SB157

HOUSE COMMITTEE REPORT

(11)
Date Referred: May 2, 1992
(HES referral waived 5/2/92)
Date of Committee Action: 5/8/92

FURTHER REFERRALS:

The FINANCE Committee considered: CSSB 157(L&C)

CS FOR SENATE BILL NO. 157 (L&C)

OPTOMETRISTS: AUTHORIZED PRACTICES

"An Act relating to optometrists."

RECOMMENDATIONS: [ ] the same title
be replaced with _____ [ ] a new title
[ ] have attached amendments(s)
[ ] do pass
[ ] do not pass
[X] no recommendations
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)
[ ] fiscal impact _____
[ ] zero fiscal note _____

APPROVES PREVIOUS: (Dept/Date)
[ ] fiscal note(s) _____
[X] zero fiscal note(s) DCED 3/18/92

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
Mark Boyer Boyer	X	Koponen		✓	
Tom Brown Brown ✓		Sharp			
		Phillips		✓	
		Larson		X	
		Ulmer		X	

Mark Boyer via-chr.
CHAIRMAN'S SIGNATURE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

FISCAL NOTE

BILL NO. CSSB 157(L&C)

Revision Date. _____ Department Affected: Commerce & Economic Development

Title: An Act relating to optometrists. BRU: Occupational Licensing

Component: Administration

Sponsor: Senator Adams

Requestor: House Finance COMPONENT SERIAL NO. 0 3 5 6

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0.0	0.0	0.0	0.0	0.0	0.0
FEDERAL FUNDS	0.0	0.0	0.0	0.0	0.0	0.0
OTHER	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME	0.0	0.0	0.0	0.0	0.0	0.0
TEMPORARY	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary)

The bill amends the optometry statutes to authorize the use of pharmaceutical agents in the practice of optometry. New funds are not required to implement this bill.

Prepared By: Jennifer Strickler Phone: 465-2144

Division: Occupational Licensing Date: 05/05/92

Approved by Commissioner: Glenn A. Olds Asst. Comm

Agency: Commerce & Economic Development Date: 5.4.92

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

Rev 10/90

CS FOR SENATE BILL NO. 157 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered: 3/18/92
Referred: Judiciary

Sponsor(s): SENATOR ADAMS

A BILL

FOR AN ACT ENTITLED

"An Act relating to optometrists."

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

* Section 1. AS 08.72.175(a) is amended to read:

(a) The board may issue a license endorsement authorizing a licensee to **prescribe and** use the pharmaceutical agents described in AS 08.72.272, if the licensee or applicant for a license passes the written and practical portions of an examination on ocular pharmacology, approved by the board, that tests the licensee's or the applicant's knowledge of the characteristics, pharmacological effects, indications, contraindications, and emergency care associated with the **prescription and** use of pharmaceutical agents. The endorsement expires at the same time as the license to which it attaches. The endorsement may be renewed upon satisfactory completion of continuing education requirements established by the board by regulation.

* Sec. 2. AS 08.72.272 is repealed and reenacted to read:

Sec. 08.72.272. USE OF PHARMACEUTICAL AGENTS. (a) A licensee may prescribe and use a pharmaceutical agent in the practice of optometry if

(1) the pharmaceutical agent is a drug topically applied to the human eye and its appendages; and

(2) the person holds a license endorsement issued by the board authorizing the prescription and use of pharmaceutical agents.

(b) A licensee may not purchase, possess, prescribe, or use a pharmaceutical agent unless the licensee has obtained a license endorsement under AS 08.72.175.

* Sec. 3. AS 08.72 is amended by adding a new section to read:

Sec. 08.72.273. REMOVAL OF FOREIGN BODIES. A licensee may remove superficial foreign bodies from the eye and its appendages. This section is not intended to permit a licensee to perform invasive surgery.

Alaska State Legislature

Senator Al Adams

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Official Business

TO: Representatives Mike Navarre and Eileen MacLean, Co-chairs
House Finance Committee

FROM: Senator Al Adams AdA

RE" Senate Bill 157, "An act relating to optometrists"

DATE: May 4, 1992

This is to request a hearing on the aforementioned legislation. Accompanying this memorandum is background information for committee review.

Senate Bill 157 expands the authorized pharmaceutical agents available for use in the practice of optometry. It accomplishes this by repealing and rewriting AS 08.72.272.

The Senate Labor and Commerce Committee substitute, which I support, adds a new Section 1 to clarify that the Board of Optometrists may issue a license to optometrists to both prescribe and use the pharmaceutical agents described in AS 08.72.272. This was done to eliminate uncertainty in the use of pharmaceutical agents in the office setting in addition to prescribing use by clients at home. The substitute bill also deletes a prior version's subsection which authorized the use of oral pharmaceutical agents.

An updated fiscal note has been requested from the Department of Commerce.

Thank you.

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American Optometric Association

JEFFREY A. GONNASON, O.D.

My name is Jeffrey A. Gonnason, O.D., a doctor of optometry. I am a life-long Alaskan, president of the Alaska Optometric Association, and past president of the Alaska State Board of Examiners in Optometry. I have been in private practice in Alaska for over 15 years. On behalf of the Alaska Optometric Association representing over 60 of Alaska's Doctors of Optometry, I wish to thank the committee for hearing this issue in the public interest. Documents of support are available from Alaska and across the nation relating the 16 years of experience by other states that allow optometrists the use of therapeutic medications.

The purpose of this legislation is to update the Alaska optometry statutes with regard to the use of pharmaceutical agents. Currently, only diagnostic drugs are used for examining the eye. Passage of this legislation would allow qualified Alaska optometrists to treat the conditions they currently diagnose in a manner consistent with their education and training. Alaska statutes currently require optometrists to "keep informed of and use current professional theories and practices" (AS 08.72.240). In the 30 states where optometrists routinely use drugs to treat eye disease, problems have virtually been non-existent over a 16 year track record. Alaska's O.D.'s do not have this earned and justified privilege.

Optometry as a profession has grown progressively more sophisticated and capable. Most doctors of optometry complete 8 to 9 years of college: 4 years undergraduate and 4 years of graduate training in optometry school, as well as a residency program. 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.

Alaska state education funds would be better spent if these doctors could practice their healing arts in their own native state. It is difficult to get new graduates to come to Alaska because they cannot currently utilize the full extent of their training.

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Optometrists possess an education similar to dentists, podiatrists, and medical doctors. None of these other practitioners, including general medicine, have the extensive training and education specific to eye disease and ocular pharmacology. Yet of these practitioners, only optometry is limited in its use of pharmaceutical agents. We have far more extensive education, as well as training in the use of highly specialized eye instrumentation, than the general medical doctors, nurses, and health aides that are currently allowed to treat eye disease in Alaska.

Last year the American Public Health Association, which represents over 52,000 health professionals, passed a resolution entitled "Access to Treatment for Eye Care". This resolution recommends that legislators update their state optometry practice acts to allow optometrists to use therapeutic pharmaceuticals.

This bill will not allow "grandfathering" of present practitioners. Current statutes already 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 already require passing "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. I can assure you that the Board would exercise the utmost caution in stringent requirements for pharmaceutical endorsement.

The malpractice insurance rate paid by optometrists are the same in states that do allow as those that do not yet allow treatment of eye disease. This is an unbiased reflection of quality, cost-effective care. Malpractice rates have actually been reduced recently. My rate went from $356 last year down to $250 this year. This is positive proof of the public safety of optometry, with 16 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 classified as physicians under federal Medicare Law, with respect to all services authorized by state law. Medicare patients are denied access to therapeutic eye care from optometrists in Alaska. U.S. Public Health, Indian Health, and military optometrists in Alaska have used medications for many years. If they enter private practice as many have done, they are then restricted by outdated Alaska statutes.

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The only reason for this legislation is to provide much better access to quality, affordable, and cost-effective eye care for Alaskans. This is especially true in our smaller towns and villages. In Alaska, optometrists outnumber ophthalmologists 3 to 1 and are widely distributed throughout the state, while the ophthalmologists are only in the Juneau, Fairbanks, and Anchorage areas (including Soldotna). Time and expense would be saved by the public and the state health payers by reducing unnecessary travel, lost work time, 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. According to the Journal of the American Medical Association, April 1985, "The cost of primary care increases when it is provided by specialists, without necessarily improving its quality...". These cost savings have been well documented. Increased competition and freedom of choice among providers is also a cost containment reality.

The optometrist is often the first contact for a patient suffering from an eye disorder. In most cases, needed treatment can begin immediately, an important aspect in the treatment of many eye diseases. Early diagnosis and treatment allows the optometrist to eliminate patient suffering, and can prevent serious complications.

Optometrists are reasonable, educated, caring professionals with a clean track record nationally. We are state licensed with strict standards. We are 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 and non-medical colleagues with unrestricted license for new educational developments, we practice under a limited license and must return to the legislature for statute changes as optometric education and eye care technology advances. The State Board of Optometry should be allowed to determine the scope of practice by regulation, as is done by other health professions in Alaska to keep current with health care advances.

We are fortunate to have a legislature that will respond to the health care needs of all Alaskans. By lending your approval to expansion of primary eye care 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 health administrators, educators, Native organizations, community and regional health groups, insurance providers, medical doctors, dentists, nurses, pharmacists, and mostly by our patients all over the state who choose to trust us with their eye care.

The Impact Of The Use By Kansas Optometrists Of Therapeutic Pharmaceutical Agents

By Stacy Fitch, O.D.

ABSTRACT: From July 15, 1987 through December 31, 1988, the Kansas Optometric Association collected information from Kansas optometrists regarding the number of diagnostic cases seen, their respective therapies, and the number of miles saved. This paper attempts to show the impact of the Kansas therapeutics law on optometrists and their patients.

INTRODUCTION

April 17, 1987 was just a typical day for most of us. But, for Kansas optometrists, it was a milestone. On that day, Kansas became the 17th state to pass a therapeutic law, which has greatly expanded the practice of optometry in Kansas.

The Kansas Optometric Association (KOA) conducted a study for the first year and a half after implementation of this law which asked KOA members to voluntarily keep track of all diagnoses made, therapies, the number of therapeutic encounters, the miles saved, and the referrals made to other doctors. This information was returned to the Kansas Optometric Association.

The Kansas therapeutics law for optometry includes the administering and dispensing of topical pharmaceutical drugs, as well as, the removal of superficial foreign bodies from the cornea and conjunctiva. Any anti-inflammatory agents administered are limited to a 14-day supply and may only be used topically.

RESULTS

Forty-three offices representing 47 optometrists responded to the study. This represents 23% of the 203 optometrists initially certified at SBEO to use therapeutics. Therefore, the results of this study will significantly understate the actual impact. Overall, the total mileage saved by the patients treated by optometrists during the 1½ year period is over 128,000 miles. This represents a major savings of time and out-of-pocket travel expenses for patients.

In Table 1, 23 major diagnoses are listed, with the number of cases of each per month, dating from July 1987 through December 1988. The cases that were referred to another doctor are not included in the table. Two cases of scleritis treated by rural optometrists are not included in the table. A case of scleral melt secondary to cataract surgery is not listed in the table, but is included in the study. This case was co-managed by an optometrist and a surgeon. This case alone saved the patient 1600 miles, encompassing all trips made to the optometrist.

The percentage of cases seen by optometrists practicing in cities versus those practicing in rural areas is considered in Table 2.

Table 3 shows the percentage of cases per month.

DISCUSSION

In Table 2, the greatest percentage of cases were seen by rural optometrists. It would seem that patients are turning to optometrists for their primary eye care in rural areas because of greater convenience. However, it is difficult to draw concrete conclusions in this regard because the majority of optometrists responding to this study are optometrists practicing in rural areas. It may be reasonable to assume that urban optometrists didn't respond because the miles saved would not be great. However, a higher urban OD's response would have reflected significant cost savings over emergency room visits.

In Table 3, the greatest percentage of cases seen per month occurs approximately one year after the implementation of the therapeutics law. There could be several reasons for this. The patients may be more aware of what optometrists can treat now than when the law first passed. Optometrists may also be more confident in treating more sophisticated ocular maladies. Also, as found in the study, optometrists are receiving more referrals from hospitals and general physicians.

CONCLUSION

Prior to April 17, 1987, none of the cases in this study would have been handled by optometrists because the Kansas optometry laws did not allow it.

The mileage saved by the patients became very important in rural areas, which have an optometrist available, but not an ophthalmologist. Since Kansas is largely a rural state, patients are benefiting from the revised optometry laws in time saved, money saved, elimination of unnecessary referrals, as well as improved health care.

ACKNOWLEDGEMENTS

Thanks to Michael P. Malone, O.D. for his assistance in the study and for the use of his optometric office to compile the information, the KOA for supplying the material to write this paper, and the many optometrists who participated in this study.

REFERENCE

Kansas Optometry Laws, 65-1501, 65-1501a.

YOU WILL HEAR

You have heard or will hear a number of reasons why the use of therapeutic drugs by optometrists is dangerous. Let me consider some of these.

YOU WILL HEAR that optometrists are not properly trained to use pharmaceuticals for therapy. This is simply not true. The course of study in this area is the same as that of medicine and more extensive than that of dentistry. Not only are the hours of pharmacology the same for medicine and optometry, but it should be noted that the medical student must study all organs equally, whereas, the optometry student can specialize in the eye once general pharmacology is completed. The drug interactions and systemic effects of the drugs administered for ocular conditions are studied in great detail. Students see numerous patients with pathology which requires pharmaceutical therapy. These students are supervised by ophthalmologists. So when other ophthalmologists say our students do not receive appropriate clinical instruction they are providing misinformation, by reacting emotionally not rationally.

YOU WILL HEAR that a profession which is non-medical should not be allowed to use drugs. Yet dentistry and podiatry are non-medical and use therapeutic drugs, and surgery in the course of their professional practice and no harm has come to the public. The real issue here is not whether optometrists are medical or non-medical; the fact is that optometrists are well trained health-care professionals.

YOU WILL HEAR that these therapeutic pharmaceutical agents can have systemic effects, effects on other parts of the body, and that there could be interactions with other drugs a patient may be taking. These are true statements and optometrists along with physicians, dentists, podiatrists and pharmacists study these areas and responsibly incorporate it into their practice. The information necessary for responsible use of these agents is in the public domain and accessible to all health professionals, not just to physicians. It was the result of scientific investigations and is not exclusively "medical".

YOU WILL HEAR that there will be public safety problems if optometrists are allowed to use these agents. Very unlikely situations and cases will be put forth, coupled with the assumption of absolutely no professional judgment on the part of the optometrist. These "strawmen" prove nothing. Yet, two states, West Virginia and North Carolina, have had this law for over 10 years and there have been no substantiated problems as a result. The reason I use the word substantiated is that there have been claims of problems but none that have been corroborated, and some have been found to be fraudulent. Twelve states have this law and the safety of the public is just fine. Better access, better quality care and cost containment have been the result.

In conclusion, optometry schools are educating and training optometry students well in the areas of diagnosis of eye pathology and in the responsible use of pharmacological agents. These students will graduate with the appropriate professional judgment to provide high quality eye care to their patients.

EDITORIAL

Lyman C. Norden, O.D., Editor

What makes optometric primary eye care better?

This issue contains another of several letters I've received stating that optometric primary eye care is better, not just less costly than ophthalmologic. Actually, I agree. Now how do we convince others?

It's easy to show that optometric care is less costly. All you have to do is look at financial balance sheets. Look at optometric training sites versus medical. Look at HMOs and governmental agencies in which optometrists provide the primary eye care. It's also easy to show that optometric training in primary vision care is better. All you have to do is look at curriculum. Optometric training involves far more hours in optics, refraction, and psychophysics of vision than does medical – and primary *vision* care is what most consumers really want from their eye care providers.

Ophthalmology, however, counters with a compelling argument that *medical training* makes its delivery of primary ocular *health* care superior to optometry's. Of course optometry then has to convince anyone still listening that its training in ocular health care is good enough to do the same. Perhaps we should start with our own compelling argument that optometric training is superior to medical training for the delivery of primary eye care, which includes *both* primary vision care and primary ocular health care. But first we must ask ourselves, "What is there about optometric training that results in better primary ocular health care?" Following are a few observations and opinions from one who has spent some 20 years in multidisciplinary practice settings, optometric training sites, and affiliated medical training sites.

First there is the matter of attitude, developed either in training or prior to training and then nourished by it. Medicine has a long-standing and often-dramatized association with life-and-death issues in patient care and in training for patient care. We see it in the media every day and we hear it in legislative sessions every year. It would be understandably difficult to train in such an environment without being caught up in the egocentrism that can result. This is not saying that egocentrism is bad. It's probably necessary for making clinical decisions about death and serious illness. But let's be realistic. People don't typically seek primary eye care for fear of death, blindness, or any other disabling illness. Most people seek primary eye care because they either want to see better or look better, or both. Optometrists seldom have trouble coming back down to earth when dealing with the vast majority of patients who simply want primary vision care. Similarly, optometrists seldom have trouble coming back down to earth when dealing with legislators and policy makers who simply want what is best for their constituents.

Optometrists are better able to communicate one-on-one with their patients. This is one of the principal reasons why optometry has been able to survive and grow within our medicine-dominated health care system. When given a choice, most people elect to receive their primary eye care from an optometrist. An important reason for this is that optometrists are better able to understand what people really want and need from their primary eye care providers. This ability to communicate effectively with primary care patients better enables the optometrist to elicit compliance in the pharmacologic management of eye disease.

I believe the development of these communication skills is inherent in optometric training because that training is based upon subjective refraction. In subjective refraction, the doctor in training bases virtually every step of the clinical examination on the patient's response to a question. How many doctors do you go to for health care who actually listen and respond to virtually everything you say for 30 minutes or more? How many doctors do you go to for health care who actually base their diagnoses more upon what you tell them than upon what they see in your tests? Unlike optometric training, fundamental medical training involves numerous clinical decisions based more upon laboratory tests and clinical observations than upon conversation with the patient. Optometrists, however, talk *with* their patients. This is why optometrists are more likely to obtain compliance from patients requiring ocular disease management.

I believe these communication skills are further refined in optometric training because that training involves both the prescription and fitting of prosthetic devices (eyeglasses and contact lenses). By comparison, medical training typically involves the prescription of pharmacologic agents, dispensed by a third party. Prescription medications are purchased and dispensed away from the prescribing doctor's office and quickly forgotten, whether they worked or not. Who wants to pay for another office visit and lose another half day in the doctor's waiting room because they're not sure a prescribed medication really worked? A prosthetic device, however, requires individualized fitting and when it doesn't perform satisfactorily, the patient usually knows it and returns it to its source, at which point the underlying problem must be confronted. Eyeglasses obtained from the prescribing optometrist which don't perform as expected are usually brought to the attention of the doctor in a remarkably efficient feedback loop. This direct feedback system is not a part of ophthalmologic training. Refracting ophthalmologists insulate themselves with opticians (and seem to think they are more virtuous than optometrists for doing so).

Not only must optometrists constantly stand ready to prove themselves to the patients for whom they prescribe, they must do so at virtually every turn within the total health care system. Medicine, because of its status in the eyes of the public, legislators and policy makers, seems always to be assumed right in everything it says until overwhelmingly proven wrong. Optometry on the other hand seems always to be assumed wrong until it proves itself incontrovertibly right.

Being challenged at every turn ultimately makes optometry better at what it does. Optometry has always had ophthalmology nearby, eager to point out any perceived errors in clinical judgement when a case goes bad. This naturally makes optometrists more conscientious and conservative in their treatment of patients. What other health care profession has a more active and therefore more effective quality assurance program?

Nothing in this discussion should be construed as a criticism of medical training. I see nothing wrong with medical training, nor am I in a uniquely credible position to criticize it. But I know what I like, and don't like, in every brand of health care I consume – and so do our patients. The point is that, for the provision of primary eye care, optometric training is better than medical training.

Optometric Education

The growth of the optometric profession is in no small measure due to the remarkable expansion of optometric education during the past thirty years. Because optometry is a relatively young profession, it has been able to benefit from the tremendous expansion in technology during recent years. Many people are not aware of the truly significant changes that have recently taken place in the profession and its educational base.

Fifteen schools and colleges of optometry in the United States now provide an educational experience that is equivalent in length and scope to that which is provided by schools of medicine and dentistry. All medical, dental and optometry programs are four years in length and require the same level of professional training. In fact, a comparison of the current catalogs of the University of North Dakota School of Medicine (UND) and Southern California College of Optometry (SCCO) demonstrates that the admission requirements of SCCO are actually more stringent than those of the UND.

Admission Requirements (Quarter Units)

	UND	SCCO
Calculus	Not required	3-4
Biology or zoology	8	8
Microbiology	Not required	4
Physics	8	12
General chemistry	8	12
Organic chemistry	8	4
Psychology	3	8
English	6	8
College Algebra	3	Not required
Total hours required	**90**	**90**

During the first two years of both professional programs, students receive extensive training in basic health sciences, such as pharmacology, anatomy, physiology, neurosciences, and pathology. The second two years are more clinically oriented; the medical student is trained in all aspects of medical care while the optometry student concentrates on the eye and visual system. The result is that the optometry graduate completes his training with much more extensive and in-depth training in the eye and in the diagnosis and treatment of its abnormalities than does the medical school graduate.

After graduation from the four-year professional programs, both the optometrist and the physician are examined and licensed by appropriate agencies of the state. This license allows the physician to practice all aspects of medicine and surgery, including the diagnosis and treatment of eye diseases and the performance of eye surgery. Although most physicians undergo additional training in one of the medical or surgical specialties, no further testing or licensure is required in order for them to practice as a specialist. Therefore, even though some physicians have undergone several years of additional training to become pediatricians, *any* physician is permitted to treat diseases of children, and even though some physicians have undergone several years of additional training to become obstetricians, *any* physician is permitted to deliver babies. Similarly, even though some physicians undergo several years of additional training to become ophthalmologists, *any* physician may treat diseases of the eye.

For legal and licensure purposes, it is assumed that the training received in the four years of medical school qualifies the graduate to practice all aspects of medicine with reasonable competency. **This assumption appears to work very well** since there appears to be little pressure for changes to the Medical Practice Act which would require that only specialists be allowed to treat various types of conditions.

This same assumption might well be applied to other health professions as well. If it can be demonstrated that the training a health professional receives in a given area is equivalent to or superior to that received by a physician, there seems to be no logical reason why he should not be allowed to do what the physician does in that area of health care. Since only about 4.5 percent of all physicians are ophthalmologists, it makes good sense to permit the doctor of optometry to provide primary eye care whenever possible.

Benefits of Use of DPAs Continue

Since the use of diagnostic pharmaceutical agents (DPAs) by optometrists was authorized by the 1979 North Dakota legislature, the benefit to the public of this action has continued to be demonstrated. More than 90 percent of North Dakota optometrists have been certified, and most use DPAs routinely in their diagnosis and treatment of vision problems. Contrary to the dire predictions of those who opposed the 1979 legislation, no adverse effects have been reported. In fact, the Optometry Board has not received any formal complaints or reports of problems associated with the use of DPAs by optometrists. Professional liability premiums, perhaps the best indicator of whether or not problems are occurring, have not been affected. The action of the 1979 legislature has proven to have been prudent and in the best interests of the people of North Dakota.

The North Dakota experience is the same as that in the other forty-eight states that currently permit optometrists to use DPAs. In none of these states has significant evidence been brought forth to suggest that any adverse effects are occurring. It is also worthy of special note that in the twelve states which permit optometrists to use therapeutic as well as diagnostic agents, no reports have been made of any problems associated with their use. In fact, it has been well

documented that the therapeutic agents are even less likely to cause complications than are the diagnostic agents. This underscores the fact that the optometrist of today is capable of using both diagnostic and therapeutic pharmaceuticals safely and effectively in his or her practice.

Because of the much broader geographic distribution of optometrists and the fact that fees charged by them are generally less than those charged by ophthalmologists, major savings to the public are realized when optometrists are permitted to practice at their highest level of training. The necessity of referring persons with relatively minor eye injuries or infections to a surgical eye specialist or a hospital emergency room always results in a charge for the second examination and frequently results in the loss of several additional hours from the patient's work and/or the travel of many additional miles.

Optometry *IS* Primary Eye Care

Analysts of the health-care delivery system have divided it into three broad categories which they have labeled primary care, secondary care, and tertiary care.

Primary care is that level of care delivered by "first contact" providers. These are the doctors first contacted by a person in need of health care, and they are able to diagnose and treat the great majority of persons they see. It has been estimated that from 85 to 95 percent of all health care can be classified as primary care. In general, primary-care providers do relatively little of their work in hospitals. The American Medical Association considers family and general practitioners, pediatricians, internists, and obstetrician/gynecologists to be primary medical care providers. Other primary-care providers include general dentists, optometrists and podiatrists.

Secondary-care providers are generally those who have received additional specialized training beyond that which is required of primary-care providers. Persons with unusual or complicated problems or those who require more than very minor surgery are generally referred to a secondary-care provider by a primary-care provider. Most surgeons are classified as secondary-care providers, and secondary care involves more use of hospitals and specialized facilities than does primary care. Among the medical specialties, orthopedic surgeons, ophthalmologists, anesthesiologists, and cardiologists are examples of secondary-care providers. Non-medical secondary-care providers would include dental specialists, such as orthodontists and periodontists, and optometrists who limit their practice to contact lenses.

Tertiary-care providers are those who specialize in the diagnosis and treatment of rare conditions. Their practice is almost always hospital based and requires additional training beyond the secondary level and use of sophisticated techniques and instruments. Examples of tertiary-care providers would be open-heart surgeons, brain surgeons, ophthalmologists who repair retinal detachments, and organ transplant specialists.

Because of the additional training and skills required to practice at the secondary and tertiary levels, the care provided is usually more expensive than that provided at primary level. Even in cases where the fees charged are the same, when the costs to society of education and training are considered, the cost of secondary and tertiary care is higher. Since the vast majority of all care can be provided at the primary level, it makes good sense from an economic standpoint to have as much care as possible provided at that level, and in most cases, it is. For example, even though a cardiologist may have more training in the management of high blood pressure, family practitioners are perfectly capable of managing uncomplicated cases. And even though an orthopedic surgeon may have more training in the anatomy and function of the joints, a pediatrician is perfectly capable of treating a child's simple sprained ankle.

Similarly, optometrists, although they do not have the same training as do ophthalmologists, are perfectly capable of managing uncomplicated eye conditions. Their education and training in the diagnosis and treatment of eye problems is much more extensive than that of most physicians, and **their past record of conscientious, conservative care is evidence of their ability to recognize and refer to other providers those conditions that require care at the secondary or tertiary level.**

Health Care Not Necessarily Medical Care

Although the terms *health care* and *medical care* are often used interchangably, they do not really mean the same thing.

Health care is a broad term that refers to the entire area of maintenance of physical well-being. *Medical care* is much more limited in that it refers to health care which is provided by medical doctors.

Although the various areas of health care seem to be fairly well defined, many areas overlap. For example, the Medical Practice Act, since it was the first to be enacted, is all-encompassing and permits the physician to practice all aspects of health care regardless of whether or not he or she has any training in that area. Thus, any physician may legally fill teeth or prescribe eyeglasses. On the other hand, certain procedures which would usually be considered the exclusive domain of physicians are done by some other health-care providers. Dentists are permitted to use general anesthetics and prescribe oral antibiotics and potent pain-

DICTIONARY OF VISUAL SCIENCE

SECOND EDITION

A modern comprehensive dictionary covering the terminology of the visual sciences, including the fields of ocular anatomy, ocular physiology, ocular pathology, ocular embryology, neuro-ophthalmology, ocular histology, ocular genetics, comparative anatomy of the eye, ocular prosthetics, physiological optics, psychological optics, ophthalmic optics, geometrical optics, ocular refraction, orthoptics, visual training, dispensing, aniseikonia, perimetry, contact lenses, subnormal vision aids, occupational vision, and motorists' vision, and also including the phases of remedial reading, statistics, illumination, and physical optics that relate closely to vision.

Illustrated

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nclose or bind a group
, or as a means of at-
for muscles at their
nsertion.
ı orbitale.
ris, a. Tenon's capsule.
neal (ap'o-plek"se).
of blood into the cor-

nal. Copious hemor-
the retina.
t'ilb). A unit of lumi-
d to ⅒ millilambert.
otlambert.
'ah-ra'tus, -rat'us). 1.
r group of organs, or
rgans, which collec-
m a common function.
tion of instruments,
implements used for
k, as an experiment
ion.
e a. Those parts of
an, other than the
ve and the receptor
are essential for the
of the organ. In the
ıld include all struc-
han the optic nerve
s and cones of the

e a. The structures
hich are related to
on; the ciliary ap-
the crystalline lens.
ciliary muscle and
e structures other
stalline lens which
to accommodation;
dy.
ə tear-forming and
g system, com-
mal and accessory
's, eyelid margins,
ac, lacrimal lake,
ə, canaliculi or lac-
ommon canaliculus
aier, lacrimal sac,
uct, and Hasner's
erior meatus of the

e intraocular and
r musculature of

the eye considered collectively. See under *muscle* for the specific muscles involved.

nervous a. The sensory and the motor nerves of the eye and the orbit considered collectively. See under *nerve* for the specific nerves involved.

refractive a. Cornea, aqueous humor, crystalline lens, and vitreous humor considered collectively; the surfaces and the media traversed by light entering the eye and involved in the production of the retinal image.

visual a. The two eyes, their extrinsic muscles and other contents of the orbits, the nerves, the pathways, and the visual cortex, considered collectively. Syn., *visuum.*

apparent height; magnification; magnitude; movement; position; pupil; size; strabismus. See under the nouns.

apparition (ap"ah-rish'un). 1. A supernatural visual manifestation. 2. A visual hallucination.

appearance. 1. The distinctive characteristics or features of an object or an individual as noted by visual observation. 2. The originating of an experience, particularly visual. 3. An incorrect visual or other impression.

appendages of the eye (ăpen'dih-jez). The accessory structures or adnexa of the eye, including the lacrimal apparatus, the conjunctiva, the cilia, the supercilia, the eyelids, and sometimes the extraocular muscles.

apperception (ap"er-sep'shun). The action of past experience upon received sensory stimuli, resulting in individual differences of interpretation of the same sensory stimuli.

applanatio corneae (ap"lah-na'she-o kor'ne-e). A flattened cornea due to degenerative changes.

applanation (ap"lah-na'shun). An abnormal flattening of a convex surface, especially of the cornea or the crystalline lens.

apraxia (a-prak'se-ah, ă-prak'-). The inability to accomplish an intended or purposeful movement, the nature of which is

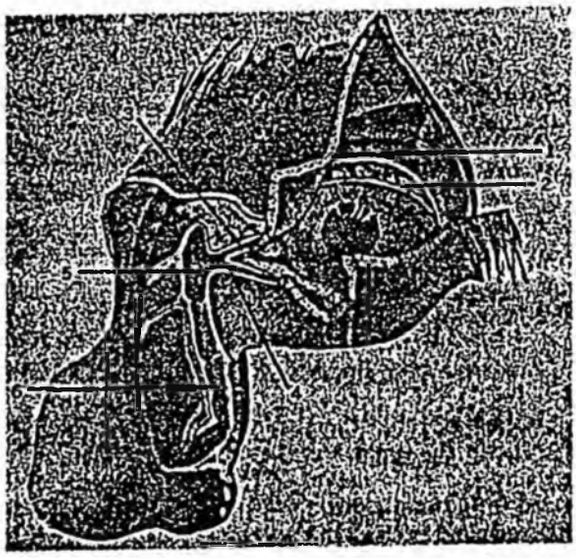

Fig. 3. The lacrimal apparatus. (1) Superior lobe and (2) inferior lobe of lacrimal gland. (3) Superior and (4) inferior canaliculus. (5) Lacrimal sac. (6) Nasolacrimal duct. (From *Text-book of Ophthalmology*, Vol. I, Duke-Elder, Henry Kimpton, 1942)

APHA recognizes contributions to public health, vision care

ATLANTA— The Vision Care Section (VCS) of the American Public Health Association (APHA) recognized the contributions of a public health leader and a public policy center at the association's 119th annual meeting.

Recognized for his important contributions to public health in general and vision care in particular, was Harris Nussenblatt, O.D., Dr.P.H., of Houston, TX, winner of the section's 1991 Distinguished Achievement Award. Dr. Nussenblatt is a founding member of the Vision Care Section and served as chair from 1982-84. He also served as section councilor, program chair and editor of the section's newsletter for many years. He was also cited for his committee work for the American Optometric Association (AOA) and the Association of Schools and Colleges of Optometry (ASCO) by Les Caplan, O.D., M.P.H., awards chair.

"In summary, Dr. Harris Nussenblatt's record is one of academic excellence with significant contributions to public health and eye care issues. His work has always been attune to changes in health care delivery while being both a leader and team player — all of which has improved the health and well-being of the public," said Dr. Caplan.

The section's Outstanding Paper Award went to Mordachai Soroka, Ph.D., of the Center for Vision Care Policy, State College of Optometry, State University of New York. The award paper, titled "Comparison of Examination Fees and Availability of Routine Vision Care by Optometrists and Ophthalmologists," was recently published in *Public Health Reports*. Dr. Soroka's national survey determined that ophthalmologists' fees are $19 more than optometrists' fees for routine eye examination. In addition, he reported that the waiting time for routine examinations with ophthalmologists was 15 days longer than for optometrists, which added a barrier for access to services.

Harris Nussenblatt, O.D., Dr. P.H.

The VCS sponsored numerous papers presented during the conference. The papers highlighted a patchwork quilt of subjects and their effect upon public health. Panel presentations addressed model diabetes control programs, screening underserved populations, and eye care in underdeveloped countries.

Papers were presented by ODs as well as physicians, nurses, government representatives and scientific researchers, according to Debbie Hettler, O.D., M.P.H., Chicago, IL, program chair for the VCS.

"The meeting offered a great opportunity to interact with health professionals from around the world and enhance the role of optometry in the total health care system," said Ian Berger, Ph.D., VCS Action Board representative, Houston, TX.

SCCO program covers AIDS and vision problems

FULLERTON, CA— "Eye/Vision Problems Associated With AIDS," was the topic of a recent, special edition of the Southern California College of Optometry's (SCCO) Vision and You cable television program. The program featured SCCO faculty members John Nishimoto, O.D., and Russell Jew, O.D., discussing the devastating effect of AIDS on the eyes. In some cases, eye signs of AIDS are the first to be noticed as the retina is almost always affected by the malady. AIDS can have serious consequences on the patient's vision, the doctors noted.

Dr. Nishimoto and Dr. Jew emphasized that all HIV-positive patients should have an eye examination every three months. Sometimes, the first sign of full-blown AIDS is seen in the eye and treatment to prevent the AIDS virus from multiplying rapidly must be started in order to save at least some vision.

The AIDS virus has been noted in the tear layer of the eye, so optometrists should

Frescura, luminary of European optometry, dies at 85

Romeo Frescura, a founding member of the European Optometry Society (SOE), has died at the age of 85 in Imperia, Italy. The second of four generations in the optical field, Frescura was a consultant to the Italian government for eye care and served as president of the optometric trade union there. Active in optometric education in Italy, France and Germany, he served as president of the SOE for nearly 20 years. He is survived by his son, Ugo Frescura, president of the SOE since 1985.

Deaths

ST. LOUIS-- The American Optometric Association derives its great strength and spirit from its people, and mourns all those it loses. The following are those members whose passing has been reported to the *AOA News* as of Dec. 1, 1991

The Evening Sun

A12 Baltimore, Thursday, June 2, 1989

Editorial

Double vision

Governor Schaefer justified his veto last week of the "eye drops" bill by saying the measure would have "lowered the standard of medical care here." In fact, the governor's action ensures that Maryland, alone in the nation, will retain a double standard of eye care — one for those who have access to an ophthalmologist, and another for those who cannot afford the higher fees or live in rural areas of the state not served by an ophthalmologist.

The "eye drops" battle has been a legislative fixture for so long that it can almost be seen as an duel between lobbyists. But the political fight shouldn't obscure the real issue here, which is rank protectionism for one branch of the medical profession. Maryland's law governing the practice of optometry was adopted in 1914, and since then not one word has been changed. Meanwhile, every other state in the nation has allowed optometrists to use eye drops ("pharmaceutical agents") in order to check patients for disease. This is not a radical idea; optometrists everywhere else in the country routinely use this important diagnostic tool. Maryland optometrists are trained in the use of diagnostic eye drops and are authorized to use them in the state's Veterans Administration Hospitals or in public health facilities, but not in their private offices.

One result of Maryland's backward law is that the number of new applicants taking the state's optometry exam has dropped by half in the last five years. In other words, affordable eye care will become harder to procure — a sign that does not bode well for vision in this state.

Second Opinion

Frank Pesci

Last week, Gov. William Donald Schaefer vetoed a bill that would finally allow optometrists in Maryland to use eyedrops for diagnostic purposes. For years the bill has been a turf battle in Annapolis between optometrists and ophthalmologists.

Schaefer's veto makes Maryland the only state left which still denies optometrists the right to use eyedrops to dilate patients' pupils. Can you imagine that?

Schaefer said he was swayed by medical authorities and his own ophthalmologist who requested he veto the bill. He said he didn't believe that optometrists' training requirements adequately compare to the training required of ophthalmologists.

Sen. Arthur Dorman, D-21st-Beltsville, an optometrist, didn't buy Schaefer's reasons for the veto.

Dorman would like to know the real reason for the veto.

Dorman knows the real reason. He just doesn't want to say. So I'll say it for him.

The real reason is Bruce Bereano, Annapolis' number one money-making lobbyist. Bereano represents the ophthalmologists, and in 1986 he raised tens of thousands of dollars for Schaefer's gubernatorial campaign.

Two months ago, I ran into Bereano after breakfast at the Maryland Inn. Winking, he spoke about getting a veto of the eyedrop bill if it passes. Do you see a quid pro quo?

I learned a long time ago that the sleaze factor in politics comes in bipartisan doses. The Republicans have their Ed Meese, and in Maryland the Democrats have Schaefer and Bereano.

Frank Pesci of New Carrollton, who writes regularly for this page, is a former member of the Maryland House of Delegates.

Opinion

Schaefer's eye-drop veto

Gov. William Donald Schaefer was in a quandary last week. He had to decide whether to sign or veto a bill allowing optometrists to administer eye drops to dilate patients' pupils, a procedure that helps the optometrists detect eye disease.

On the side of signing the bill were the governor's own health secretary, optometrists, consumers, the General Assembly, which passed the bill earlier this year, and the fact that every other state in the union allows optometrists to administer eye drops.

On the side of vetoing the bill were ophthalmologists, who stand to lose customers and money if the bill becomes law, and Bruce Bereano, the ophthalmologists' high-powered lobbyist, who also raised tens of thousands of dollars for Schaefer's gubernatorial campaign.

No contest, if you're this governor. Schaefer vetoed the bill.

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DOCUMENTS WHICH HAVE NOT BEEN FILMED BUT ARE AVAILABLE IN THE ORIGINAL FILE INCLUDE:

CORRESPONDENCE AND COMMENTS RELATIVE TO SB 157 FROM:

1. CALLISTO MEDICAL CLINIC, KETCHIKAN, 2/18/92
2. STATE OF FLORIDA, DEPT. OF HEALTH AND REHABILITATIVE SERVICES, 4/23/90
3. THE COMMONWEALTH OF MASSACHUSETTS, DIVISION OF INSURANCE, 3/26/90
4. IOWA STATE BOARD OF OPTOMETRY EXAMINERS 2/17/90
5. COMMONWEALTH OF KENTUCKY, BOARD OF OPTOMETRIC EXAMINERS, 4/24/89
6. AMERICAN ASSOCIATION OF RETIRED PERSONS NEVADA STATE LEGISLATIVE COMMITTEE, 4/24/89
7. VALLEY EYE AND LASER CENTER, RENTON, WASHINGTON, 3/13/89
8. NORTHWEST EYE CENTER, SEATTLE, WASHINGTON, 2/08/89
9. SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES 12/21/88
10. COMMENTS OF LESLEY W. WALLS, O.D., M.D. TO THE VIRGINIA STATE BOARD OF MEDICINE, 12/20/88
11. WEST VIRGINIA BOARD OF OPTOMETRY, 10/16/86