sup>th</sup> ~~legislature~~ legislature to finally pass diagnostics as the 50<sup>th</sup> & last out of 50 states. (Maryland got a veto & over-ruled it).

→ The "compromise" was to not fight the bill, not to forever restrict our profession to antiquated laws. It expired in 1987.

→ HB 222 is our "compromise" offer, asking only for minimum tools - 2 categories of eye drops. JAG

We, the undersigned authorized representatives of the Legislative Committee of the Alaska Optometric Association and the Legislative Affairs Committee of the Alaska Association of Ophthalmology, assign the support of our respective organizations to the attached negotiated bill that amends the current Alaska optometry statute. By our signatures below and on the attached bill we attest that support. We will, if called upon, testify before the Alaska State Legislature in favor of the bill as written. This agreement expires at the end of the 1987 session of the 15th Alaska Legislature.

Lynn J. Coon, O.D. 3/29/87

Oliver M. Korshin, M.D.

Edward E. Crouch, M.D.

**JEFFREY A. GONNASON, O.D.**

Doctor of Optometry  
Medical Park Eye Care  
2211 E. Northern Lights - Suite 202  
Anchorage, AK 99508

April 25, 1990

Telephone: (907) 276-2080

*Home*  
*333-1912*

Senator Dick Eliason  
P.O. Box V  
Juneau, AK 99811

Dear Senator Eliason:

On behalf of the Alaska Optometric Association, I would please request an opportunity to gain your support for HB 222, updating the Alaska optometry statutes.

Having passed the House recently, HB 222 now awaits action in Senate HESS. We would very much appreciate a hearing and an opportunity for a Senate vote in the remaining session time.

All 50 states currently allow optometrists to use diagnostic drugs, and 25 states currently allow the use of therapeutic drugs for treatment of eye diseases, especially states with rural areas. HB 222 is the minimum first step into therapeutics, adding 2 categories of topical-only drugs to our current authorized list. This will allow treatment of infection or inflammation of the anterior eye. (Eyedrops for pinkeye or allergies, for example). The Division of Occupational Licensing supports HB 222.

In your packet I have enclosed my letter to Senator Fischer, as well as letters of support from Alaska medical doctors and Senator Murkowski, plus information and experience from some of the other states that allow ocular therapeutics.

Even though optometrists in Alaska should be allowed to practice with professional judgement in using any drugs or technical procedures within their scope of training, HB 222 only allows a first step to keep with the reality of conservative changes and help ensure passage this session.

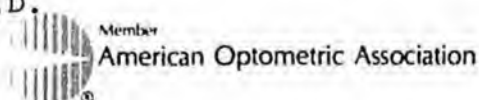
HB 222 will provide Alaskans with much greater access to quality eye-care, especially if the patient does not live in Anchorage, Fairbanks, or Juneau; cost savings by eliminating travel time and expense, and increasing competition among providers. HB 222 will benefit consumers and the state, as well as allowing for freedom of choice in eyecare.

As immediate past president of the Alaska State Board of Examiners in Optometry, and legislative chair for the Alaska Optometric Association, I thank you for your consideration of improved eyecare for all Alaskans.

Sincerely,



Jeffrey A. Gonnason, O.D.



*Michael E. Darling, D.D.S.*

2211 EAST NORTHERN LIGHTS BOULEVARD

SUITE 204

ANCHORAGE, ALASKA 99504

TELEPHONE 274-2889

April 24, 1990

Senator Paul Fischer  
P.O. Box V  
Juneau, AK 99811

Dear Senator Fischer:

I am aware of proposed legislation allowing optometrists in the state of Alaska to increase the scope of their practice to include the use of therapeutic medications. I am strongly in favor of such legislation.

Being a health professional trained in the diagnosis and treatment of eye diseases, the optometrist is an asset in the medical community that the Alaskan public cannot fully utilize currently.

An optometrist's education is on a par with dentistry and medicine as applied in clinical situations involving eyecare. Nationally, 25 states currently authorize the use of therapeutic drugs by O.D.'s to fully utilize the training of optometrists.

The nationwide experience over the past 14 years has been excellent, especially in the delivery of eye care to rural areas. Also, state social service agencies have found therapeutic treatment by optometrists to be less expensive to both the consumers and taxpayers.

Please give your full support to HB 222. This legislation will greatly increase the access and availability of eye care, at a lower cost to the public and state social service agencies.

Sincerely,



Michael E. Darling, D.D.S.  
MED/dpb

FRANK H. MURKOWSKI  
ALASKA

COMMITTEES:

VETERANS' AFFAIRS (RANKING MEMBER)  
ENERGY AND NATURAL RESOURCES  
FOREIGN RELATIONS  
SELECT COMMITTEE ON INTELLIGENCE  
SELECT COMMITTEE ON INDIAN AFFAIRS

United States Senate

WASHINGTON, DC 20510  
(202) 224-6665

222 West 7th Street, Box 1  
ANCHORAGE, AK 99513  
(907) 271-3735

101 12th Avenue, Box 7  
FAIRBANKS, AK 99701  
(907) 456-0233

P.O. Box 1647  
JUNEAU, AK 99802  
(907) 586-7400

120 TRADING BAY ROAD, SUITE 250  
KASLOO, AK 99611  
(907) 203-6608

108 MAIN STREET  
KETCHIKAN, AK 99901  
(907) 225-6880

April 9, 1990

Dr. Jeffrey A. Gonnason, O.D.  
Medical Park Eye Care  
2211 E. Northern Lights - Suite 202  
Anchorage, Alaska 99508

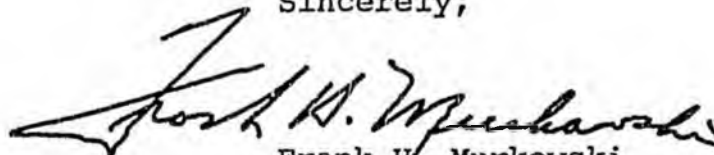
Dear Jeff:

It was a pleasure to visit with you during your recent visit to Washington. I appreciate your taking time to stop by my office.

Lisa Moore has provided me with the written information which you left. I concur with you that optometrists should not be discriminated against in federal and state legislation. I wish you luck with the Alaska legislature on the prescription drug issue. Please let me know the outcome.

If I can be of any assistance to you, please let me know.

Sincerely,



Frank H. Murkowski  
United States Senator



# Fairbanks Clinic

Quality Care Since 1932

March 10, 1990

Mark Boyer  
P. O. Box V  
Juneau, Alaska 99811

Dear Mr. Boyer:

I am writing this letter in support of House Bill 222 concerning optometry prescribing privileges. I was on active duty as a medical officer in the United States Air Force from 1981 through July of 1988. During the last five years of that time, I was assigned to the USAF Clinic at Eielson Air Force Base. Part of my duties there was to serve as direct supervisor for the optometrists. During that period of supervision, the Air Force changed their prescribing rules and began to allow optometrists, with appropriate training, to prescribe certain classes of medication. In order to obtain these prescribing privileges, the optometrist had to show documented proof of ocular therapeutic training during his original professional schooling or evidence of adequate education in ocular therapeutics since graduation from optometry school. With documentation of the appropriate training, these optometrists were then permitted to prescribe medications in classes similar to those mentioned in House Bill 222.

I have had the opportunity to work with several Air Force optometrists who have been credentialed under these rules and have found that they have been able to provide increased service to their patients. I have not seen any significant problems associated with optometrists prescribing practices.

I feel that it would be of benefit to the residents of Alaska to permit optometrists to prescribe those medications noted in House Bill 222. I believe that appropriately trained optometrists are capable of effectively and safely treating relatively minor eye problems with medications as specified in House Bill 222 and therefore am in favor in passage of this bill.

Sincerely,

Enlow R. Walker, M.D.  
Family Practice

ELW:ct

# Tanana Valley Clinic

Family Medical Care  
Since 1959

February 26, 1990

#### OBSTETRICS & GYNECOLOGY

Richard B. Anderson, M.D.  
Richard C. Pade, M.D.  
Richard B. Stone, M.D.  
Roger D. Wainwright, M.D.  
Peter L. Bock, F.A.C.  
Jan Swanson, CNP

#### UROLOGY

John W. Baker, M.D.  
Robert S. Graham, M.D.  
Arline S. Kesteven, M.D.

#### INTERNAL MEDICINE

Michael J. Hayes, M.D.  
Jonathan R. Shaw, M.D.

#### PEDIATRICS

Marvin E. Bergeson, M.D.  
J. Thomas Fiske, M.D.  
Richard C. Rosen, M.D.  
Nancy A. Schultz, M.D.  
Mark H. Scuffie, M.D.

#### FAMILY PRACTICE

Harvey Adkins, M.D.  
Dorothy E. Thurman, M.D.  
Jean M. W. Torgue, M.D.  
Charles Moore, M.D.  
David L. Lewis, F.A.C.  
Dorothy Rogers, F.A.C. & Tan Clinic

#### PHYSICAL THERAPIST

Case Carson, L.P.T.  
Brenda Conover, L.P.T.

#### PATIENT EDUCATION

Lee Robinson, R.N.

#### ADMINISTRATION

Paul Davis, Administrator  
Sandra J. Farrow, Coordinator/Asst. Admin.

Representative Mark Boyer  
Alaska State Legislature  
P.O. Box V (MS 3100)  
Juneau, Alaska 99811

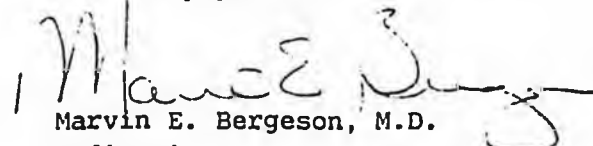
Dear Representative Boyer:

I am writing to you requesting support for the proposed House Bill 222 allowing optometrists in the State of Alaska to practice at a level consistent with their training which would include limited use of therapeutic drugs, i.e. anti-infectives and anti-inflammatory drugs. I worked for many years in the military which utilized optometrists and allowed them to use the drugs as both diagnostic and therapeutic agents. I found that the optometrists I worked with were very confident and judicious in the use of these therapeutic agents.

There are only four ophthalmologists in Fairbanks and none in the remainder of the Interior; however, there are many optometrists. Allowing optometrists to treat diseases of the eye within their spectrum of expertise would allow many more Alaskans to be adequately taken care of. Optometrists are trained for four years after completing a Bachelor of Arts degree, and in most cases this training includes 150 hours of Pharmacology. Currently all fifty states allow optometrists to use drugs in a diagnostic area, and 25 of the states also allow them to use drugs therapeutically.

Alaska, with its vast land area and remoteness of villages and cities, would certainly benefit by allowing optometrists to use their clinical expertise with the use of diagnostic and therapeutic drugs.

Sincerely yours,

  
Marvin E. Bergeson, M.D.  
Pediatrics

MEB:sr

*to Senator Ellison from Roy Boy*  
*Senator; Dr. Payne will consider this*  
**Malpractice: O.D.'s**  
**vs. Ophthalmologists** *in*

For years leaders of the optometric profession have been testifying before state legislatures to the effect that modern O.D.'s are as capable of practicing primary eye care as are ophthalmologists. Ophthalmology leaders have tried in vain to convince the optometric profession, as well as the state legislators, that the diagnosis and management of medical eye problems requires medical education?

There's no optometric leader who's had greater influence on legislation than John Classé, O.D., J.D. In his article "Malpractice—A New Era Dawns," (September, 1989) Dr. Classé quotes a 1979 study which revealed that O.D.'s have considerably lower rates of malpractices than even that of general medical practitioners.

The subtle message here is that optometrists are doing a better job of treating eye disease than are ophthalmologists. Yet this survey covered O.D.'s who were practicing traditional optometry, i.e. refractions and contact lens fittings, and wasn't germane to the use of diagnostic and therapeutic pharmaceutical agents. This particular reference was used before state legislatures, however, with real impact.

The net result is that intelligent, well-trained optometrists are attempting to meet the same standards as ophthalmologists who have the advantage of medical education and have had the opportunity to have between 9,000 and 10,000 patient contacts during their training. No matter how conscientious the optometrist, there is no substitute for clinical experience.

—Walter S. Kirkconnell, M.D.  
 Vice President &  
 Legislative Chairman  
 Florida Society of  
 Ophthalmology

*Dr. Classé's response to the*  
*NAIC study he alludes to does show that,*  
*in the late 1970s, optometrists were rarely*  
*sued for malpractice. The same results is*  
*incident today, based upon evidence supplied*  
*by Poe and Associates, the largest broker*  
*of professional liability policies for op-*  
*tometrists. The Poe data shows that op-*  
*tometrists pay about \$450 on the average*  
*for malpractice insurance coverage, and that*  
*this premium does not vary based upon*  
*whether an optometrist is in a state allow-*  
*ing therapeutic or in one allowing*  
*diagnostics only*

*In an era when Medical Economics*  
*reports that the average physician pays over*  
*\$10,000 for comparable insurance coverage,*  
*it is evident that optometrists have a very*  
*positive track record. Furthermore, although*  
*I know of no studies that actually compare*  
*the management of eye disease by optometrists*  
*and ophthalmologists, I must note that the*  
*largest report of malpractice claims against*  
*ophthalmologists—authored by Dr. Jerome*  
*Beitman—found that the leading category*  
*of claims was drug complications, princi-*  
*ally caused by misuse of steroids and*  
*glaucoma medications. The only comparable*  
*study of malpractice claims against*  
*optometrists—which is an analysis of claims*  
*spread over 12 years—found that drug-*  
*related complications for optometrists were*  
*extremely rare. On that basis, one could argue*  
*that optometrists actually do a better job of*  
*treating eye disease since they seem to ex-*  
*perience fewer complications that result in*  
*litigation.*

**Rx Release Requirements**

The articles by Dr. Classé and Dr. Harris ("Doctor, I Want A Copy of My...", December, 1989) prompt me to ask several questions. When do the authors expect just the prescription requirements to go into effect for Eyeglasses II? What may an O.D. charge an attorney for copies of complete records? Would they recommend release of the copies prior to the

receipt of the fee, or to let the attorney have to receive the money copies? In our area, requests from data which include drug \$20.

—Peter S

The authors respond. By consent of the parties, release requirements of Circuit Court for the 7th Circuit, effective November 1, 1989, are effective in September. It is reasonable to assume that release requirements when the court issues has made no announcement of court's action, but that a formality and not a li

An optometrist may charge a fee for copying or summarizing records. What is reasonable depends upon the amount of time and effort required to produce the information. The professional charging for this service is reasonable when the information is a reasonable fee is included in the fee for records, the optometrist

**Correction**

Three articles comprising the December issue did not identify clearly the authors were. All three were co-written by John G. J.D., and Michael G. J.D. Dr. Harris was the author for "How To Answer Retail Lens Rx's," Dr. Classé was the author for "What's Involved in Providing Spectacle Rx's" and "Requests For Records—Your Legal Responsibility"

Provided by Roy Boy O.D



**JEFFREY A. GONNASON, O.D.**

Doctor of Optometry  
Medical Park Eye Care

2211 E. Northern Lights - Suite 202  
Anchorage, AK 99508

Senate HESS

Page 1

— — —  
Telephone: (907) 276-2080

On behalf of the Alaska Optometric Association and about 60 doctors of optometry represented in Alaska, I wish to thank the committee for hearing this issue in the public interest. A copy of my testimony to House HESS has been provided to you in your packet, along with letters of support from several medical doctors, Senator Murkowski, and documents relating the experience of some of the 25 other states that currently allow the use of therapeutic medications by optometrists. With minimum time, I will only present a summary of the facts in this issue.

HB 222 is very limited compared to many of the other states' laws, only adding 2 topical drug categories to our current authorized list. This bill will allow us the minimum tools necessary to treat common conditions in the practice of primary eye care.

Alaska statutes currently require optometrists to "keep informed of and use current professional theories and practices" (AS 08.72.240).

Most doctors of optometry complete 8 years of college: 4 undergraduate and 4 years of graduate training in optometry school. 92% of all students currently entering optometry school hold bachelor's degrees or better. Admission requirements and tests are similar to those for medical and dental schools. The biomedical sciences presented in other health professional programs are taught in optometry school with the same quality of instruction. Course work in diagnosis and treatment of eye disease and ocular pharmacology is much more extensive than that presented in medical school. Clinical training occurs in various clinics, HMO's, Public Health, Indian Health, and VA Hospitals. Optometry schools are accredited by the same national agencies that accredit medical schools.

Optometrists possess an education similar to dentists, podiatrists, and physicians. Yet of these professions, only optometry is limited in its use of pharmaceuticals. We have far more extensive education, and training in the use of specialized eye equipment, than the general medical doctors, nurses, and health aides that currently treat eye disease in Alaska.

This bill will not allow "grandfathering" of present practitioners. Current statutes require each Alaska optometrist to pass additional examinations determined by the State Board to receive a license endorsement for pharmaceutical agents. Current regulations for a license also require passing the "TREATMENT AND MANAGEMENT OF OCULAR DISEASE", a nationally recognized and standardized examination offered by the International Association of Boards of Examiners in Optometry (IAB), of which Alaska is a member.



Member

American Optometric Association

**JEFFREY A. GONNASON, O.D.**

Doctor of Optometry  
Medical Park Eye Care  
2211 E. Northern Lights - Suite 202  
Anchorage, AK 99508

Senate HESS

Page 2

Telephone: (907) 276-2080

The malpractice insurance rates paid by optometrists are the same in states that do allow as those that don't yet allow treatment of eye disease. Rates have actually been reduced recently. My rate went from \$356 last year down to \$220 this year. This is positive proof of the public safety of optometry, with 14 years of therapeutic experience and one of the lowest litigation rates of the health professions. The courts hold optometrists to the same standards of care applicable to medical doctors and dentists.

Optometrists are considered physicians by federal Medicare law, with respect to all services authorized by state law. Indian Health and military optometrists in Alaska use medications under federal authority. If they enter private practice as many have done, they are then restricted by outdated statutes that give medicine a monopoly on eyecare.

The only reason for this legislation is to provide much better access to quality, affordable eye care for Alaskans. This is especially true in our smaller towns and villages. Time and expense would be saved by the public and the state health payors by reducing unnecessary travel, not having to pay more than one doctor, or not having to pay the higher fees of a surgical eye specialist for a common primary care condition. These cost savings have been well documented. Increased competition and freedom of choice among providers is also a cost containment reality.

Optometrists are reasonable, educated, caring professionals with a clean track record nationally. We are state licensed, and regulated by the State Board, by legal liability concerns, by community opinion, and by medicine and the legislature looking carefully over our shoulders. Unlike our other medical colleagues with unrestricted license for new educational developments, we must return to the legislature for statute changes as our education and scope of practice capability expands.

We are fortunate to have a legislature that will respond to the health care needs of all Alaskans. By lending your approval for a beginning step toward expansion of primary eyecare services by optometrists, you will be supporting the basic goal of improved quality of life for all Alaskans. Our support is from a broad base: State administrators, educators, Native groups, regional health groups, insurance providers, medical doctors, dentists, nurses, pharmacists, and mostly by the Alaskan people all over the state who trust us with their eyecare. Thank you for your consideration.

Sincerely,



Jeffrey A. Gonnason, O.D.

Legislative Chair  
Past President  
State Optometry Board



Member  
American Optometric Association

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

April 27, 1990

The Hon. Dick Eliason, Chairman  
Labor & Commerce Committee  
Alaska State Senate  
P.O. Box V  
Juneau, Alaska 99811

Dear Sen. Eliason:

re: CSHB222Am

Impeding passage of optometric primary care therapeutics will preserve the monopoly of a privileged class of practitioner - holders of the MD degree - who are no longer entitled to a monopoly on the basis of exclusive education or training. In fact, general practitioners have always been only marginally qualified to treat infections and inflammations of the eye.

We cannot achieve cost containment and accessibility in health care until all professions are allowed to practice in accordance with their training. Over half the states now allow optometry to practice therapeutics at or above the level provided in HB222.

I invite you to be on the side that recognizes and encourages progress in meeting peoples needs.

Very truly yours,

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

PWB/lr

cc: Sen. Pat Rodey  
Sen. Jan Faiks  
Sen. Jay Kerttula  
Sen. Jack Coghill

**JEFFREY A. GONNASON, O.D.**

Doctor of Optometry  
Medical Park Eye Care  
2211 E. Northern Lights - Suite 202  
Anchorage, AK 99508

— — —  
Telephone: (907) 276-2080

T E S T I M O N Y

HB 222

MAY 2, 1990

SENATE HESS COMMITTEE

ALASKA STATE LEGISLATURE

**JEFFREY A. GONNASON, O.D.**

Doctor of Optometry  
Medical Park Eye Care  
2211 E. Northern Lights - Suite 202  
Anchorage, AK 99508

Senate HESS

Page 1

Telephone: (907) 276-2080

On behalf of the Alaska Optometric Association and about 60 doctors of optometry represented in Alaska, I wish to thank the committee for hearing this issue in the public interest. A copy of my testimony to House HESS has been provided to you in your packet, along with letters of support from several medical doctors, Senator Murkowski, and documents relating the experience of some of the 25 other states that currently allow the use of therapeutic medications by optometrists. With minimum time, I will only present a summary of the facts in this issue.

HB 222 is very limited compared to many of the other states' laws, only adding 2 topical drug categories to our current authorized list. This bill will allow us the minimum tools necessary to treat common conditions in the practice of primary eye care.

Alaska statutes currently require optometrists to "keep informed of and use current professional theories and practices" (AS 08.72.240).

Most doctors of optometry complete 8 years of college: 4 undergraduate and 4 years of graduate training in optometry school. 92% of all students currently entering optometry school hold bachelor's degrees or better. Admission requirements and tests are similar to those for medical and dental schools. The biomedical sciences presented in other health professional programs are taught in optometry school with the same quality of instruction. Course work in diagnosis and treatment of eye disease and ocular pharmacology is much more extensive than that presented in medical school. Clinical training occurs in various clinics, HMO's, Public Health, Indian Health, and VA Hospitals. Optometry schools are accredited by the same national agencies that accredit medical schools.

Optometrists possess an education similar to dentists, podiatrists, and physicians. Yet of these professions, only optometry is limited in its use of pharmaceuticals. We have far more extensive education, and training in the use of specialized eye equipment, than the general medical doctors, nurses, and health aides that currently treat eye disease in Alaska.

This bill will not allow "grandfathering" of present practitioners. Current statutes require each Alaska optometrist to pass additional examinations determined by the State Board to receive a license endorsement for pharmaceutical agents. Current regulations for a license also require passing the "TREATMENT AND MANAGEMENT OF OCULAR DISEASE", a nationally recognized and standardized examination offered by the International Association of Boards of Examiners in Optometry (IAB), of which Alaska is a member.

JEFFREY A. GONNASON, O.D.

Doctor of Optometry  
Medical Park Eye Care  
2211 E. Northern Lights - Suite 202  
Anchorage, AK 99508

Senate HESS

Page 2

Telephone: (907) 276-2080

The malpractice insurance rates paid by optometrists are the same in states that do allow as those that don't yet allow treatment of eye disease. Rates have actually been reduced recently. My rate went from \$356 last year down to \$220 this year. This is positive proof of the public safety of optometry, with 14 years of therapeutic experience and one of the lowest litigation rates of the health professions. The courts hold optometrists to the same standards of care applicable to medical doctors and dentists.

Optometrists are considered physicians by federal Medicare law, with respect to all services authorized by state law. Indian Health and military optometrists in Alaska use medications under federal authority. If they enter private practice as many have done, they are then restricted by outdated statutes that give medicine a monopoly on eyecare.

The only reason for this legislation is to provide much better access to quality, affordable eye care for Alaskans. This is especially true in our smaller towns and villages. Time and expense would be saved by the public and the state health payors by reducing unnecessary travel, not having to pay more than one doctor, or not having to pay the higher fees of a surgical eye specialist for a common primary care condition. These cost savings have been well documented. Increased competition and freedom of choice among providers is also a cost containment reality.

Optometrists are reasonable, educated, caring professionals with a clean track record nationally. We are state licensed, and regulated by the State Board, by legal liability concerns, by community opinion, and by medicine and the legislature looking carefully over our shoulders. Unlike our other medical colleagues with unrestricted license for new educational developments, we must return to the legislature for statute changes as our education and scope of practice capability expands.

We are fortunate to have a legislature that will respond to the health care needs of all Alaskans. By lending your approval for a beginning step toward expansion of primary eyecare services by optometrists, you will be supporting the basic goal of improved quality of life for all Alaskans. Our support is from a broad base: State administrators, educators, Native groups, regional health groups, insurance providers, medical doctors, dentists, nurses, pharmacists, and mostly by the Alaskan people all over the state who trust us with their eyecare. Thank you for your consideration.

Sincerely,



Jeffrey A. Gonnason, O.D.

Legislative Chair  
Past President  
State Optometry Board



Member

American Optometric Association

Donald R. Schieve, M.D.  
5220 Neil Road Suite 110  
Reno, Nevada 89502

April 24, 1989

Senator Ray Shaffer  
Legislative Building  
401 S. Carson Street  
Carson City, NV 89710

Dear Senator Shaffer,

As an Ophthalmologist and practicing M.D. for over 25 years, I strongly support S. B. 296. The passage of this bill will *definitely benefit* the citizens of our State.

My credentials are as follows: (i) After residency, I practiced as a Board Certified Pathologist for 16 years in Reno; (ii) I then took a second residency in Ophthalmology and practiced in Morgantown, WV for 9 years, prior to my return to Reno in 1988, where my Ophthalmology practice is now located.

During my 9 years as an Ophthalmologist in West Virginia, I was able to observe first hand the *positive results* of the passage of a bill very similar to S.B. 296.

In all the cases I observed the patient was: (i) better served and treated; (ii) more efficiently referred, when needed, to the correct specialist; and (iii) enjoyed a lower medical cost.

As I am sure you are aware, West Virginia was the first of twenty-four states that have passed legislation similar to S.B. 296 during the last fourteen years.

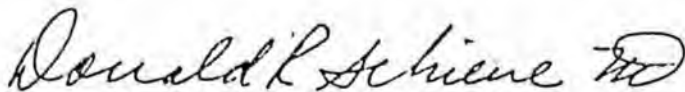
As an Ophthalmologist, I am aware of the opposition some of my fellow Ophthalmologists may place before you. These objections are generally voiced by a small group of Doctors who believe their practices are being infringed upon, "a turf battle".

Medicine, science, and technology continue to bring forth new frontiers. We cannot practice medicine as we did twenty years ago. Status quo in medicine does not benefit the patient.

*We must continue to grant rights to Doctors to treat their patients in areas in which they are properly trained, even though these Doctors do not carry the title "M.D."*.

I urge you, and your fellow committee members, to vote in favor of S.B. 296 and continue the advancement of proper and economical medical care for the people of Nevada.

Sincerely yours,



Donald R. Schieve, M.D., Ophthalmologist



# NORTHWEST EYE CENTER

State of the Art Technology  
and Old Fashioned Care

February 8, 1989

State Senator Gary Nelson  
106-A Inst. Building  
Olympia, WA 98504

Dear Senator Nelson:

We are three ophthalmologists practicing in Seattle. We are writing in support of Senate Bill 5193, and feel that Doctors of Optometry should be allowed to use topical therapeutic drugs. We have had the opportunity and pleasure of sharing in the care of many patients with optometrists in your legislative district: Doctors Michael Medin and David Ross. These doctors provide excellent care. They have shown good judgment in their patient care decisions. We feel they will continue timely and proper care with therapeutic drug use. In the past two years we have participated in educational courses with these doctors. We have encountered a high level of interest and enthusiasm in these endeavors.

It is our hope that passage of this therapeutic bill will result in a greater unity between optometrists and ophthalmologists and ultimately our patients will be the beneficiaries.

If you have any questions or concerns, we would be happy to discuss them with you.

Yours very truly,

J. Stephen Brown, Jr., M.D.

Michael W. Field, M.D.

William E. Hancock, M.D.



# Valley Eye and Laser Center

March 13, 1989

House of Representatives  
Legislative Building, Room #  
Olympia, Wa. 98504

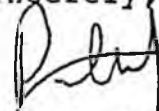
Dear Representative

I am writing to express my strong support for Senate Bill #5193. I have been practicing medicine as an ophthalmologist, specializing in eye disease and surgery for the past ten years.

I have reviewed the proposed change in Legislation carefully, and find it is a reasonable approach for expanding the scope of optometric practice. My experience with optometrists has shown me that they are very competent, careful, and ethical practitioners.

Please support this bill and move the issue out of the political arena, so all ophthalmologists and optometrists can get back to our main concern, the care of eyes.

Sincerely,



Paul N. Jcos, M.D.