SB

157

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

NC 1

Bill Version: SB 157

Revision Date: _____ Department Affected: _____ (S) Publish Date: 5/3/91

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

Component: Administration

Sponsor: Senator Adams

Requestor: Senate HESS COMPONENT SERIAL NO. 0 3 3 6

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL						
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	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

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, Administrative Officer Phone: 465-2144

Division: Occupational Licensing Date: March 11, 1991

Approved by Commissioner: Glenn A. Olds

Agency: Department of Commerce & Economic Development Date: 3-11-91

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

Rev 10/90

Alaska State Legislature

Al Adams
District L

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Official Business

TO: Senator Drue Pearce, Chair
Senator Labor and Commerce Committee

FROM: Senator Al Adams APA

RE: Senate Bill 157

DATE: May 7, 1991

I would like to request a hearing on the aforementioned legislation in the Senator Labor and Commerce Committee. I understand you have already received back-up information from the Senate HESS Committee.

If you have questions or concerns, please feel free to contact Martha Stewart in my office.

ALASKA'S DOCTORS OF OPTOMETRY

Fact sheet for SB 157

A: Access:

Alaskans in communities like Sitka, Kodiak, Homer, Ketchikan and others do not have access to eye care. Most Alaskan communities have no medical specialists, and the local optometrist is the most highly trained, specialized, and instrument-equipped professional in town, with over 60 of us scattered throughout the state.

B: Better Care:

The optometrist is often the first contact for a patient suffering from an eye disorder. Needed treatment can be started immediately, which is an important aspect in treating many eye diseases.

C: Cost Containment:

Optometrists' fees are generally lower than those of medical specialists and hospitals; the cost of a 2nd visit to another doctor or clinic would be eliminated; travel time and expense would be eliminated as well as extra time away from work. These are documented cost savings from other states. Increased competition with freedom of choice among health providers also holds down costs.

D: Doctors of Optometry:

Optometrists have been prescribing drugs for their patients across the nation for the past 15 years, with 26 states currently allowing therapeutic drug treatment of eye diseases. No laws have been repealed, and 13 more states have bills pending. There have been no problems nationally, and the malpractice insurance premiums for optometry are the same in states with and without therapeutic drug laws.

E: Education:

Optometry training is on a par with medicine, dentistry and podiatry. An undergraduate college degree plus a 4 year doctorate program and often a residency in a hospital-based setting. The letter from Dr. Les Walls, a medical school professor and now an optometry school dean, best explains our education. Older optometrists who did not originally receive advanced therapeutic training would not be grandfathered. They would be required to return to school for additional training and pass rigid State Board standards and exams to be endorsed to use therapeutics.

F: Fairness:

Under the current state law, the optometrists in most communities must refer their patients needing eye medication to a nurse practitioner, health aide, or general medical doctor with far less training than optometrists have.

G: Government:

Approximately 5 agencies of the Federal Government have studied optometry and found us competent in therapeutic treatment and surgical co-management. Military and Indian Health optometrists have used therapeutic drugs for many years. Optometrists are considered "physicians" under federal Medicare law, being allowed to provide any services the state law allows. The national American Public Health Association recently passed a resolution supporting optometry therapeutics in all states.

This legislation is in the best interest of the public health.

7-LS0881\A.1
Luckhaupt
03/13/92

AMENDMENT

OFFERED IN THE SENATE

TO: SB 157

Page 1, following line 2:

Insert a new bill section to read:

"* **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."

Page 1, line 3:

Delete "**Section 1**"

Insert "**Sec. 2**"

Renumber the following bill sections accordingly.

Page 1, line 4, following "may":

Insert "prescribe and"

Page 1, line 13, following "authorizing the":

Insert "prescription and"

Page 2, line 1:

Delete "or administer"

Insert "prescribe, or use"

7-LS0881\A.2
Luckhaupt
03/13/92

AMENDMENT

OFFERED IN THE SENATE

TO: SB 157

Page 1, line 7:

Delete "(A)"

Delete "or"

Insert "and"

Page 1, lines 8 - 12:

Delete all material.

Department of Commerce & Economic Development / POSITION PAPER

SB 157: "An Act relating to optometrists."

This bill authorizes the use of therapeutic pharmaceutical agents in the practice of optometry after a license endorsement has been earned by providing proof of competency in the use of those drugs.

It further authorizes optometrists to remove superficial foreign bodies from the eye and its appendages. The bill states it is not intended to allow "invasive surgery."

The Board of Pharmacy has expressed objections to the prescriptive rights for oral medications, citing the list as being vague.

The department does not oppose SB 157.

Glenn A. Olds, Commissioner

Date: 3-13-92

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

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Ketchikan, AK 99901
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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

Frank H. Murkowski
United States Senator

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

SB 157

MAY 13, 1991

SENATE L & C 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

Telephone: (907) 276-2080

May 10, 1991

I am representing the Alaska Optometric Association, which is affiliated with the American Optometric Association. My term recently expired as a member and president of the State Board of Examiners in Optometry. I am a life-long Alaska Native from Southeast, and currently practice in Anchorage.

Optometrists in Alaska practice under a restricted license, so that any time we have an increase in training, scope or a new procedure, we must return to the Legislature to update our practice act, unlike our other medical and non-medical colleagues. In 1988, Alaska was the 49th state to allow optometrists to receive a license endorsement to use certain drugs on the eyes of their patients, after meeting strict Board requirements and examinations. This bill would amend the law, allowing the use of therapeutic medication by Board qualified optometrists, using their professional judgement and expertise to treat common eye disorders that do not require the services of a surgical sub-specialist. I will present a brief summary of the facts that demonstrate the public need for this legislation.

A: Access:

Alaskans in communities like Sitka, Kodiak, Homer, Ketchikan and others do not have access to eye care. Most Alaskan communities have no ophthalmologists, who are surgical specialists in secondary and tertiary care, but the local optometrist is the most highly trained, specialized, and instrument-equipped provider of primary medical eye care available. There are over 60 doctors of optometry scattered throughout Alaska.

B: Better Care:

The optometrist is often the first contact for a patient suffering from an eye disorder. Needed treatment can be started immediately, which is an important aspect in treating many eye diseases. Under current state law, the optometrists in most Alaskan communities must refer their patients needing eye medication to a nurse practitioner, health aide, or general medical doctor with far less training in eye treatment than the optometrist. The family doctor of optometry is a valued and trusted friend to many people in the community, who would prefer to have a choice for primary eye treatment.

JEFFREY A. GONNASON, O.D.
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C: Cost Containment:

Optometrists' fees are generally lower than those of ophthalmologists and hospitals. The cost of a 2nd visit to another doctor or clinic for medication would be eliminated; travel time and expense would be eliminated, as well as extra time away from work. These are experienced cost savings from other states. Increased competition with freedom of choice among health providers also holds down costs. Anchorage has the state's lowest fees for routine eye exams for both M.D.'s and O.D.'s because of competition, and the optometrist's fees are lower.

D: Doctors of Optometry:

Optometrists have been prescribing therapeutic medication for their patients across the nation for the past 15 years, with 26 states currently allowing therapeutic drug treatment of eye diseases. No laws have ever been repealed, and 13 more states have therapeutic bills pending. There have been no problems nationally, and all the predictions of public harm have proven false. The malpractice insurance premiums for optometry are the same in states with and without therapeutic drug laws. The courts hold optometrists to the same standard of care as medical doctors.

E: Education:

Optometry training is on a par with medicine, dentistry and podiatry. An undergraduate college degree, plus a 4 year doctorate program and often a residency in a hospital-based setting. Of all the other health professions with a similar education, optometrists are the only ones not allowed to prescribe medications in Alaska. The letter from Les Walls, M.D., a medical school professor and now an optometry school dean, best explains optometry education. Older optometrists who did not originally receive advanced therapeutic training would <u>not</u> be grandfathered. They would be required to return to school for additional training and pass the same rigid State Board standards and exams to be endorsed to use therapeutics.

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F: Federal Government:

Approximately 5 agencies of the Federal Government have studied optometry and found competentcy in therapeutic treatment and surgical co-management. Military and Indian Health optometrists have used therapeutic drugs for many years. Optometrists are considered "physicians" under federal Medicare law, being allowed to provide any eye treatment services the state law allows. The national American Public Health Association recently passed a resolution supporting optometry's use of therapeutics in all 50 states.

This legislation is in the best interest of the public health. All these facts are backed by volumes of documentation, research, and experience on a national basis. I can provide more detailed information on any question you may have. Thank you for this opportunity.

Sincerely yours,

Jeffrey A. Gonnason, O.D.

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

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 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.

Member
American Optometric Association

Tanana Valley Clinic

Family Medical Care

Since 1959

April 18, 1991

Alaska State Legislature
Juneau
Alaska 99811

To the Legislators:

I am writing to you requesting support for the proposed Senate Bill 157 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,

Marvin E. Bergeson, M.D.
Pediatrics

MEB:sr

1001 Noble Street • Fairbanks, Alaska 99701
(907) 452-1611 • FAX (907) 456-8770

Fairbanks Clinic
Quality Care Since 1932

April 23, 1991

Alaska State Legislature
PO Box V
Juneau, Alaska 99811

Dear Sirs:

I am writing this letter in support of Senate Bill 157 concerning optometry prescribing privileges.

I was on active duty as a medical officer in the United States Air Force from 1981-1988. 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 its 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 therapeutics training during his original professional schooling or evidence of adequate education in ocular therapeutic 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 Senate Bill 157.

I have had the opportunity to work with several 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 optometrist-prescribing practices.

I feel that it would be a benefit to the residents of Alaska to permit optometrists to prescribe those medications noted in Senate Bill 157. I believe that appropriately trained optometrists are capable of effectively and safely treating relatively minor eye problems with medications, as specified in Senate Bill 157, and therefore am in favor of passage of this bill.

Sincerely,

Enlow R. Walker, M.D.
Family Practice

ERW/hlb

1867 Airport Way • Fairbanks, Alaska 99701
(907) 452-1761

April 4, 1991

To the Legislature.

This is a letter of support for the bill in Legislation which will permit Optometrist; to prescribe and dispense medication.

The clinic where I work is located in Metlakatla and the nearest Ophthalmologist is in Juneau. Patients that have an acute eye problem and need to be evaluated by an "eye specialist" are referred to the Optometrist, Dr. E. Christiansen, in Ketchikan for evaluation and a treatment plan. After Dr. Christiansen evaluates the patient, he calls the referring physician to tell them his findings and recommendations. On occasion, Dr. Christiansen has recommended that the patient be seen by an Ophthalmologist for care we send the patient to Juneau. But, not all patients have needed to be referred to the Ophthalmologist. It has saved the clinic unnecessary travel expenses for those patients Dr. Christiansen can treat.

For the above reasons, I support the bill which will permit the Optometrist to prescribe and dispense medications.

Thank you.

Barbara Fine

Barbara Fine, RN
P. O. Box 652
Metlakatla, Alaska 99926

April 8, 1991

Alaska Legislature
Juneau, AK

Dear Legislators,

We are writing this letter to inform you that we support the bill in legislation that will allow Optometrists to prescribe medications for the treatment of eye disease.

I was previously a patient of Ed Craig, O.D. who practiced in our community for many years. In fact it was he who first detected my glaucoma in 1985 and referred me to an ophthalmologist in Seattle for treatment. My health is not as good as it once was and I find it impossible to travel to Seattle for my follow-up visits. Dr. Eric Christiansen has taken over Dr. Craig's practice and has been following the status of my the glaucoma for a year. I feel comfortable with his care and follow-up. I had a bad experience with the ophthalmologists that travel to our city periodically and do not wish to see them for care. It frustrates my husband and I when we cannot get a prescription for eye drops renewed or changed during a follow-up visit at Dr. Christiansen's office. The doctor must call the ophthalmologist in Seattle and have him call my prescription to a pharmacy in Ketchikan. Dr. Christiansen has told us the ophthalmologist in Seattle is uncomfortable with this arrangement due to my inablility to travel to Seattle for follow-up. Optometrist's are available any time because they live here. If their education trains them to understand the prescription of medications for treatment of eye disease then they should be allowed to prescribe it. It would save Alaskan's with eye problems time, money, and frustration. It would also improve our ability to obtain treatment immeadiately if we need it. Please consider passing this important legislation. Thank you.

Regards,

Ruth Terwilliger

Ruth Terwilliger

Ruth A. and Wesley B. Terwilliger
Marine View, Apt. 509
Ketchikan, AK 99901

April 5, 1991

Alaska State Legislature
P.O. Box V
Juneau, AK 99811

Dear Legislator:

I am writing in support of Senate Bill 157 (Optometry Pharmaceuticals). I am glad to hear Alaska is currently addressing the issue of optometrists being allowed to prescribe a variety of therapeutic agents.

This action is long overdue and has already been approved in 26 other states.

I am a Colonel in the Air Force, a board certified Family Physician and Chief of the Emergency Room, Family Practice, and Primary Care Department at Elmendorf Air Force Base Regional Hospital. I have thus had frequent professional exposure to optometrists and thus feel I can speak quite objectively.

I feel optometrists are fully qualified to expand their prescribing service to their patients.

I would hope an objective review of this issue be undertaken and passage of the bill be the outcome.

Sincerely,

Richard M. Stratton

Richard M. Stratton, M.D., Colonel, USAF, MC

Kachemak Bay Medical Clinic
Professional Corporation
PAUL D. RAYMOND M.D.
4285 Hohe St., Suite 2
Homer, Alaska 99603
(907) 235-4050

May 2, 1991

Dear Legislator:

I am writing this letter in support of Senate Bill 157, which involves the use of pharmaceutical agents by optometrists. As a family practitioner in a rural area of Alaska, without the presence of ophthamologists we depend greatly on qualified optometrists for evaluation and treatment of superficial and anterior chamber eye disease. This would include administrating topical steroids, antibiotics and antiglaucoma agents to the human eye. Obviously, this would be inherent on the licensee having been endorased under AS 08.72.175.

The ability of appropriately trained optometrists to diagnose and treat anterior chamber and superficial eye disease would prove beneficial not only for rural physicians but also would serve in the patients' best interests concerning long term cost containment. In my experience the optometrists in the geographical area in which I practice appropriately refer ophthamologic patients to board certified ophthamologists when indicated.

I appreciate your support.

Sincerely,

Paul D Raymond MD

Paul D Raymond M D
D Raymond MD

PDR:nmc
cc: Boyd Walker

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. 3/20/87

Lynn J. Coon, O.D.

Oliver M. Korshin, M.D.

Edward E. Crouch, M.D.

CALLISTO
MEDICAL CLINIC
"Numquam occidens stella"

Thomas L. Conley M.D., FAAP
Physician Services

Peggy Midgett Jones
Patient Coordinator

Jean Kemmerer
Office Manager

Susan Walsh R.N.
Nursing Services

February 18, 1992

Senator Drue Pearce
Alaska State Legislature
State Capitol
Juneau, Alaska 99801-1182

Dear Senator Pearce:

I am writing in general support of SB157 which would permit appropriately trained optometrists to use and prescribe ophthalmologic medications. I do think it needs some reworking in a number of areas.

As a member and for five years chairman of the Alaska State Medical Licensing Board I was involved in hammering out the compromise between optometrists and ophthalmologists that permitted use of certain topical agents under the provisions of AS 08.72.175 and AS 08.72.272. It was obvious at the time that eventually optometrists would be back asking for expansion of this authority to use all topical medications and authority to remove foreign bodies from the eye for indeed their training qualifies them to make these judgments and to perform these tasks.

Opposition from ophthalmology in 1988 to Sections 175 and 272 was spirited and can be expected to be spirited in regard to the request for the expansion of authority proposed in SB 157. It was couched in terms of protection of the public health and such surely will be the countering argument in 1992. However such arguments are clearly a smoke screen, optometrists are indeed adequately trained in these areas and the battle is rather one over turf and resultant compensation. In such a contest the state should stand neutral - as long as in this case both groups are trained adequately in the area - and let the market decide the outcome.

I would recommend however some reworking of the bill. It would seem appropriate to delete reference to oral medications for such moves outside the competence of optometry with the exception that oral anti-glaucoma medications might be administered with telephonic consultation and quickly referral. As to topical medications the authority should extend to prescription in addition to administration. This might require some changes in the pharmacy and medicine sections of Chapter 08, a task which legislative research should be able to handle.

Finally, believing as I do that licensing boards should pay their own way, I would tack a $50.00 endorsement fee onto the licensing fee of any optometrist who seeks this authority to help defray the administrative and testing costs of the endorsement.

To put the whole thing in prospective it should be pointed out that physicians assistants, who have much less formal training than optometrists, are routinely prescribing much more potent and dangerous drugs (including topical ophthalmologic drugs) than are proposed here. Medicine accepts their practice. It is therefore logically inconsistent for it to oppose the use of topical medications and the removal of ocular foreign bodies by optometrists. It will be argued that physician assistants are under supervision and so they are in theory. However the required once a quarter in-person supervision hardly makes for close scrutiny. I am not by any means attacking the physician assistant system, which I support, and which has extended medical care to many Alaskans who would otherwise lack it. It has indeed worked fairly well. In similar manner it can be expected that well trained optometrists will, granted the authority asked here, extend competent eye care to many Alaskans who would otherwise not receive such.

Sincerely,

Thomas L. Conley, M.D.

TLC:ts

ANPA
Alaska Nurse Practitioner Association

February 24, 1992

Subject: SB 157 Qualified optometrists to prescribe limited therapeutic pharmacologic agents for treatment of primary eye diseases.

Dear Legislator:

It is the position of the Alaska Nurse Practitioner Association to support the efforts of the Alaska Optometric Association to obtain limited therapeutic pharmacologic prescriptive authority. The ability to diagnosis and treat common eye problems will be evident in the decreased cost for long term problems related to untreated eye problems.

Often, the optometrist is the only eye specialist travelling to the bush areas. Without the ability to treat the common eye problems seen in the bush, patients would have to pay travel costs to a regional center instead of being treated in the village. The expediency of treatment lowers the costs to both the patients and the state. Untreated eye conditions can develop into more costly long term conditions requiring travel to a larger medical center and specialized treatment.

We hope you will join us in support of SB 157

Sincerely,

Wendy Thon, ANP
Alaska Nurse Practitioner Association
Secretary

American Public Health Association

1015 Fifteenth Street, NW
Washington, DC 20005
202/789-5600

March 10, 1992

Dear Alaska Legislator:

At its 118th Annual Meeting, the American Public Health Association (APHA), which represents a combined national affiliate membership of over 52,000 public health professionals and community health leaders, adopted a resolution entitled "Access to Treatment for Eye Care by Optometrists". A copy is enclosed for you information.

This resolution acknowledges that the expansion of clinical privileges of optometrists has increased the availability, accessibility, and cost effectiveness of eye care to the American public. The resolution recommends that States update their optometric practice acts to allow for optometric use of those diagnostic and therapeutic pharmaceuticals which have been determined by the State Board of Examiners in Optometry as being within the scope of competency of pharmaceutically certified optometrists. We further recommend that dispensing of such pharmaceuticals be regulated by state pharmacy laws.

Currently, 30 states allow optometrists to use therapeutic drugs for the benefit of their patients. APHA urges your support for legislation which encompasses the principles endorsed in the APHA resolution, and would result in better access to comprehensive eye care of the American citizens.

Thank you for considering the American Public Health Association's view.

Very truly yours,

William H. McBeath, M.D., M.P.H.
Executive Director

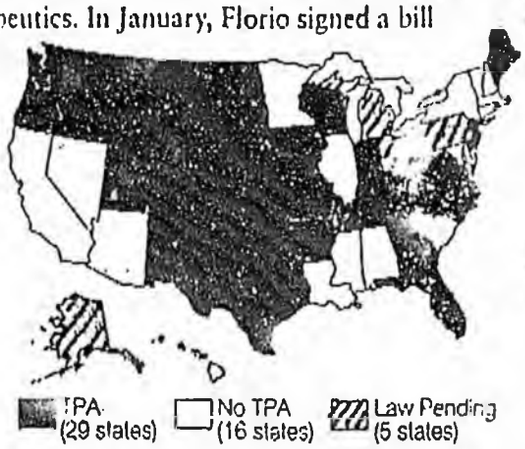
Enclosure

Dr. Bill Faulkner, Optometrist
400 L. Street, Suite 104 Anchorage, Alaska 99501
(907) 276-1984 Fax (907) 276-1981

PROFESSIONAL NEWSLETTER February 1992
Things you should know

A TPA For New Jersey

■ New Jersey Governer Jim Florio has made his the first industrial state to allow O.D.s to use therapeutics. In January, Florio signed a bill allowing O.D.s to use all topical therapeutics. The bill excludes orals, injectables and controlled substances. In other news, Ohio and Michigan lawmakers were slotted to vote on TPAs in late January and early February.



Not Enough Dilation

■ Although 75 percent of adults at high risk for

* Ohio's law was signed by their Governor about 2 wks ago — as you can see, these changes are inevitable.

One - this law is probably more important for Alaska - because of its size - than for any of the other states.

By increasing access to eye care, this will help keep a "lid" on increasing health care costs.

Also, it is bothersome that folks we went to school with are able to practice differently (better) because they live in Washington, Iowa, etc. —

Thanks for your understanding —

Bill Faulkner

Employee Benefits Division
Medicare Claim Administration
P. O. Box 1998
Portland, Oregon 97207-1998
Telephone No. (503) 222-6831

Form Approved
OMB No. 0938-0222

Medicare

10/14/87 F00 511 SS05

JEFFREY A GONNASON OD
2211 E.-NORTHERN LGHT
ANCHORAGE, AK 99504

CORRESPONDENCE NO. 8072648000300G

WE RECEIVED YOUR LETTER ABOUT A RECENT MEDICARE NEWSLETTER ARTICLE PERTAINING TO OPTOMETRISTS .

THE NEWSLETTER ARTICLE WAS IN ERROR REGARDING THERAPEUTIC TREATMENT OF EYE DISEASES OR DISORDERS BY OPTOMETRISTS.

EFFECTIVE 4/1/87, A DOCTOR OF OPTOMETRY IS CONSIDERED A PHYSICIAN WITH RESPECT TO ALL SERVICES THAT THE OPTOMETRIST IS AUTHORIZED TO PERFORM UNDER STATE LAW. IF STATE LAW AUTHORIZES THERAPEUTIC TREATMENT BY AN OPTOMETRIST, MEDICARE CAN CONSIDER THE CHARGE FOR PAYMENT.

SINCERELY,

SRisner
MEDICARE CLAIMS ADMINISTRATION
AETNA LIFE INSURANCE COMPANY

Medicare News

Volume 13, Issue 2 February, 1987

IN THIS ISSUE

SERVICES RELATED TO NONCOVERED SERVICES

All providers are reminded that routine services "related to" noncovered services (e.g. cosmetic surgery, noncovered organ transplants), including services related to the followup care, are not covered services under Medicare.

In addition, services provided primarily for the purpose of administering a noncovered injection, are excluded from Medicare payment. For example, if the primary treatment is noncovered dimethyl sulfoxide (DMSO) or ethylenediamine-tetra-acetic acid (EDTA chelation therapy), the associated office visits and lab tests will also be excluded from payment.

COVERAGE FOR OPTOMETRIST EXPANDED

Coverage has been expanded on services performed by optometrists on or after 4/1/87. Medicare will then allow payment for vision care services of optometrist when:

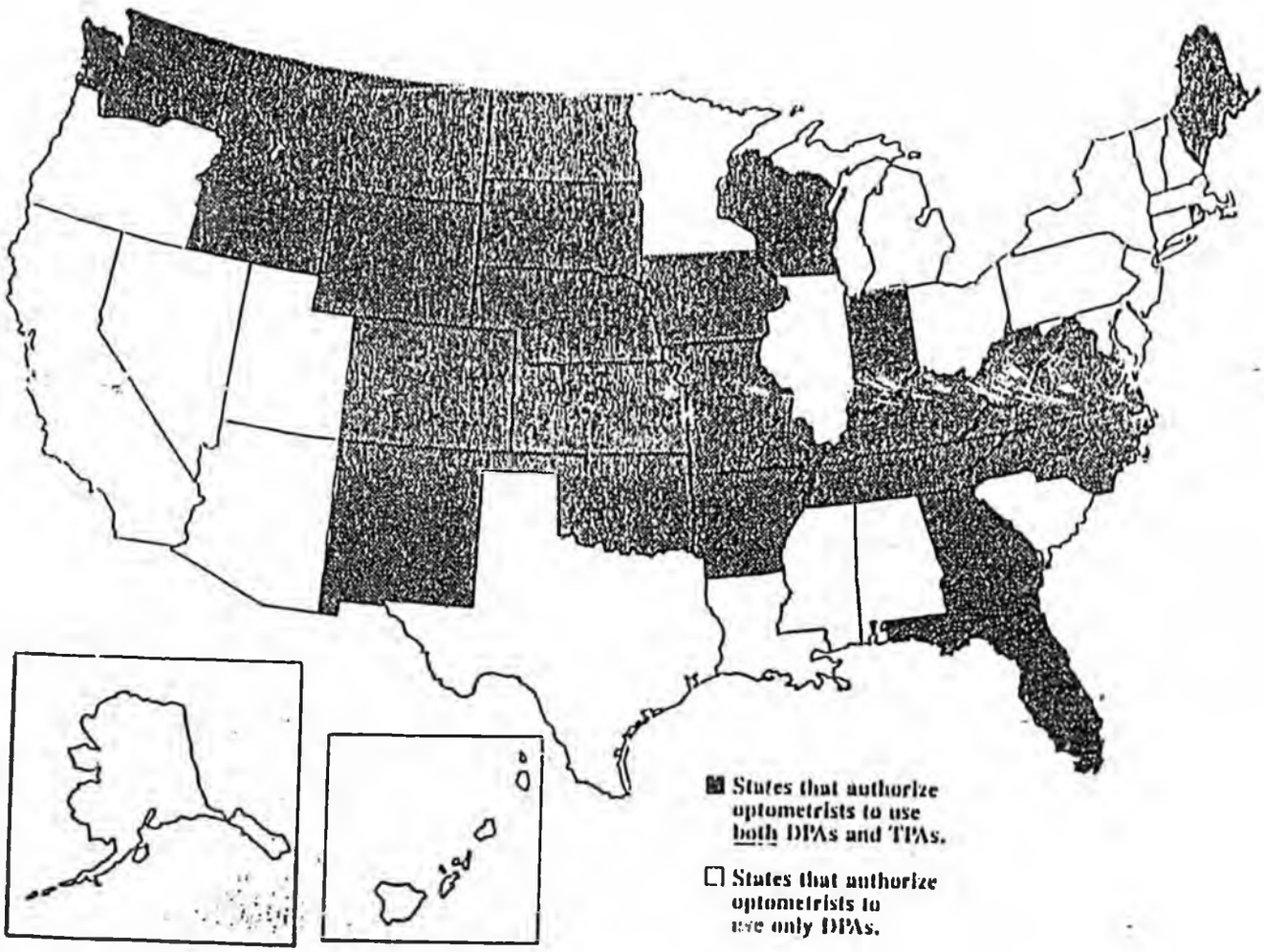
1) the optometrist is legally authorized by the state to perform the service, and

2) the service is already covered by Medicare when performed by a physician

Previously Medicare allowed payment to optometrist for services related to the treatment of Aphakic patients only.

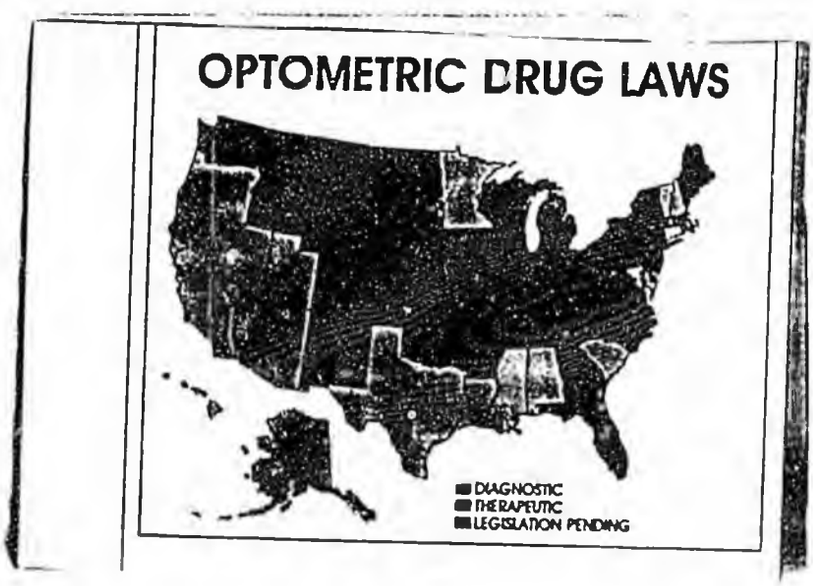
TREATMENT STATES

Twenty five, one half, of the fifty states of our great Union allow Optometry to utilize therapeutic medications as part of their health care delivery system. The U.S. Military, Public Health Service, Indian Health Service, and Veterans Administration also permit qualified optometrists to use therapeutic medications as a broad base eye care delivery system.



■ States that authorize optometrists to use both DPAs and TPAs.

□ States that authorize optometrists to use only DPAs.



AARP

Bringing lifetimes of experience and leadership to serve all generations.

NEW JERSEY STATE LEGISLATIVE COMMITTEE

CHAIRMAN
Mr DeWill Reinecke
17 Primrose Trail
Morristown, NJ 07960
(201) 766-2406

VICE CHAIRMAN
Mr. David Brown
16 Woodbridge Avenue
Metuchen, NJ 08840
(201) 549-0001

SECRETARY
Mrs Carol Kenny
352 E. Virginia Ave.
Manasquan, NJ 08736
(201) 223 8342

December 6, 1990

Dr. Larry C. Wallis
Legislative Chairman
New Jersey Optometrist Association
88 Lakedale Drive
Trenton, NJ 08648

Dear Dr. Wallis:

The members of the New Jersey State Legislative Committee (NJSLC) of the American Association of Retired Persons (AARP) have reviewed the provisions of Assembly Bill A-743. The bill would allow optometrists to prescribe and utilize eye medications, limited to eye drops or ointments. The NJSLC also conferred with your association and the Academy of Ophthalmology and Otolaryngology before making a decision.

I am happy to report that the committee strongly supports Bill A-743. Its passage would be in the best interests of our members and would benefit all New Jersyians. The facts weigh heavily in favor of expanding the responsibility of optometrists to include the use of therapeutic pharmaceuticals. Some of these compelling facts are:

a) It will be less costly, especially for seniors and the disabled, to be treated by an Optometrist for Optometrists are more readily accessible than Ophthalmologists.

b) Optometrists receive excellent training including training in Pharmacology.

c) The need for a second visit to an Ophthalmologist for treatment would be eliminated.

d) Optometrists have been using therapeutic eye drops and ointments in 24 states and the District of Columbia without any significant or prevailing problems.

In the interests of good eye health and easier access to such, AARP supports A-743.

Sincerely,

DeWitt C. Reinecke

DeWitt C. Reinecke
Chairman, New Jersey State Legislative Committee

DCR/rg

cc: Honorable Joseph I. Roberts, Jr.
655 Creek Road
Bellmawr, NJ 08031

V2532

MINN.

OPTOMETRIC THERAPUETIC DRUG LEGISLATION

COMMON QUESTIONS AND ANSWERS

WHAT IS THE PURPOSE OF THIS LEGISLATION ?

This legislation would give qualified optometrists the right to prescribe topical medication and four specific types of oral medication to treat common eye health problems of the front part of the eye.

WOULD ALL OPTOMETRISTS AUTOMATICALLY BE ALLOWED TO USE THESE DRUGS?

Only those optometrists that have demonstrated adequate education and have shown competency by passing national board exams in treatment and management of ocular disease would be allowed these privileges.

HOW WILL THE OLDER OPTOMETRIST BE HANDLED AFTER PASSAGE OF THIS LEGISLATION?

Again, only those optometrist completing all mandated requirements for certification will be allowed to use drugs to treat eye disease. No one, however, will be forced to become certified. If an older optometrist does not wish to become certified to use therapeutic drugs, he/she will simply continue to practice in the way that current law allows them. There will be no grandfathering!

WHAT IS THE RATIONALE FOR ALLOWING OPTOMETRISTS TO TREAT EYE DISEASE?

Optometrists have been responsible for accurately diagnosing eye disease for years. Since the most difficult part of treating an eye disease is accurately diagnosing the condition,treatment by optometrists is a logical extension of their scope of practice.

WHAT IS THE EDUCATION OF AN OPTOMETRIST TODAY?

The average student entering optometry school today has a bachelor of science degree and the same required courses as a student entering medical or dental school. The actual optometry program is an additional four years of intensive training specifically on the eye. General and ocular pharmacology are stressed along with in depth training in differential diagnosis of eye disease and treatment and management of those diseases At least two years of this training are spent examining patients in a variety of clinic and hospital settings.

WHAT ARE THE BENEFITS TO THE CITIZENS OF MINNESOTA ?

By allowing optometrists this expanded scope of practice, citizens of the state will be given: 1. Better access to eye care

2. More efficient delivery of eye care

3. Cost containment in eye care expenses

HOW MANY OTHER STATES OFFER OPTOMETRISTS THESE THERAPEUTIC DRUG PRIVELEDGES?

At this time, 23 states have passed legislation allowing optometrists the use of therapeutic drugs. Some states have had these laws in effect for thirteen years. Minnesota is one of the last states in the Midwest to enact this expansion of optometric practice.

WHAT HAS THE EXPERIENCE BEEN IN STATES WHERE OPTOMETRISTS PRESCIBE THERAPEUTIC DRUGS?

After many years and millions of patient encounters the optometric use of therapeutic drugs has had an overwhelming positive history. The patients in these states are enjoying the increased access and more efficient delivery of primary eyecare while at the same time reducing expenses. No adverse affects have been experienced.

WHAT ADVERSE EFFECTS COULD HAPPEN WITH THE USE OF THESE THERAPEUTIC DRUGS AND HOW WILL THE OPTOMETRIST DEAL WITH THEM?

The therapeutic drugs we are speaking of have a very,very low incidence of adverse effects. The most common reactions being nothing more than a simple rash. The diagnostic drugs that optometrists were given the priveledge to use in 1982 actually have a higher potential for adverse effects and in the 7 years they have been used, no significant adversed reactions have been reported. In the rare event , however, that there would be a serious adverse response to a drug, the optometrist is trained in emergency medical procedures such as CPR and would get the patient to an emergency medical facility just as any other health care provider would do in a similar situation.

WHAT WILL HAPPEN TO MALPRACTICE RATES FOR OPTOMETRISTS WHEN THEY START PRESCIBING MEDICATION?

Optometry has enjoyed such a good malpractice history that it has seen only a 20% increase in malpractice rates over the past five years while the medical profession has seen an increase of 500% during that same period. In fact, this year optometric malpractice rates in all states, including those where optometrists prescribe therapeutic drugs, are actually decreasing by almost 40%.

HOW ARE OPTOMETRISTS AND OPHTHALMOLOGISTS DISTRIBUTED GEOGRAPHICALLY IN MINNESOTA?

Optometrists are well distributed throughout Minnesota with offices in 99% of all counties while ophthalmologists are primarily located in the metropolitan areas and have full time offices in only 25% of the counties.

In fact outside the Twin cities and Rochester there are only 55 ophthalmologists in 28 towns to serve over 2,000,000 residents. In that same outstate area there are 292 optometrists in 118 communities.

WHY MUST OPTOMETRISTS GO TO THE LEGISLATURE IN ORDER TO GIVE PATIENTS FULL BENEFIT OF THEIR TRAINING?

Unfortunately optometry has no choice. Medicine has a practice act that allows them the ability to treat patients to the full extent that their training prepares them. As their training advances their patient's care advances. Optometry's practice act,however, requires a legislative change in our practice act every time we want to pass improved education and technology to our patients. Stop and think about how many coronary by-passes would have been done today if MDs were required to legislate first.

WHO OPPOSES THIS LEGISLATION ?

Organized ophthalmology formally opposes this legislation in Minnesota. In our neighbor state to the south,however,the Iowa academy of ophthalmology actually endorsed the same optometric legislation in 1984.

WHAT DOES THE OPPOSITION SAY?

The Minnesota academy of ophthalmology claims that optometrists are inadequately trained to treat eye disease with medication. They further believe that harm will come to residents of Minnesota if optometrists are allowed this therapeutic privilege.

WHO SHOULD YOU BELIEVE?

The dispute between ophthalmology and optometry is not new....

In the 1960's ophthalmology opposed optometric testing for glaucoma. They claimed optometry was inadequately trained and that harm would come to the citizens of Minnesota if optometry was allowed this privilege. Optometry won the fight and has prudently and safely tested for glaucoma to the benefit of Minnesota citizens since. Ophthalmology's claims proved unjustified

In the 1970's ophthalmology opposed optometric use of drugs for diagnostic purposes. They claimed optometry was inadequately trained and that harm or even death would occur to the citizens of Minnesota if optometry was allowed this privilege. Optometry again won the fight and has prudently and safely utilized diagnostic drugs to the benefit of Minnesota citizens since.

In the 1980's ophthalmology is opposing optometric use of drugs for therapeutic purposes. They are using the very same arguments they have used unsuccessfully for years. Their claims have proved false in every preceding case. Who do you think you should believe this time?

COMMONWEALTH OF KENTUCKY

BOARD OF OPTOMETRIC EXAMINERS

1000 W. MAIN STREET

GEORGETOWN, KENTUCKY 40324

863-5816
AREA CODE 502

April 24, 1989

Sen. Robert Ney
State House
Columbus, Ohio 43266-0604

Dear Sen. Ney:

I am happy to give you the following progress report since the passage of SB 104 which went into effect in Kentucky on July 15, 1986.

There has been no increase in complaints from the general public since the passage of this Bill, and there has not been any complaints dealing with the use of therapeutic drugs. Insurance rates for our optometrists have actually decrased. One of the main advantages of this legislation is that, due to the large amount of rural areas in Kentucky, the public has been saved countless numbers of miles and dollars.

When this Bill went into effect the board required each TPA certified O.D. to keep a drug log setting out specific information on each patient prescribed for. The following information was turned in to our office in December, 1987.

Number of Rx's written - 37,817
Number of patients prescribed for - 36,493
Number of conditions treated collectively - 2,158
Number of different conditions treated - 62
Miles saved - 843,368
Dollars saved - $1,115,086.00

I have enclosed a copy of SB 104 for your information. Please contact us if we can be of any help.

Sincerely yours,

John C. Schertzinger

J. C. Schertzinger, O.D.
President

cc: Darlene Eakin
Earl K. Green

JCS/at

WEST VIRGINIA BOARD OF OPTOMETRY

DALE E. PALMER, O.D.
SECRETARY-TREASURER

WEST VIRGINIA BOARD OF OPTOMETRY
POST OFFICE BOX 67
NUTTER FORT, WEST VIRGINIA 26301
(304) 624 5317

October 16, 1986

Dan J. Lex
P.O. Box 2186
Cheyenne, Wyoming 82003

Dear Mr. Lex:

This letter is in response to your inquiry of October 8, 1986, regarding the therapeutic drug experience. For the sake of brevity, I will answer each question by number:

(1) Law became effective March, 1976.

(2) Therapeutic alone would probably be in the neighborhood of 250,000 to 400,000. Combined with diagnostics, the number would be 1,300,000 based on 100 doctors using diagnostics on 1,200 patients per year. Therapeutic figure is conservative estimate of four cases per week, per doctor times 10 years. Actual numbers could double this.

(3) No cases of misuse of therapeutic drugs have been reported to our board, and no cases have come to court involving misuse of therapeutic drugs.

(4) Based on an average of $20.00 office visit for therapeutic patient verses average of $40.00 for ophthalmology, a savings of $5,000,000 to $8,000,000, and I would consider this conservative.

(5) The cost of malpractice insurance has not been adversely affected by therapeutic drug use at all.

Sincerely,

Dale E. Palmer

Dale E. Palmer, O.D.
Secretary-Treasurer

DEP:jj

BOARD OF EXAMINERS IN OPTOMETRY
STATE OF OKLAHOMA

OFFICE OF THE SECRETARY-TREASURER
P.O. BOX 719
BRISTOW, OKLAHOMA 74010

November 5, 1987

Senator Steven Rees
5716 Jordan Canal Road
Kearns, Utah 84118

Dear Senator Rees,

In response to your questions regarding doctors of Optometry prescribing pharmaceuticals for treatment of eye disease, we are pleased to answer the following questions.

U. Have public complaints regarding Optometrists increased as a result of law authorizing Optometrists to administer and prescribe therapeutic drugs?

Ans. The Central Office of the Oklahoma Optometric Association, with a WATS line open to all Oklahomans with any complaints, has not received a single call relating to this question. Also, the Board of Examiners has not received a single call from the public regarding administering and prescribing therapeutic drugs.

V. Have Optometrists experienced significant increases in malpractice insurance rates since being granted the right to use therapeutic drugs?

Ans. Carriers report, almost uniformly, that malpractice rates for Optometrists are so low that they cannot administer a program without some subsidy from related insurers. To subsist under these conditions they typically add premise liability and unrelated hazards. We can state without equivocation that the only creditable malpractice suit pursued in this state was against an Optometrist who failed to get certified with diagnostic and therapeutic privileges, was sued successfully, whereas such a suit would not have been successful if he had been certified.

W. Does the public seem to be more confused about different kinds of eye care practitioners since Optometrists were granted therapeutic drug use authority?

Ans. There is inherently a blur in the public perception of the eye care field. The administration of therapeutic drugs would be to those who are perceptive, a natural evolution and consequence of progressive education. To those who do not follow the field closely, they have assumed that Optometrists render the service.

BOARD OF EXAMINERS IN OPTOMETRY
STATE OF OKLAHOMA

OFFICE OF THE SECRETARY-TREASURER
P.O. BOX 719
BRISTOW, OKLAHOMA 74010

Dr. Floyd White, President
1104½ N. Broadway
Hugo, Oklahoma 74743
Dr. James Johnson, Jr., Vice-President
2801 N.W. Expressway
Oklahoma City, Oklahoma 73112
Dr. George E. Foster, Secretary-Treasurer
P.O. Box 719
Bristow, Oklahoma 74010

X. What are the major problems and advantages which have resulted from enactment of the therapeutic use law?

Ans. In a rural state, a principal advantage is the proximity and availability of the distribution system of Optometrists. They are available. The therapeuric law has dovetailed most beautifully with new Medicare provisions recognizing the legal scope of optometric practice. If there is a problem, it is the need for expanded public awareness. We should cite as an advantage the forced cooperation between Ophthalmologists and Optometrists to a degree that never existed before in the public interest.

Yours truly,

George Foster, O.D., Sec. Treas.
Board of Examiners in Optometry

GF/eh

COMMENTS OF JOSEPH C. TOLAND, O.D., M.D., BEFORE THE VIRGINIA STATE BOARD OF MEDICINE'S AD HOC COMMITTEE ON OPTOMETRY, DECEMBER 20, 1988 PUBLIC HEARING, REGARDING CERTIFICATION OF OPTOMETRISTS TO PRESCRIBE AND ADMINISTER OCULAR RELATED THERAPEUTIC PHARMACEUTICAL AGENTS.

My name is Joseph C. Toland. I graduated from the Pennsylvania College of Optometry with a Doctor of Optometry degree in 1954. Following five years of practice as an optometrists, including military service in the United States Air Force, I entered Hahnemann Medical School and graduated with the M.D. degree in 1963. I then undertook a three year residency in ophthalmology at Thomas Jefferson Medical School which was completed in 1967. I was Board Certified as an ophthalmologist in 1969.

I am currently an instructor in ophthalmology at the Thomas Jefferson Medical School and Professor of Pathology and Director of Ophthalmological Services at the Pennsylvania College of Optometry. In this capacity, I have intimate knowledge of the education of ophthalmology residents and optometry students.

I am here this morning to compare optometric and ophthalmologic education as it is related to the examination, diagnosis, treatment and management of ocular diseases of the primary care patient. With my background as an optometrist, I do not think there is anyone better qualified than myself to evaluate this question from the perspective of both an

optometrist and an ophthalmologist. I have taught ophthalmology residents and optometry students to use therapeutic agents in conjunction with these clinical skills.

The education of both professions in basic biomedical sciences, in the clinical sciences, and eventually patient care in hospitals, clinics and private practitioner's offices parallel one another.

During their education and training, both the optometrist and ophthalmologist are given a global view of ocular disorders, which are divided into the following sections:

1. Anterior segment disorders i.e. lids, conjunctiva, cornea, anterior chamber, iris and lens.
2. Posterior segment disorders i.e. choroid, retina, optic nerve.
3. Medical disorders
4. Glaucoma
5. Neuro-eye disorders
6. Surgery

Some optometrists and ophthalmologists may wish to develop an expertise in sub-speciality and may elect to take additional training.

The training of both disciplines is quite similar and intense with the "hands-on" clinical care of patients. Here

is where the optometric intern and ophthalmological residents learn to examine, diagnose, treat and manage ocular disorders.

It is almost a "one-on-one relationship" between the intern/resident and clinical instructor. In all cases, the intern/resident does the initial evaluation and work-up and then he presents that patient to the instructor. The case must be present in an organized fashion and the intern/resident must be able to justify and defend his diagnosis, treatment and management.

It is here that the intern/resident's basic knowledge of pharmacology and pathophysiology is tried and tested. He must be able to support his diagnosis with his clinical findings. He must justify his use or non-use of pharmacological agents with his knowledge of the disease processes.

In our clinics we have a saying, "Our sailors go to sea". The interns/residents not only have the book knowledge of the disease processes, but also have the experience in treating them. This is required to be a good clinician. At the end of clinic sessions, the important teaching cases are reviewed and discussed by all the staff to enhance the learning experience.

Primary care patients, whether seen in an optometric or ophthalmological institution, present with approximately the same percentage of healthy or unhealthy eyes. These

patients, depending on the circumstances, are either treated at the primary level or referred to another level of care.

Secondary and tertiary care patients with ocular problems are generally referred to an ophthalmological institution. It is here where patients with more advanced medical and surgical problems are evaluated and treated. Much of the ophthalmology resident's training is involved with caring for these patients.

In summary, I wish to state that ophthalmological training programs concentrate on advanced medical and surgical cases. Clinical optometric programs provide equal teaching experience in eye disorders and diseases at the primary level. Optometrists are more than adequately educated and trained to diagnose, manage and treat ocular conditions with therapeutic agents.

Thank you for allowing me to testify before your Board.

Joseph C. Toland, O.D., M.D.
Professor of Pathology and
Director of Ophthalmological Services
Pennsylvania College of Optometry
1200 West Godfrey Avenue
Philadelphia, PA 19141

COMMENTS OF LESLEY L. WALLS, O.D., M.D. BEFORE THE VIRGINIA STATE BOARD OF MEDICINE'S AD HOC COMMITTEE ON OPTOMETRY, DECEMBER 20, 1988 PUBLIC HEARING, REGARDING CERTIFICATION OF OPTOMETRISTS TO PRESCRIBE AND ADMINISTER OCULAR RELATED THERAPEUTIC PHARMACEUTICAL AGENTS.

I. Introduction

My name is Dr. Lesley L. Walls and I am from Oklahoma where my job is Dean of the College of Optometry in Tahlequah, Oklahoma.

I am privileged to be a graduate of both optometry school (University of California at Berkeley-1968) and Medical School (University of California at Davis-1972).

My career has been in both Academic Medicine (Northeastern Ohio Universities College of Medicine, 1975-1977; University of Oklahoma Tulsa Medical College, 1977-78 and 1981-88 and Oral Roberts University College of Medicine, 1978-79) and Optometry (Northeastern State University, 1979-81 and February 1988 - present). I served as Department Chairman for Family Practice Tulsa Medical College from 1981-1988. I am very familiar with the curricular requirements of medical and optometric programs.

II.

Let me offer some specific observations on my own experience with optometric and medical education.

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

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

In optometry schools there are courses in general pathology and ocular signs of systemic disease since

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

III.

The possession of and use of sophisticated equipment such as binocular indirect ophthalmoscopes, slit lamps, goldman tonometers, goniolenses, Fundus photography, etc. are far superior in a modern optometric practice than in any primary care physicians office such as family practice, internists and pediatricians. Coupled with training and experience in the utilization of this type sophisticated equipment makes the optometrist better prepared to evaluate, diagnose and treat most ocular conditions when compared to the other listed primary health providers. This is not to demean or to cast these fine primary care providers in a bad light, rather, it is simply a fact that we must accept.

Because of the above there is no question that a well trained and well equipped optometrist can more than measure up to medical standards of care for primary physicians in the

area of diagnoses and management of various ocular diseases/disorders.

IV.

I will now briefly discuss my personal experience with side effects of ocular pharmacologic therapy. This section will be very brief as I have never had a patient with anything other than a very minor side effect from ocular pharmaceutical agents. I feel that the optometric curriculum in conjunction with current basic life support certification is adequate preparation to handle an emergency should it occur.

In summary I would like to point out that ophthalmologists are vitally needed. The medical profession would be in sad shape without them because of their expertise in the area of ocular trauma, cataract surgery, retinal surgery, and other ocular problems requiring advanced medical management. However, in a state such as Virginia the ophthalmologists are primarily in larger cities with a poor distribution in the rural communities.

I also strongly feel that optometrists are vitally needed. Optometrists are well distributed in rural communities and by definition serve as primary care health professionals. In my opinion, the patient, particularly in a state like Virginia, will be the beneficiary of modern optometric practice. With the use of pharmaceutical agents, for diagnostic and therapeutic purposes, serious disease detection will be facilitated thus making the referral system

into medicine more efficient. As well, this will save the patient a lot of inconvenience and time. I feel the Virginia State Board of Medicine should allow the people of the state of Virginia to benefit from modern optometry which includes the use of diagnostic and therapeutic pharmaceutical agents. I believe the key to utilizing these medications by any health care professional is proper education and training.

Lesley L. Walls, O.D., M.D.
Dean, College of Optometry
Northeastern State University
Tahlequah, OK 74464
918/456-5511

COMMENTS OF THOMAS L. LEWIS, OD, Ph.D. BEFORE THE VIRGINIA STATE BOARD OF MEDICINE'S AD HOC COMMITTEE ON OPTOMETRY, DECEMBER 20, 1988 PUBLIC HEARING, REGARDING CERTIFICATION OF OPTOMETRISTS TO PRESCRIBE AND ADMINISTER OCULAR RELATED THERAPEUTIC PHARMACEUTICAL AGENTS.

My name is Dr. Thomas Lewis. I am Dean of Academic Affairs at the Pennsylvania College of Optometry. I earned a Doctor of Optometry Degree from the Pennsylvania College of Optometry and a Ph.D. in Anatomy from the Daniel Baugh Institute of Anatomy, School of Medicine, Thomas Jefferson University. I completed a post-doctoral fellowship in the Department of Ophthalmology, School of Medicine, Washington University, St. Louis, Missouri.

Since 1975 I have been a member of the faculty at the Pennsylvania College of Optometry and have held various teaching, clinical and administrative positions. I have extensive teaching experience both at the undergraduate and continuing education levels. In addition to my role as Dean, I hold the rank of Associate Professor.

I thank you for the opportunity to be am here this morning to discuss some of the basic elements of optometric education as they relate to the diagnosis and treatment of ocular diseases.

The fundamental philosophy of professional optometric education is equivalent to that of all other health professional programs including medicine, dentistry,

osteopathy, and podiatry. The biomedical and clinical sciences are taught in the classroom, applied in the clinics and refined through internships, externships, and residencies.

As with other health professions, the vast majority of students entering optometry school have completed four years of college and hold a baccalaureate degree. Pre-requisite requirements for optometry are similar to other health care professional programs.

The basic biomedical courses taught in the schools and colleges of optometry are extensive. They include: Gross Anatomy, Histology, Human Physiology, General Biochemistry, General & Systemic Pathology, Microbiology, and Neurosciences. The intent of these courses is to give the student an in-depth understanding of the structure and function of normal body systems, in addition to basic histopathological concepts of general pathologies. The curricula focus on important aspects of such basic sciences as Endocrinology and Neurology given the increasing number of diseases which affect the eye arising from these systems.

Biomedical science courses also develop for students a greater understanding of systemic diseases. Courses in medical urgencies and emergencies and clinical medicine (taught by physicians) discuss the role of the primary care optometrist, including emergency medical care such as CPR, in the management of patients with systemic diseases.

Optometrists learn to recognize systemic disease through proper history and patient interview, direct observation, and various clinical signs and tests.

It is important to note that all the biomedical sciences taught in other health professional schools are also included in optometric curricula, and that the quality of the instructors is similar. In fact, many schools of optometry use the same faculty that teach in medical and dental schools.

Two areas which require special comment include pharmacology and the diagnosis and treatment of ocular diseases. On an average, 156 hours of pharmacology are presented at the schools and colleges of optometry. This is equal to or greater than the didactic education of other health professions that use therapeutic pharmaceutical agents. The courses are taught by highly qualified faculty, including pharmacologists. Within these courses, greater emphasis is placed on ocular pharmacology than in pharmacology courses presented to other health professionals. Pharmacology courses in optometry schools emphasize the systemic manifestations of ocular drugs, ocular manifestations of systemic drugs, drug toxicities and adverse reactions.

Ocular disease diagnosis and treatment is covered extensively and comprehensively in optometric curricula. The courses include a detailed discussion of the histopathological laboratory appearance, history, symptoms, clinical picture, etiology, prognosis and management of

ocular diseases. Special emphasis is placed on the importance and potentially life-threatening implications of certain systemic diseases which may manifest through ocular signs and symptoms.

The management of ocular disease is approached in a manner which supports the role of the optometrist in dealing with these conditions at the primary care level. This is done by emphasizing early diagnosis, by differentiating simple ocular conditions from those requiring advanced medical and/or surgical treatment, by differentiating those conditions which respond well to treatment vs. those that are resistant, and by stressing the need for timely and appropriate referrals. The diagnosis and treatment of ocular diseases is taught by highly qualified experts in optometry as well as board certified ophthalmologists and sub-special ophthalmologists.

Clinical training programs at the schools and colleges of optometry begin during the first year of the curriculum with maximum patient care exposure during years three and four. All schools and colleges support multi-disciplinary faculties of medical, optometric, ophthalmological, social, psychological, and rehabilitative practitioners and specialists.

At the Pennsylvania College of Optometry a student is scheduled for approximately 2,000 hours of clinical training and examine about 1,200 patients by graduation. Approximately 20% of the clinical encounters involve interaction with

physicians. Optometry students use therapeutic drugs with direct supervision on a daily basis. They apply the knowledge they have learned in the classroom on real patients in the clinic.

All therapeutic education is primary care oriented. Training is directed toward the diagnosis of patients' problems as the highest priority, treatment of non-surgical ocular conditions, and follow-up care to completion with adjustments in treatment or referrals when indicated.

At many schools and colleges of optometry, the on-campus clinical training is not the sole source of the students' clinical experiences. As in medicine, an externship program plays a significant role in training. Fourth year optometry students are required to complete externships in private practice, as well as institutional settings. Students gain exposure to and direct experience with diagnostic and therapeutic drugs, treatment of ocular diseases as well as observation of ocular medical and surgical techniques. Public, private and community resources with supervised preceptors serve as settings for externs. These would include ophthalmology practices and clinics, health maintenance organizations, military hospitals and clinics, V.A. hospitals, public health hospitals, community teaching hospitals, Indian health services, and multi-disciplinary clinics. Optometric practices in states which currently allow the use of therapeutic drugs to treat eye diseases are an ideal location for externships. At the completion of

their clinical training, optometry students have developed the appropriate competencies to accurately diagnose, treat and manage ocular disease.

Hopefully, this gives the committee an overview of the current status of optometric education. Thank you for allowing me to testify this morning.

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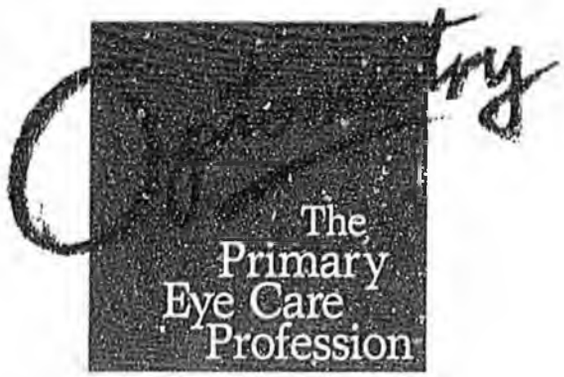

OPTOMETRY: THE PROFESSION

Optometry is an independent primary health care profession.

It encompasses the prevention and remediation of disorders of the eye/vision system through the examination, diagnosis, treatment and/or management of visual efficiency and eye health. The recognition and diagnosis of related systemic manifestations are designed to preserve and enhance the quality of life and environment.

Doctors of Optometry are primary health care providers who diagnose, manage and treat conditions and diseases of the human eye and visual system as regulated by state law.

These health care professionals are specifically educated, clinically trained and state licensed to examine the eyes for the presence or absence of vision problems, eye diseases or ocular manifestations of systemic diseases such as diabetes, hypertension, hyperthyroidism, etc. The primary vision care needs of consumers have shaped the scope of optometric practice as it is today.

American Optometric Association

EDUCATION OF THE DOCTOR OF OPTOMETRY

To establish perspective, there is value in comparing the general characteristics of the education of selected health professionals: optometry, medicine, podiatry, nursing and pharmacy.

Perhaps the most current review is reported by Robert F. Rushmer, M.D.[1] noted author and Director, Center for Advanced Studies in Biomedical Sciences, School of Medicine, University of Washington. He observed that each has state board requirements; all but pharmacy have national boards. All these educational institutions require accreditation at regular intervals. The admission requirements for medicine are less specific or demanding than in some other categories.

Each of these educational processes involves some years of basic sciences, preclinical education and clinical experience. Rushmer concludes, "In general, the basic educational experience of these five professions are remarkably similar and cannot account for consistent under utilization of 'non-medical' health professionals."

Addressing the concern for the provision of primary care, Dr. Rushmer makes the observation that the numbers of general practitioners and family physicians are grossly inadequate to afford the luxury of initial contact with physicians as the standard procedure; this is compounded in remote areas and central cities.

He points to the need for utilization of other health professions. Dr. Rushmer states, "Pharmacists undoubtedly have a sounder education in the details of dosage and distinctions among pharmaceutical agents than do physicians. Similarly, optometrists have a more extensive exposure to the basic principles of physiological optics than do physicians."

"From earliest times, the training of physicians has been based in large measure on apprenticeship, and vestiges of this orientation are clearly visible today in the clinics and the wards of teaching hospitals." "The residents, training to be specialists, usually serve as surrogate faculty for both interns and medical students." In contrast the training of optometrists can be described as a combined didactic, laboratory and clinical curriculum, the design of which has many parallels to dentistry.

By being exempt from the provisions of the statutes governing the practice of optometry, physicians in general are legally entitled to test eyes and prescribe glasses. Ophthalmologists complete a three year apprenticeship-style residency program concerning diseases of the eye; ophthalmology being a subspecialty of surgery. Beyond that of general medicine no licensing is required to practice ophthalmology.

In comparing the specialties Dr. Rushmer states, "...the upgraded curricula of optometry schools generally provide more extensive basic knowledge, training and experience in correcting refractive errors that most ophthalmologists receive. Training and clinic experience in detection of eye pathology now renders recent graduates of optometry school capable of filling an extremely important role in this specialized area of health care. The persistent opposition of the medical profession has retarded but only partially impeded optometrists from providing ever expanding service in the care of the eye."

1. Rushmer, R.F.: National Priorities for Health: New York, Wiley, 1980.

American Optometric Association

The Primary Eye Care Profession

WHAT SERVICES DO DOCTORS OF OPTOMETRY PROVIDE?

The scope of practice for the profession of optometry has progressed beyond the point of simply examining the eyes to prescribe glasses or contact lenses. Optometry is now the main provider of primary eye/vision care services in America.

The most frequent services provided by a Doctor of Optometry are included on the form on the reverse side of this page.

Codes for Optometry

For a more complete listing, refer to AOA's Codes for Optometry published by the American Optometric Association. This digest contains the applicable procedural codes from AMA's Current Procedural Terminology, Fourth Edition (CPT-4); diagnosis codes from the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM); and materials codes from HCFA's Common Procedure Coding System (HCPCS).

The publication is available through the AOA Order Department, 243 North Lindbergh Boulevard, St. Louis, Missouri 63141.

American Optometric Association

EXAMINATION	CPT NEW	ESTAB
Brief	90000	90040
Limited	90010	90050
Intermediate	92002	92012
Comprehensive	92004	92014
Refraction	Y__	N__

HOSPITAL SERVICES	INIT	SUBSQ
Brief	90200	90240
Limited		90250
Intermediate	90215	90270
Extended Intermediate		90260
Comprehensive	90220	90280

CONSULTATIONS	INIT	SUBSQ
Brief		90640
Limited	90600	90641
Intermediate	90605	90642
Extensive	90610	
Comprehensive	90620	
Complex	90630	90643
Afterhours	9905_	
Emergency Care	9906_	
Special Rpts	99080	

SPECIAL PROCEDURES	CPT
Gonioscopy	92020
Visual Fields/Threshold	92083
Visual Fields/Screening	92082
Extended Ophthalmoscopy	92225
Photog/Fundus R-L	92250
Photog/External R-L	92285
Endothelial Microscopy	92286
A-Scan	76519
Ophthalmodynamometry	92260
Color Vision Exam	92283
Provocative Test	92140
Serial Tonometry	92100
Lacrimal Probe/Irrigation	68800
Epilation	67825
Medication/Supplies	99070

VISION THERAPY SERVICES	
DIAGNOSTIC SERVICE	
Sensorimotor Exam	92060
Developmental Exam	90775
TREATMENT SERVICE	
Vision Therapy Trmt	92065
LOW VISION TREATMENT	
Microscopic System	92354
Telescopic System	92355

OPHTHALMIC LENS TREATMENT GLASS __ RESIN __		CPT
Monofocal Lens	RE-LE	92340
Bifocal Lens	RE-LE	92341
Multifocal	RE-LE	92342
Monofocal Aphakia	RE-LE	92352
Bifocal Aphakia	RE-LE	92353

CONTACT LENS TREATMENT		CPT
Treatment of Disease/CL	RE-LE	92070
CL Therapy/except Aphakia	RE-LE	92310
Corneal L/Aphakia/1 eye	RE-LE	92311
Corneal L/Aphakia/2 eyes	RE-LE	92312

OPTICAL SERVICE	HCPCS	
Frames	V__	V__
Lenses	V__	V__
Coating	V__	V__
Tint	V__	V__
Oversize	V__	V__
Balance Lens	V__	V__
Prism	V__	V__
Scratch Resist. Coat.	V__	V__
UV Coating	V__	V__
Safety	V__	V__
Soft CL	V__	V__
Gas Perm. CL	V__	V__
Toric CL	V__	V__
Extended Wear CL	V__	V__
Repair	V__	V__

DIAGNOSIS ICD-9

Abnormal Pupil	379.40	Diab., Per History	250._	Mod. Profound	369.10	Pinguecula	372.51
Accom. Disorder	367.50	Diab. Retinopathy	362.00	Mod/Severe, OD OS	369.20	Presbyopia	370.40
Amblyopia	368.00	Diplopia	368.20	Unequal, both	369.30	Pterygium	372.40
Aniseikonia	367.32	Drusen	362.57	Iritis, Iridocyclitis	364.0	Ptosis	374.3
Anisometropia	367.31	Dry Eyes	375.15	Keratitis	370.90	Retinal Detachment	361 9
Aphakia OD OS	379.31	Ectropion	374.10	Kerat. Sicca	370.33	Retinal Tear	361.0
Asthenopia	368.13	Entropion	374.00	Keratoconus	371.6	Ret. Degen./Periphrl	362.60
Astigmatism	367.20	Epiphora	375.20	Krukenberg's Spindle	371.13	Strabismus	378.9
Blepharitis	373.00	Esophoria	378.41	Lacrimal Disorder	375.	Sudden Vision Loss	368.11
Blepharospasm	333.81	Esotropia	378.00	Macular Degeneration	362.5	Subj. Hemorrhage	372.72
Blindness, legal	369.40	Exophoria	378.42	Migraine	346.8	Suppression	368.31
Cataract OD OS	366.90	Exotropia	378.10	Myopia	367.10	Transient Vision Loss	368.12
Chalazion	373.20	Glaucoma	365.90	Nystagmus	379.50	Trichiasis	374.05
Color Vision Def	373.20	Glaucoma Suspect	365.00	Ocular Hypertension	365.04	Uveitis	364.3
Conj. Foreign Body	930.10	Headache, Per History	784.00	Ocular Migraine	368.15	Vascular Lesions	362.17
Conj. Hemorrahage	372.72	Hordeodum	373.11	Opaque Post Capsule	366.53	Viral Warts	078.1
Converg. Excess	378.84	Hyperphoria	378.43	Optic Atrophy	377.1	Visual Distortion	368.14
Corneal Abrasion	918.10	Hyperopia	367.0	Optic Nerve Drusen	377.21	Visual Field Defect	368.4
Corneal Edema	371.24	Hypertensive Retinop.	362.11	Paresis	378.55	Vitreous Floaters	379.24
Cornea Foreign Body	930.00	Hypertropia	378.31	Photophobia	368.13	Xanthelasma	374.51
Corneal Ulcer	370.00	Prof. Impair/OD OS	369.00	Photopsia	368.15	Normal State	V65.5

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DOCTORS OF OPTOMETRY AS PRIMARY EYE CARE PROVIDERS

Often third party entities do not realize the scope of practice of the profession of optometry. The following illustrations will help the third party entity to better understand the scope of practice of a doctor of optometry.

When a patient is seen for a routine examination because of blurred vision, one of the diagnoses that a doctor of optometry may make is that of cataract. The doctor of optometry will follow that patient until such time that cataract surgery becomes necessary. The patient will then be sent for a consultation with an eye surgeon to have the cataract removed. After the surgery, the doctor of optometry will, in most cases, provide the post-operative care.

When a patient is seen with the symptom of blurred vision, another diagnosis considered is macular degeneration. In a few cases, laser treatment will slow the degenerative process and if laser treatment is indicated, the doctor of optometry will refer to a retinal specialist for laser treatment. After the treatment, the doctor of optometry will again assume the management role for the patient.

If a patient's intraocular pressure is higher than "normal" (ocular hypertension) and yet the patient does not have glaucoma, then that patient will periodically be re-evaluated by the doctor of optometry looking for changes indicative of beginning glaucoma.

When a patient has diabetes, the doctor of optometry periodically evaluates the retina to determine if and how the diabetes is affecting the eye. If laser treatment becomes necessary, the doctor of optometry will set a consultation with a retinal specialist to have the retina treated with laser. After the laser treatment, the doctor of optometry will again manage the care of the patient.

A choroidal nevus is a large pigment spot within the retina. These are generally benign but need to be evaluated periodically to insure they do not turn into malignant melanomas. Doctors of optometry routinely manage these patients.

When a family physician is concerned about a possible pituitary tumor, he/she will often refer to a doctor of optometry for visual fields testing to determine if a visual field defect is present. If there is no field defect, he/she may simply follow the patient.

However, if a field defect is present, then the patient would be sent in for a CT-scan and other possible neurological evaluations.

(OVER)

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Headache is possibly the most common symptom that confronts doctors. Very often the family physician will refer a patient with headaches to a doctor of optometry to determine if the headaches are ocular in origin before other costly neurological evaluations are done. Doctors of optometry and family physicians often work together to manage patients because it is often more effective as well as more cost effective than using other specialists.

Corneal dystrophies cause a clouding of the cornea of the eye. The doctor of optometry follows a dystrophy and, in certain cases, a corneal transplant may be necessary. If a corneal transplant is required, the patient is sent for a consultation with a corneal specialist for surgery. After surgery, patients are again evaluated and followed by the doctor of optometry.

WHAT ABOUT QUALITY ASSURANCE?

Success in eyecare programs necessitates the assurance of quality eyecare.

The typical framework of an optometric quality assurance program consists of the following three components:

1. Credentials Committee -- Evaluates all candidates for network participation to assure the best qualified optometrists are involved.
2. Quality Assurance Committee -- Establishes and reviews standards of care to assure quality of services delivered.
3. Utilization Review Committee -- Establishes and monitors utilization norms for the delivery of eye care.

More information about an optometric quality assurance program can be found in **QUALITY ASSURANCE: Framework of a Quality of Care Review Program.** The publication is available from the Vision Care Benefit Plans Center, American Optometric Association, 1505 Prince Street, Suite 300, Alexandria, VA 22314.

American Optometric Association

The Primary Eye Care Profession

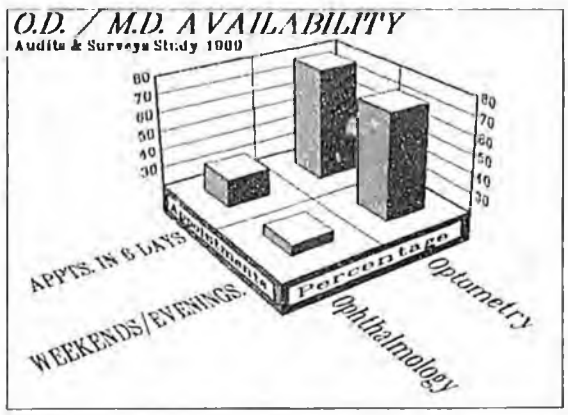
REPORT ON COST AND AVAILABILITY OF ROUTINE EYECARE

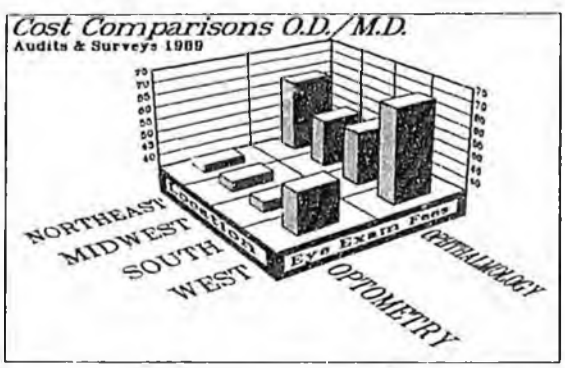
In June 1989, Audits and Surveys, a New York City firm, released its study on a comparison of optometric and ophthalmological care with respect to:

- Appointment availability
- Cost of routine care

Availability for Primary Care

A potential patient must wait three weeks for an appointment with an ophthalmologist. The same potential patient will wait approximately one week for an appointment with an optometrist. Doctors of optometry are much more likely to be available on weekends than ophthalmologists for primary care. 75% of the optometrists and only 25% of the ophthalmologists offer weekend appointments. This is an important fact for the Monday through Friday worker.





Cost of Routine Eyecare

The study, utilizing over 1,000 telephone interviews in all regions of the United States, found that optometry is more cost effective than ophthalmology for routine eyecare. Over the entire nation, optometry charged an average of $20.00 less for a primary care eye examination.

Summary

In summary, optometry is more available and more cost effective for routine eyecare. Optometry is competent to render comprehensive and follow-up care. Optometry is the primary eyecare profession that serves as the entry point into eyecare.

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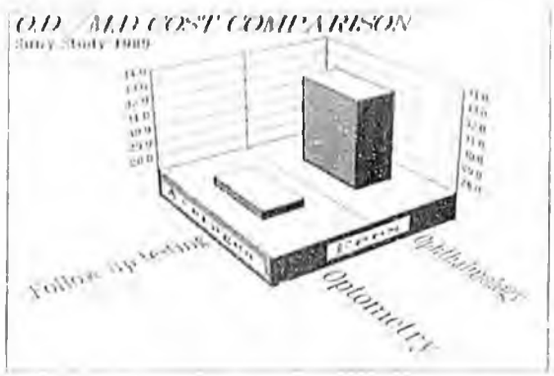


- According to a 1989 study conducted by the Center for Vision Care Policy, the comparison of follow-up testing indicated that charges for services such as gonioscopy, visual fields, extended ophthalmoscopy and photography were significantly lower when services were provided by doctors of optometry. These services are common procedures used in the diagnosis of eye disease.

- Data from the July 1985 issue of REVIEW OF OPTOMETRY shows that the average fee for an optometric examination in 1985 was $36. Comparing the 1985 extrapolated $50 estimated median fee for an ophthalmological exam (data from the February 21, 1983 issue of MEDICAL ECONOMICS) with the $36 estimated average for an optometric exam, one finds that the former is now some 39% higher than the latter.

- Data from the February 21, 1983 issue of MEDICAL ECONOMICS shows that the median fee for an ophthalmological eye examination was $41 in 1982 compared to $31 in 1978 -- an average increase of 7.2% a year. Linear extrapolation would suggest a median fee for an ophthalmological eye exam of $36 in 1980 and $50 in 1985.

- Data from the April 1982 issue of OPTOMETRIC MANAGEMENT shows that the median fee for an optometric examination was $30 in 1980. Comparing the 1980 interpolated $36 estimated median fee for an ophthalmological exam with the $30 estimated median fee for an optometric exam, one can determine that the former is 20% higher than the latter.

- According to an actuarial report prepared in 1982 by the Health Care Finance Administration (HCFA), "Services performed by optometrists cost about 10% less than those done by ophthalmologists".

- InterStudy, a noted HMO consulting firm, concludes that the most cost effective group HMO models are those where optometrists perform <u>all</u> routine eye examinations and also manage certain eye diseases and conditions.

- Capitol Health Care, an independent practice association (IPA) in Salem, Oregon, found that eye examinations by optometrists were 7% to 9% less than the charges by ophthalmologists.

- In a 1979 study done by Blue Cross/Blue Shield of Michigan, it was found that for eye examinations with tonometry, the average charge by par optometrists was $26.81 compared to $38.00 for a par ophthalmologist, and $39.92 for a non-par ophthalmologist.

- Table 1, <u>Civilian Consumer Spending for Vision Care and Sight Correction Services in 1975</u> which appears in the report, THE IMPACT OF NATIONAL HEALTH INSURANCE ON THE USE AND SPENDING FOR SIGHT CORRECTION SERVICES, published by Gordon R. Trapnell Consulting Actuaries in 1976, indicates that in 1975 the cost of a diagnostic examination performed in the office of an ophthalmologist was more than 20% higher than the cost of a diagnostic examination performed in the office of an optometrist.

The above studies indicate that Doctors of Optometry are indeed cost effective in providing eye/vision care services.

Optometry

The Primary Eye Care Profession

Where Are the Optometrists in the U.S.?

KEY

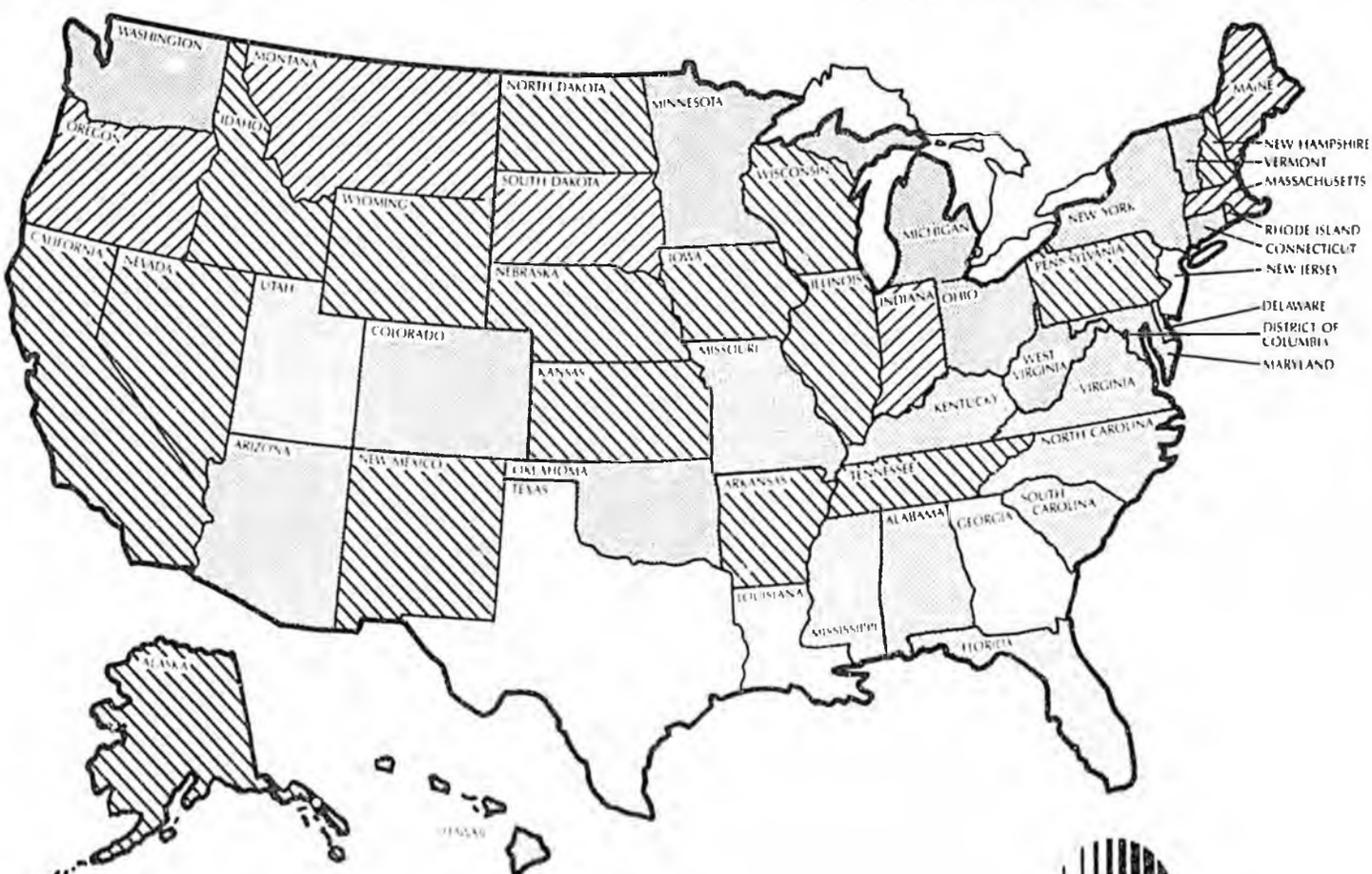
ACCEPTABLE RATIO
(More than 13 practicing O.D.s per 100,000 population)

ABOVE AVERAGE RATIO
(11-13 practicing O.D.s per 100,000 population)

AVERAGE RATIO
(9-11 practicing O.D.s per 100,000 population)

BELOW AVERAGE RATIO
(7-9 practicing O.D.s per 100,000 population)

CRITICAL RATIO
(less than 7 practicing O.D.s per 100,000 population)



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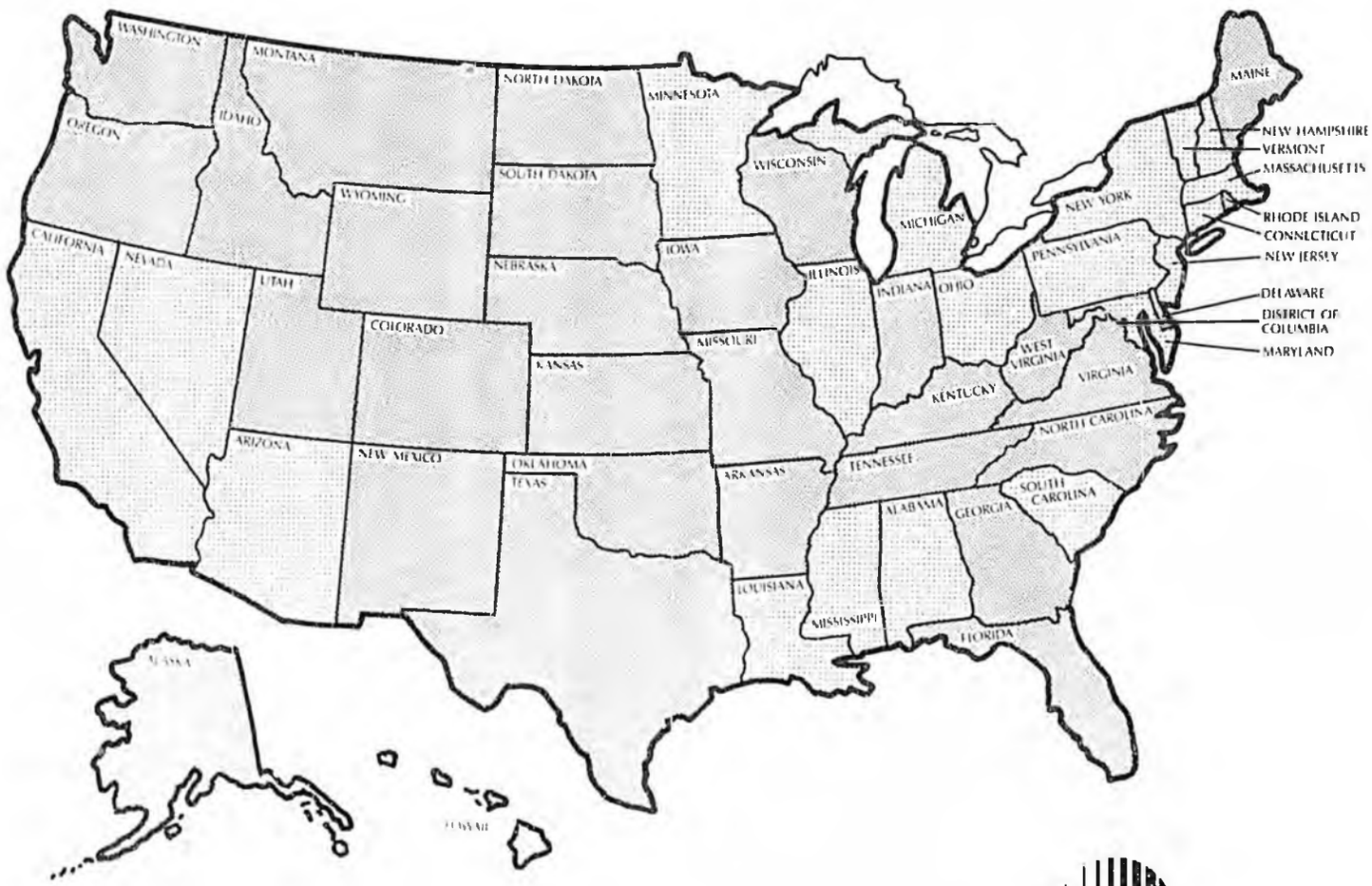
The Primary Eye Care Profession

State Pharmaceutical Legislation

DIAGNOSTIC USE

DIAGNOSTIC AND THERAPEUTIC USE



American Optometric Association

AS OF JULY 1, 1991

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 oprometrists 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 the 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 ophthalmologist's say our students do not receive appropriate clinical instruction they are providing misinformation; by reacting emotionally and irrationally.

You will hear that a profession which is non-medical 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 whether or not optometrists are well trained healthcare professionals.

You will hear that these therapeutic pharmaceutical agents can have systemic effects, effects on other parts of the body, and that there can 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 reasonably 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 judgement on the part of the optometrists. These "straw men" 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 found to be fraudulent. 24 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 judgement to provide high quality eye care to their patients.

Contributed by Thomas F. Dorrity, Jr., O.D.

Summer, 1989

An Analysis of Pharmacology Training in Schools of Optometry, Medicine and Dentistry

1985

Marti Waigandt, B.S.
Alex Waigandt, Ph.D.

Introduction

In recent years, a great deal of controversy has existed over the issue of drug licensure for optometrists. Members of the medical community have come out on both sides of the issue, some stating that optometrists are neither qualified to use nor require pharmaceuticals in practice and others stating that pharmaceuticals are both necessary and important in optometric practice.[1,2,3]

The role of the optometrist has changed markedly from the mid-19th century entrepreneur who merely corrected refractive errors to the highly skilled professional licensed to examine, diagnose and treat conditions of the visual system.[4,5] In addition to correcting refractive errors, the optometrist can often recognize early stages of pathological conditions such as diabetes, hypertension, arteriosclerosis, cataracts and glaucoma.[6] Since many of these conditions are asymptomatic at the onset, it is of vital importance that optometrists serve as portals of entry and make referral to the appropriate health care provider.[7] Optometrists refer 5.6 percent of their patients each week.[8] Improved and more complete ocular and visual care would undoubtedly be accomplished with the use of pharmaceutical agents. This would result in increased benefits and service to the patient. With the use of these agents, the training and skills of the optometrist would be maximized.

Not only has the role of the optometrist expanded, but so has the public need for his services. In the United States, approximately two out of every five persons require eye care, most of which is provided by optometrists.[9] Approximately 19,300 optometrists currently provide eye and vision service to 69 percent of the counties in the United States. About 9,500 active ophthalmologists provide service in only 33 percent of the counties in the U.S. and they are concentrated primarily in metropolitan areas.[10] Therefore, where a large proportion of the population has no access to an ophthalmologist they may have access to an optometrist.[11] It is important that every adjunct to diagnosis, including pharmaceutical agents, be made available to the optometrist in order to serve the public.

With regard to the diagnostic agents utilized by optometrists, the risks of adverse drug reactions are minimal. The safety and efficacy of these drugs has been established and substantiated in the professional literature.[12,13,14] One study showed that, for an 85 year period, "possibly ten deaths were reported associated with the topical application of these drugs, but only when misused."[15] Additionally, use of diagnostic pharmaceutical agents by optometrists in England, the United States Armed Services and in over thirty states in which use of these drugs is allowed has not resulted in any incidence harmful to the welfare of the public.[16]

The public need for optometrists to use drugs has been stated and the safety of these drugs has been demonstrated. Therefore, the question is: Are optometrists qualified to use pharmaceuticals? It is the intent of this study to analyze optometrists in terms of academic qualifications as compared to clinicians currently licensed to use pharmaceuticals.

Methods

Fourteen states contain colleges of optometry: Alabama, California, Illinois, Indiana, Massachusetts, Michigan, Missouri, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee and Texas. These states were designated as study states and collectively contain 111 colleges of medicine, dentistry and optometry. Of these school types, 37 colleges of medicine, 31 colleges of dentistry and 15 colleges of optometry were selected for participation in the study. The department chairperson or director of pharmacology in each school was identified as the study respondent.

Data were generated from the subjects' responses to an instrument whose purpose was to query the amount of hours devoted to the study of pharmacology. The investigation, being descriptive in nature[17] viewed hours spent in each of 13 major pharmacology study categories and total class hours in the study of pharmacology as separate dependent variables. These categories included: (1) basic principles in pharmacology, (2) drug effects on the nervous

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system, (3) psychopharmacology, (4) central nervous system stimulants and depressants, (5) anesthetics, (6) cardiovascular agents, (7) ocular pharmacology, (8) respiratory and gastrointestinal tract agents, (9) endocrine pharmacology, (10) chemotherapy, (11) poisons and antidotes, (12) drug interactions and (13) prescription writing. A 14th variable involved the total hours each school type spends on the study of pharmacology. This instrument was designed through a review of the literature[10] and with the consultation of experts in the field; and, indicative of a pharmacology education sequence for health practitioners.

Results from the instrument were analyzed using the statistical package for the social sciences (SPSS) and calculated on an AS 9000 computer system at a major university. Treatment of the data was performed implementing: (1) descriptive tables utilized to analyze the demographic data, (2) means, standard deviations and analysis of variance (ANOVA) to analyze the major pharmacology study categories and (3) comparative analyses on the major pharmacology study categories whose F-ratio indicated significant differences. The .01 level was selected for statistical significance.

Results

Of the 83 schools surveyed, 41 schools responded (49.4 percent response rate overall). (Note: Several schools responded after the study deadline of May 1, 1984, but those data are not reflected in these results.) Eight were schools of optometry (53.3 percent response rate), 19 were schools of medicine (51.3 percent response rate) and 14 were schools of dentistry (45.2 percent response rate). Table 1 presents the states surveyed and the schools whose responses are reflected in the research data. With only one exception (Massachusetts), every state is represented by at least one school type and five states are represented by all school types studied.

TABLE 1
States surveyed and schools reflected in the research data

State	School Type	Number of Schools Responding
Alabama	Optometry	1
	Medical	2
	Dental	1
California	Optometry	2
	Medical	3
	Dental	1
Illinois	Optometry	1
	Medical	2
	Dental	1
Indiana	Optometry	1
	Medical	1
	Dental	0
Massachusetts	Optometry	0
	Medical	0
	Dental	0
Michigan	Optometry	0
	Medical	1
	Dental	1
Missouri	Optometry	1
	Medical	0
	Dental	0
New York	Optometry	0
	Medical	2
	Dental	1
Ohio	Optometry	1
	Medical	2
	Dental	2
Oklahoma	Optometry	0
	Medical	1
	Dental	1
Oregon	Optometry	0
	Medical	0
	Dental	1
Pennsylvania	Optometry	0
	Medical	2
	Dental	3
Tennessee	Optometry	0
	Medical	2
	Dental	0
Texas	Optometry	1
	Medical	1
	Dental	2
TOTAL		41

The results of the pharmacology study questionnaire in terms of mean responses and statistical comparisons between the study groups in each of the 14 categories are presented in Tables 2, 3 and Figure 1. Table 2 presents means, standard deviations and analysis of variance of classroom hours spent on major pharmacological study categories for the school types. Table 3 shows the comparisons between school type for major pharmacology study category whose F-ratio indicates significant differences. Figure 1 illustrates the total class hours in pharmacology training for schools of optometry, medicine and dentistry.

Basic Principles in Pharmacology

The range of hours in category 1 of the instrument is 15. Four schools spend only three hours and two spend 18 hours on this category. The overall mean for the entire sample is 8.71 hours. An F-ratio of 5.48 shows that there are significant differences among the three school types in hours spent in this study category.

Schools of optometry are not significantly different than either schools of medicine ($t = 2.51$, $df = 16.2$, $p = .02$) or schools of dentistry ($t = 0.04$, $df = 14.3$, $p = .97$). Medical schools do, however, spend more hours on this category than schools of dentistry ($t = 3.01$, $df = 30.8$, $p = .005$).

Drug Effects on the Nervous System

The second category for comparison within the pharmacology study instrument involves class hours spent studying drug effects on the nervous system. The range of hours was found to be 23 with two schools spending only five hours and one school spending 28 hours on this category.

The mean is 13.24 overall and an F-ratio of 8.61 showed that there are significant differences among the three school types on this category of the instrument. Comparatively, optometrists and dentists do not differ on this category ($t = 0.99$, $df = 13.1$, $p = .922$), whereas medical schools devote more hours than either optometry ($t = 2.97$, $df = 14.8$, $p = .009$) or dental schools ($t = 3.83$, $df = 30.9$, $p = .001$).

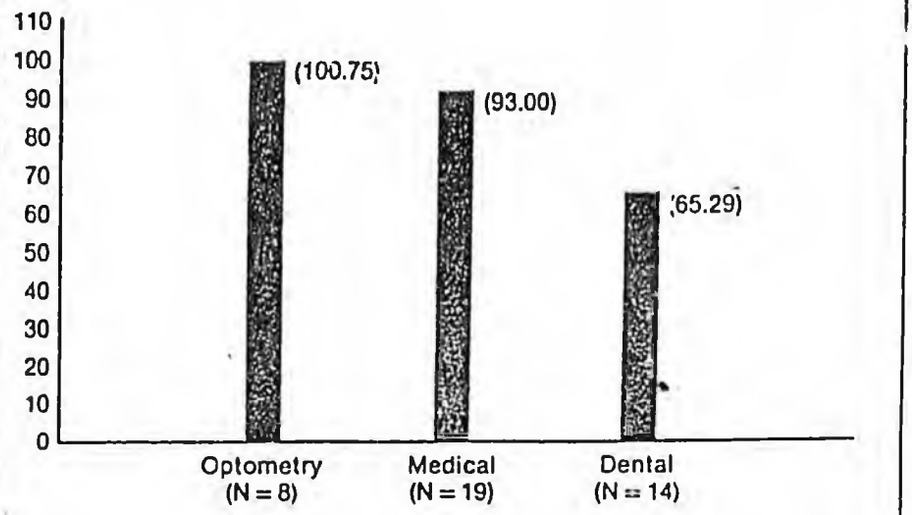
Psychopharmacology

The range for hours spent teaching psychopharmacology is 10. The grand mean for this category is 4.75 with the three school types averaging between four and six class hours. According to the calculations, there are no significant differences ($F = 1.74$, $p = .189$/n.s.) among optometry schools ($\bar{X} = 4.37$, $SD = 3.25$), schools of medicine ($\bar{X} = 5.47$, $SD = 2.24$) and schools of dentistry ($\bar{X} = 4.00$, $SD = 1.80$).

Central Nervous System Depressants and Stimulants

The fourth category within the questionnaire involves classroom hours spent on the CNS depressants and stimulants. No significant differences are present among schools of optometry, medicine and dentistry for hours spent in this content area ($F = 1.02$, $p = .368$/n.s.). The three school types average between seven and ten class hours on the CNS depressants and stimulants.

FIGURE 1
Total Class Hours in Pharmacology Training for Schools of Optometry, Medicine and Dentistry



Anesthetics

The hourly range on the instrument category identified as anesthetics is 10. The overall mean for the entire sample is 4.63. Although schools of optometry and medicine are not significantly different in this category ($t = 1.56$, $df = 21.0$, $p = .133$), an F-ratio of 6.91 indicates that significant differences do exist among the three groups. The comparisons between schools on hours spent teaching anesthetics show that schools of optometry require significantly less hours than schools of dentistry ($t = 3.80$, $df = 18.9$, $p = .001$).

Cardiovascular Agents

Category six within the pharmacology study questionnaire deals with cardiovascular agents. An F-ratio of 14.31 shows that significant differences exist among the school types on this category. According to the analysis, optometry schools and schools of dentistry do not differ on this category ($t = 1.24$, $df = 19.8$, $p = .229$). The mean hours for schools of medicine ($\bar{X} = 12.26$) fall above the grand mean of 9.49 and indicate that medical schools spend more time on cardiovascular agents than dental schools and schools of optometry (Med vs Den, $t = 3.74$, $df = 23.8$, $p = .001$; Med vs Opt. $t = 6.41$, $df = 20.7$, $p = .000$).

Ocular Pharmacology

The seventh category within the instrument asks for classroom hours spent on ocular pharmacology. The overall mean hours spent by the sample schools is 7.12. According to the data, schools of optometry average ($\bar{X} = 34.00$) more than the grand mean whereas medical and dental schools spend less time than the overall average ($\bar{X} = 0.63$ and 0.57 respectively). All three groups had relatively large standard deviations that indicate extensive variability.

The results of the analysis of variance (ANOVA) show that there are statistically significant differences among the groups on this category of the pharmacology study questionnaire. The comparative analyses show that optometry schools spend more hours than schools of medicine ($t = 8.97$, $df = 7.0$, $p = .000$) and schools of dentistry ($t = 8.94$, $df = 7.0$, $p = .000$) teaching ocular pharmacology to their students.

TABLE 2
Means, Standard Deviations and Analysis of Variance of Class Lecture Hours Spent on Major Pharmacological Study Categories by Optometry, Medical and Dental Schools

Category	Optometry N = 8 $\bar{X}$ (SD)	Medical N = 19 $\bar{X}$ (SD)	Dental N = 14 $\bar{X}$ (SD)	Grand Mean (SD)	F-ratio	F
Basic Principles in Pharmacology	7.12 (3.04)	10.58 (3.75)	7.07 (2.95)	8.71 (3.36)	5.48	•
Drug Effects on Nervous System	10.75 (4.23)	16.26 (4.76)	10.57 (3.71)	13.24 (4.33)	8.61	••
Psycho-pharmacology	4.37 (3.25)	5.47 (2.24)	4.00 (1.80)	4.75 (2.37)	1.74	n.s.
CNS Stimulants and Depressants	7.75 (3.72)	9.89 (4.21)	8.57 (3.20)	9.02 (3.84)	1.02	n.s.
Anesthetics	3.12 (1.13)	4.05 (1.93)	6.29 (2.73)	4.63 (2.13)	6.91	•
Cardiovascular Agents	6.12 (1.88)	12.26 (2.99)	7.64 (3.83)	9.49 (3.15)	14.31	•••
Ocular Pharmacology	34.00 (10.57)	0.63 (0.89)	0.57 (0.65)	7.12 (4.59)	170.14	•••
Respiratory and GI Tract Agents	2.00 (1.77)	3.26 (1.66)	2.29 (2.02)	2.68 (1.85)	1.88	n.s.
Endocrine Pharmacology	5.50 (2.83)	7.11 (3.40)	4.14 (2.51)	5.78 (3.23)	3.93	n.s.
Chemotherapy	8.37 (4.75)	14.05 (5.50)	8.64 (4.24)	11.10 (4.96)	6.28	•
Poisons and Antidotes	1.00 (1.07)	3.31 (2.56)	1.35 (1.22)	2.19 (1.96)	5.90	•
Drug Interactions	1.50 (0.93)	1.47 (0.70)	1.71 (0.99)	1.56 (0.84)	0.35	n.s.
Prescription Writing	1.12 (0.64)	1.11 (0.87)	1.64 (1.15)	1.29 (0.95)	1.46	n.s.
Total Hours in Pharmacology	100.75 (14.24)	93.00 (15.47)	65.29 (19.40)	85.05 (16.71)	15.46	•••

•p <.01 ••p < .001 •••p < .0001

Respiratory and Gastrointestinal Tract Agents

An analysis of variance (ANOVA) conducted on responses to category eight of the instrument indicate that optometry, medical and dental schools are not significantly different (F = 1.88, p = .166/n.s.) in terms of hours spent teaching respiratory and GI tract agents. The overall mean, in terms of hours, is 2.68 and the schools devote an average of two to four hours on this category.

Endocrine Pharmacology

The ninth category within the pharmacology study questionnaire deals with hours spent teaching endocrine pharmacology. An F-ratio of 3.93 (p = .028/n.s.) indicates that no significant differences exist among the school types in terms of hours devoted to this category. All three school types are close to the grand mean of 5.78 class hours.

Chemotherapy

The range of hours the school types spend teaching chemotherapy is 30. Over 40 percent of the schools studied

TABLE 3
Comparisons Between School Type for Significant Differences ($p < .01$) on Major Pharmacology Study Category

		t-ratio	df	t Probability
Basic Principles in Pharmacology	Optometry and Medical	2.51	16.2	.023
	Optometry and Dental	0.04	14.3	.969
	Medical and Dental	3.01	30.8	.005*
Drug Effects on the Nervous System	Optometry and Medical	2.97	14.8	.009*
	Optometry and Dental	0.10	13.1	.922
	Medical and Dental	3.86	30.9	.001*
Anesthetics	Optometry and Medical	1.56	21.9	.133
	Optometry and Dental	3.80	18.9	.001*
	Medical and Dental	2.62	22.2	.016
Cardiovascular Agents	Optometry and Medical	6.41	20.7	.000*
	Optometry and Dental	1.24	19.8	.229
	Medical and Dental	3.74	23.8	.001*
Ocular Agents	Optometry and Medical	8.97	7.0	.000*
	Optometry and Dental	8.94	7.0	.000*
	Medical and Dental	0.22	31.0	.820
Chemotherapy	Optometry and Medical	2.70	15.3	.020
	Optometry and Dental	0.13	15.3	.890
	Medical and Dental	3.19	30.9	.003*
Poisons and Antidotes	Optometry and Medical	3.31	25.0	.003*
	Optometry and Dental	0.77	16.4	.480
	Medical and Dental	2.92	27.2	.007*
Total Lecture Hours In Pharmacology	Optometry and Medical	1.26	14.3	.230
	Optometry and Dental	4.90	18.5	.000*
	Medical and Dental	4.41	24.2	.000*

*$p < .01$

spend 10 hours or less on this category while only five percent spend more than 20 hours. The grand mean for this category is 11.10 hours. The ANOVA indicates that significant differences ($F = 6.28$) exist among the school type in terms of hours spent teaching chemotherapy.

Optometry schools are not significantly different than medical schools ($t = 2.70$, $df = 15.3$, $p = .02$) or schools of dentistry ($t = 0.13$, $df = 15.3$, $p = .89$). Dental and medical schools are significantly different ($t = 3.19$, $df = 30.9$, $p = .003$), however, with medical schools spending more time on chemotherapy than dental schools.

Poisons and Antidotes

Category eleven within the pharmacology study questionnaire asks for the number of hours the school types spend on poisons and antidotes. An F-ratio of 5.90 indicates that there are significant differences among the school types on this category. A comparative analysis between school type shows that medical schools spend more time than schools of optometry and dentistry (Med vs Opt, $t = 3.31$, $df = 25.0$, $p = .003$; Med vs Den, $t = 2.92$, $df = 27.2$, $p = .007$) but that optometry and dental schools do not differ on hours spent teaching poisons and antidotes ($t = .88$, $df = 16.4$, $p = .48$).

Drug Interactions

The overall mean within school types for this category of the instrument is 1.56 hours. All three school types average approximately one and a half hours teaching drug interactions. An analysis of variance ($F = 0.35$, $p = .71$/n.s.) conducted on this category indicates that schools of optometry, dentistry and medicine are not significantly different in terms of hours spent on category twelve.

Prescription Writing

The thirteenth category within the pharmacology study questionnaire involves responses relating to hours spent on prescription writing. No significant differences are found among the school types ($F = 1.46$, $p = .24$/n.s.) with all three school types devoting approximately one hour on this category.

Total Hours in Pharmacology

The last category for comparison within the pharmacology study questionnaire deals with the total classroom hours the school types spend studying pharmacology. The range of hours is 88. Of the schools surveyed, one school

spends only 39 hours teaching pharmacology whereas another spends 127. The overall average within the school types is 85.05 hours. Figure 1 shows a graphic comparison for total class hours in pharmacology training for schools of optometry ($\bar{X} = 100.75$), medicine ($\bar{X} = 93.00$) and dentistry ($\bar{X} = 65.29$).

An analysis of variance indicates that significant differences exist among the groups for total hours spent teaching pharmacology. Comparisons between schools show that no significant differences exist between optometry and medical schools ($t = 1.26$, $df = 14.3$, $p = .23$). This is consistent with what Hegeman found when she compared the pharmacology content for optometry and medical students at Indiana University, Bloomington.[19] Both schools of optometry and medicine devote more total class hours than schools of dentistry to the study of pharmacology (Opt vs Den, $t = 4.90$, $df = 18.5$, $p = .000$; Med vs Den, $t = 4.41$, $df = 24.2$, $p = .000$).

Conclusions

The safety of the pharmaceuticals in question and the need for optometrists to use such agents has been established. In the opinion of some members of the medical community, optometrists are not properly educated in the area of pharmacology, thus unqualified to utilize pharmaceuticals. However, there is no justification for this belief on the basis of the data presented. Some ophthalmologists are presumptuous enough to believe that they are the only persons qualified to conduct comprehensive eye examinations.[20] This may be due to their lack of knowledge regarding academic training for optometrists.

Based upon the results of this study, optometrists receive sufficient training in the area of pharmacology. In no category were optometrists significantly lower than both medicine and dentistry. This indicates that optometry offers at least as much training in any study area as one of the other two health professions.

The significant differences present among the groups can be attributed to the professional requirements. Ocular pharmacology is emphasized for optometry while dentistry spends more time studying anesthetics and medicine, concentrates on cardiovascular agents, drug effects on the nervous system and poisons and antidotes. Therefore, all optometrists should be permitted to utilize ocular pharmaceutical agents in order to provide the maximum benefit and service to the public. □

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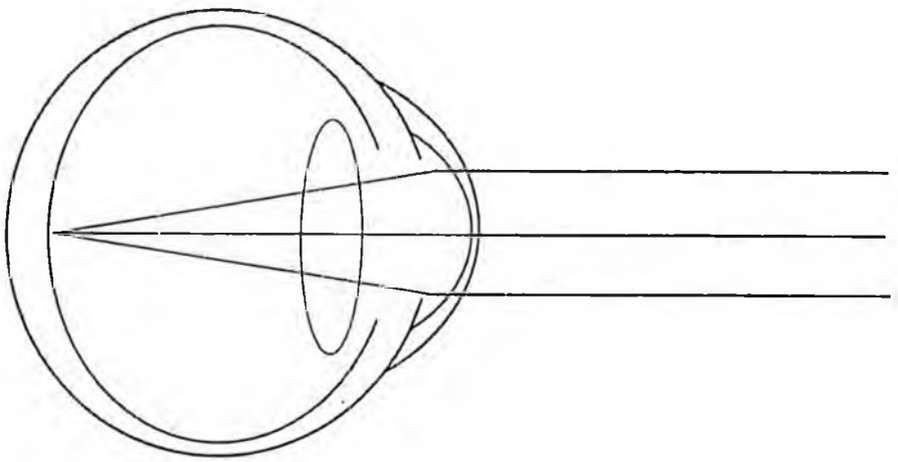
The institutional affiliation of Dr. Rogers Reading was incorrectly identified on page 23 of the Summer 1984 (Volume 10, Number 1) issue of JOE. Dr. Reading is a long-time and respected faculty member at Indiana University School of Optometry. JOE regrets the error.

FOCUS ON THE FACTS



O.D.

A LEGISLATORS' GUIDE TO OPTOMETRIC LEGISLATION IN TEXAS

Texas Optometric Association
Texas Association of Optometrists

CONTENTS

I. PURPOSE OF THIS LEGISLATION

The purpose of this legislation is to update the statutory definition of the practice of optometry in Texas. Unlike general medicine, optometrists practice under a restricted license and must amplify legislation as optometric education and eye care technology expand. Passage of this legislation would allow qualified Texas optometrists to treat the conditions they diagnose in a manner consistent with their education and training. *As a result, the citizens of Texas will have greater access to high quality, cost-effective eye care.*

II. CLARIFICATION OF TOPICAL PHARMACEUTICAL AGENTS UTILIZED IN EYE CARE

Diagnostic pharmaceutical agents (DPA's) are medications used by the optometrist in examining the eye and diagnosing vision disorders and eye disease.

Therapeutic pharmaceutical agents (TPA's) are medications used to treat an ocular disease that the optometrist has already diagnosed.

III. THE OPTOMETRIC PROFESSION

OPTOMETRISTS : Doctors of optometry diagnose, manage, and, where permitted by state law, treat conditions and diseases of the human eye and visual system. A doctor of optometry completes four years of undergraduate education and four additional years of post-graduate optometric training. Optometry is one of the largest independent health care provider groups in the United States.

OPHTHALMOLOGISTS: Doctors of medicine who specialize in surgical and advanced medical care of the human eye. Due to the low prevalence of eye disease requiring surgical care, most ophthalmologists spend the majority of their time dealing with routine eye care needs, the same care provided by the optometrist.

GENERAL MEDICAL PRACTITIONER: A medical doctor who may or may not specialize in a particular health care area. General practitioners are permitted to treat diseases of the eye.

OPTICIAN: A person trained to fabricate and dispense corrective lenses from the prescription of a doctor of optometry or medicine.

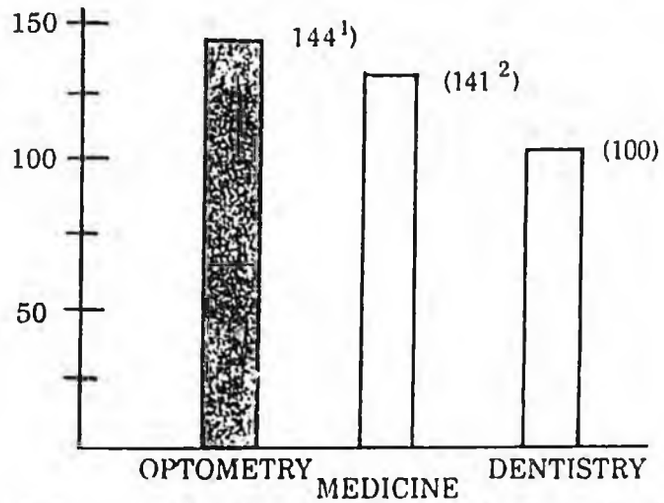
IV. TEXAS OPTOMETRY'S EXPERIENCE WITH PHARMACEUTICAL AGENTS

Texas optometrists have safely and effectively utilized diagnostic pharmaceutical agents for many years. As a result, Texans have received better primary eye care. Proper diagnosis is the most difficult aspect of treatment Optometrists are already legally required to diagnose eye disease - ***establishing a treatment plan is the next logical step.***

In 25 states, where optometrists routinely use drugs to diagnose and treat eye disease, problems have virtually been non-existent. Texas optometrists do not have this earned and justified privilege. The University of Houston College of Optometry trains doctors for eight other states that allow optometrists to prescribe and administer therapeutic medications, including our neighboring states of New Mexico, Oklahoma, and Arkansas. This training is equal to or greater than that of other health care practitioners (Graph I). Many highly qualified optometrists trained at the University of Houston College of Optometry leave their home state of Texas to practice where they can care for patients to the full extent of their training. These state education funds would be better spent if these doctors could practice their healing arts in their own native state.

Graph I

OPTOMETRIC EDUCATION IN PHARMACOLOGY SURPASSES OTHER HEALTH CARE PROFESSIONS



TOTAL CLASS HOURS IN PHARMACOLOGY TRAINING

[1] Catalogue listing University of Houston College of Optometry

[2] Average of catalogue listings of Baylor College of Medicine, UT Medical School at Houston, and Texas A&M Medical School.

V. WHY THIS LEGISLATION IS GOOD PUBLIC POLICY

This legislation is needed for one main reason - ***it will be beneficial to the citizens of Texas.*** Allowing highly trained and certified optometrists to treat ocular disease will increase patient's access to care, be cost-effective, and be more consistent with optometric education.

BETTER ACCESS TO EYE CARE

According to the American Public Health Association, more than one third of all U.S. residents have eye problems, yet only half of those needing treatment receive it. Optometrists are the largest group of eye care providers in Texas as well as the nation. According to the Texas Medical Association and the Texas Optometry Board, optometrists outnumber ophthalmologists two to one in Texas (1658 optometrists vs. 886 ophthalmologists). Unlike ophthalmology, doctors of optometry are widely distributed across the vast state of Texas (Graph II). In many communities, optometrists are the only doctor specifically educated and trained as eye care specialists. ***The American Public Health Association has recognized the need for better access to quality eye care and supports legislation that updates optometry to a <u>therapeutic</u> profession.***

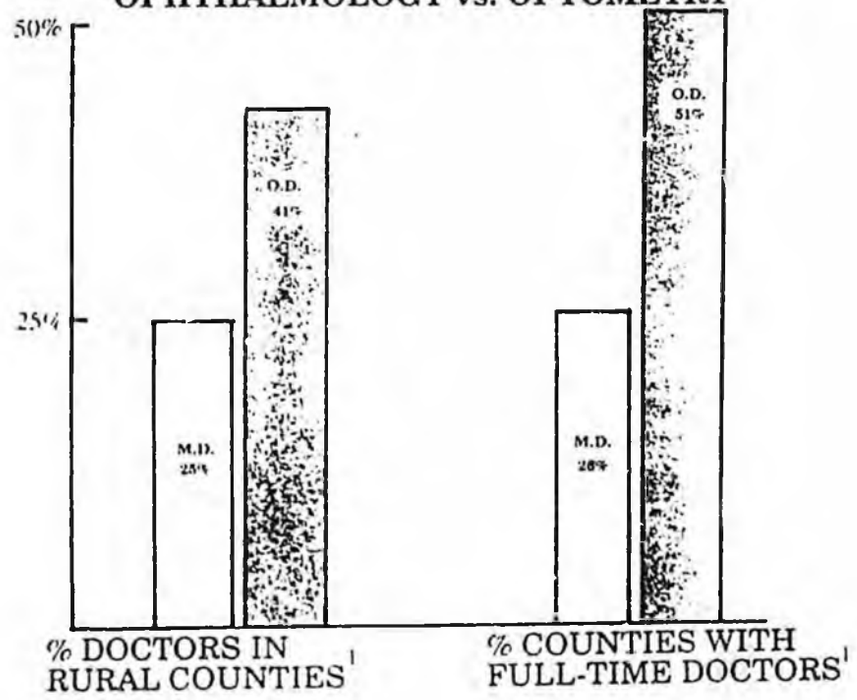
The rural health care crises is forcing medical doctors to leave rural Texas and hospitals to close. Under current law, many patients must travel long distances to costly specialty clinics. Allowing optometrists who already practice in rural areas to treat eye disease would fill these eye care gaps. Optometrists also routinely provide evening and weekend appointments, a practice rarely provided by ophthalmologists.

The optometrist is usually the first contact for a patient suffering from an eye disorder. In most cases, needed treatment will begin more promptly, an important aspect in the treatment of many eye diseases. Early diagnosis and treatment allows the optometrist to eliminate patient suffering and, in many cases, prevent serious complications from ocular and systemic disease.

Graph II

RURAL vs. URBAN EYECARE COVERAGE IN TEXAS

OPHTHALMOLOGY vs. OPTOMETRY



1 Source: state licensure records

COST-EFFECTIVE CARE

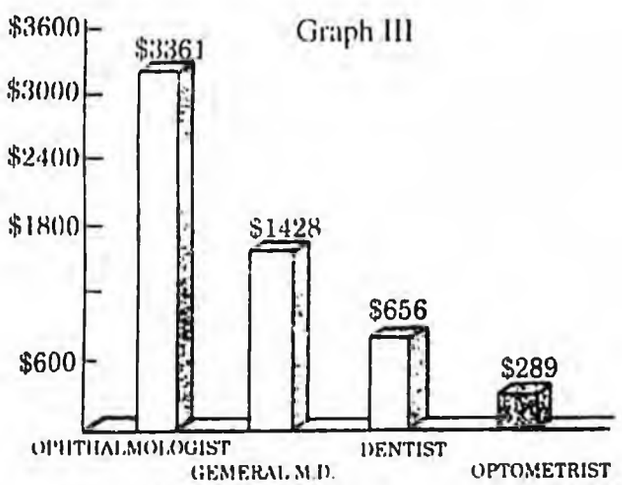
It is cost-effective to allow optometrists to practice at their highest level of competence. Allowing optometrists to treat what they have already diagnosed will save the public money by eliminating unnecessary visits to and long waits at another doctor. Extra travel time and time away from work will also be reduced.

Doctors of optometry in 25 other states, in military service, the U.S. Public Health Service and in VA Hospitals have utilized diagnostic ***and*** therapeutic medications for many years. A legislative analysis on reducing health care costs in North Carolina cited the optometric use of diagnostic and therapeutic drugs as one of the greatest means of addressing spiraling health care costs. Due to the higher cost of training, equipment, and liability insurance, ophthalmology services are often more expensive than optometric services, even though their specialized training is not warranted for the condition under treatment. According the Journal of American Medical Association, April 1985, "The cost of primary care increases when it is provided by specialists, without necessarily improving its quality...".

An unbiased reflection of quality, cost-effective care is malpractice insurance rates. Optometric professional liability insurance is among the lowest of any profession (Graph III). The insurance marketplace, which usually overreacts to the slightest risk, is so comfortable with the safety of optometric treatment of patients that therapeutic laws do not even make a blip on the premium scale. There is no better evidence of the safety of permitting optometrists to treat to the full level of their training than this marketplace response of the insurance industry. Poe and Associates, which is the biggest insurer of optometrists, has found no reason to and does not charge different rates in states that allow optometrists to use therapeutic drugs. (Graph IV).

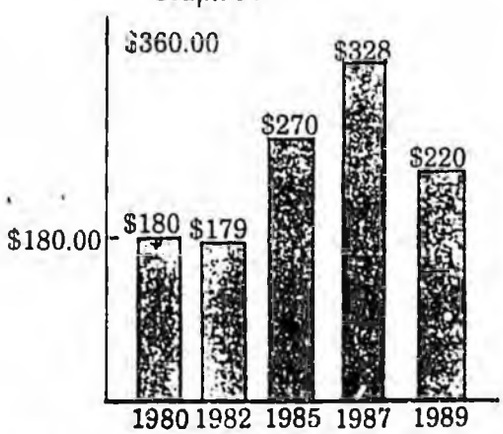
Many Texas optometrists accept Medicaid and Medicare assignment. This greatly reduces the out of pocket expenses for senior citizens and with passage of this legislation, would decrease the monetary burdens placed on these programs by unnecessary referrals to surgical specialists (ophthalmologists).

Graph III



AVERAGE MALPRACTICE PREMIUMS

Graph IV



OPTOMETRIC MALPRACTICE PREMIUMS IN NORTH CAROLINA

SOURCE: CRUMPTON INSURANCE AGENCY

OPTOMETRIC TRAINING

"My 16 years of joint clinical teaching experience confirms the fact that ophthalmological training programs concentrate more on advanced medical and surgical cases while clinical optometric programs provide equal teaching experience in eye disorders and disease at the primary care level."

Joseph C. Toland, O.D., M.D.
Optometrist, Ophthalmologist, and Professor
Jefferson County Medical College
Pennsylvania College of Optometry

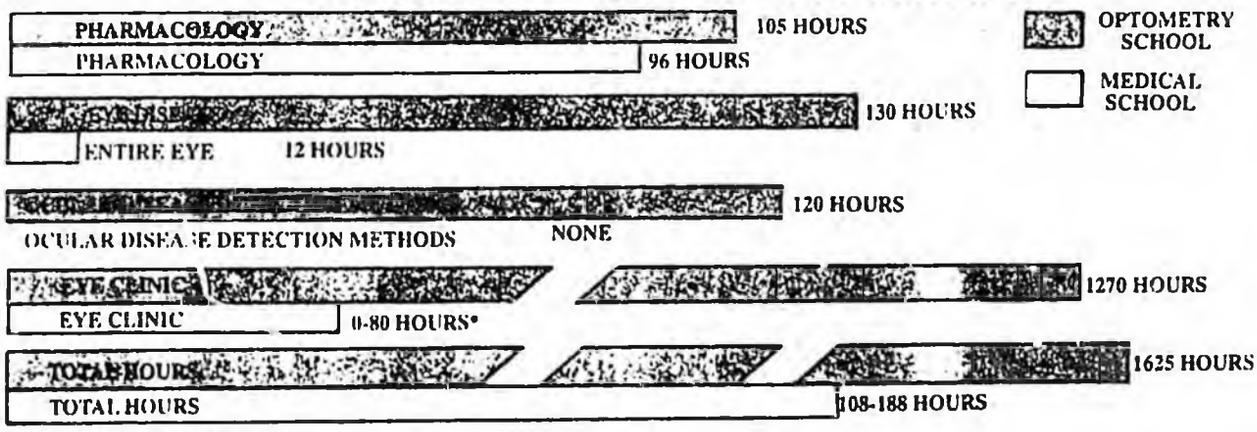
Source: Update Care Minnesota Optometric Association

Health care practitioners, including optometrists, are responsible for providing their patients with the highest level of care consistent with their education and training. Optometric education has expanded well beyond the limitations of current Texas law. State and national funding utilized in the training of health care practitioners are better served when those doctors are allowed to care for patients to the full extent of their training. Legislation allowing optometrists to treat eye disease would be consistent with their training and education.

Other medical and non-medical health care practitioners (physicians, dentists, podiatrists) routinely prescribe topical, oral, and injectable therapeutic medications. The curriculum in optometry school closely resembles that of medical, dental, and podiatry schools, including courses in anatomy, physiology, biochemistry, microbiology, pathology, and pharmacology. None of these other practitioners, including general medicine, have the extensive training and education specific to eye disease and ocular pharmacology (Graph V). Archives of Ophthalmology , October 1990, reports that *less than "50% of the medical students in the United States have exposure to a curriculum that teaches ophthalmic fundamentals that will provide them with the knowledge and skills necessary for a good medical practice"*. Yet of all these practitioners, only optometry is restricted by law in the use of pharmaceutical agents.

Graph V

AVERAGE CLASSROOM HOURS DEVOTED TO DETECTION AND MANAGEMENT OF EYE DISEASE OPTOMETRY SCHOOL vs. MEDICAL SCHOOL



*optional, only 25% choose it

Source: Analysis of Pharmacology Training in Schools of Optometry, Medicine and Dentistry. Journal of Optometric Education, Vol. 10, No. 3, Winter 1985.

THIS LEGISLATION HAS SUFFICIENT SAFEGUARDS

There has been significant change in optometric legislation over the past fifty years. This legislation will include comprehensive safeguards to assure the publics safety.

- *No "grandfathering" of currently licensed optometrists will be allowed.* Optometrists wishing to utilize therapeutic agents will have to be certified by the Texas State Board of Optomery.

- *Practitioner competency will be assured.* Strict educational requirements will be established by the Texas State Board of Optometry. Optometrists are the only doctors in Texas required by their own law to stay abreast with their field through annual continuing education requirements.

VI. IS THERE A CONTROVERSY?

"With both their incomes and egos in jeopardy, it's not surprising at all that ophthalmologists or any other similarly situated group would react the way they are. What we're seeing is economic guerilla warfare...it's a straight pocket-book issue. Ophthalmology's attempts to limit optometry's scope of practice are, not surprisingly, cloaked in the garb of public health and welfare. But they're nothing of the sort. ***Ophthalmology is trying to protect its source of revenue."***

Douglas J. Colton, J.D.
Anti-trust Attorney, Washington, D.C.
Source: Update Care Minnesota Optometric Association

Generally speaking, there is no controversy. Certain segments of the medical profession will voice opposition to this legislation. A recent publication of the American Academy of Ophthalmology contains the following observation - "according to a study commissioned by the federal government in 1982, the number of ophthalmologists already exceeds the need for them and continues to increase". Because the ophthalmological population exceeds the need for advanced specialty and surgical eye care, most ophthalmologists spend the majority of their time providing routine or primary eye care services, the same services provided by optometrists. Ophthalmology itself is divided on the issue of optometric use of therapeutic medications with many surgeons being in favor of this legislation. The basic economic reality is that a segment of ophthalmology opposes this legislation because it effects them economically. In Rhode Island, Florida, and West Virginia state courts, ophthalmology went on record that this was in fact an economic issue for them.

All doctors have a primary responsibility - their professional training and ethics mandate they provide the highest quality care possible. This legislation does not alter this professional responsibility. In reality, ***if this legislation fails to be enacted there is only one group of individuals that lose - the citizens of this state.***

NEWS REVIEW

APHA BACKS TPA LAWS FOR OD'S

The American Public Health Association has become the first national health care organization to support optometrists' right to prescribe therapeutic drugs.

At their annual meeting in October, APHA members approved a resolution recommending that the 25 states that do not currently have TPA laws adopt them.

"This expansion of the clinical privileges of optometrists has increased the availability, accesibility and cost-effectiveness of eye care to the American public through lower fees and by a reduction in double visits and hospital emergency room visits," the resolution states. In support of the APHA's stand, the resolution also states that:

- Eye health problems and vision care demands will increase significantly in the future as the U.S. population ages,
- Optometrists are the only primary eye care providers in nearly 4,000 communities nationwide,
- Optometrists outnumber ophthalmologists by nearly two to one,
- 60 percent of primary diagnostic eye exams in the US are provided by the 25,000 active optometrists,
- Optometric reimbursement rates are typically lower than those of other providers of comprehensive eye care and Medicare reimburses diagnostic and therapeutic eye care services by optometrists, and
- The Dept. of Veterans Affairs, the Armed Forces and the Public Health Service all have regulations or credentialing statements that allow optometrists to use therapeutic drugs.

APHA has sent copies of the resolution to pharmacy boards, medical boards, governors and optometry boards in the states that have not approved TPA laws.

"This is a big deal," says Richard Schuck, O.D., chairman of the American Optometric Association's Legislative Committee. "I don't know that we'll see any

(Continued on p. 10)

OPTOMETRIC DRUG LEGISLATION

The 1991 map of therapeutic drug laws in the United States is almost a duplicate of the 1990 version.

No new states joined the list of those in which optometrists can treat eye diseases, but as 1991 begins, optometrists in six states are trying.

Therapeutics bills are in some stage of the legislative process in New Jersey, New York, Ohio, Pennsylvania, Michigan and Massachusettes.

Richard Schuck, O.D., chairman of the American Optometric Association, expects TPA bills to be introduced in at least a half-dozen more states during 1991. Schuck says the first vote on a bill in 1991 could come in New Jersey. ■

IN THE NEWS: MEDICARE CUTS

Medicare rule changes resulting from the budget reconciliation that took effect Jan. 1, 1991 stipulate that patients who receive intraocular lens implants are now entitled to one pair of glasses per surgery. In the past, such patients received one pair per year.

□

The clinical skills exam developed by the National Board of Examiners in Optometry will be administered for eight boards in July.

Utah, Montana, Oregon and Idaho will join Pennsylvania, Delaware, Missouri and Connecticut in accepting the clinical skills exam in lieu of a state-administered practical exam.

□

Cromolyn sodium cannot be sold by Professional Compounding Centers of America, Inc. to retail pharmacies for compounding into drug products, according to a preliminary injunction issued by the U.S. District Court in Texas.

Fisons Corp. is the only holder of FDA registrations for the substance. ■

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Governor signs bill allowing optometrists to apply drugs

W-21

The Associated Press

OLYMPIA — Gov. Booth Gardner signed into law Tuesday one of the most controversial bills of this legislative session, one that pitted optometrists against the medical profession.

The governor's health adviser, Bob Crittenden, a physician, said he had told his boss that he had contacted all 23 states that have similar laws on the books and found there had been no problems.

The measure, Senate Bill 5193, will allow optometrists to treat eye problems with drugs. Currently they can use drugs only for diagnostic purposes.

During debate on the bill, Rep. Art Sprenkle (D-Snohomish), a physician, said that provision was "like letting the fox design the hen house."

The governor also signed into law a bill boosting the penalty for disturbing an Indian grave or cairn to an maximum of five years in jail and a $10,000 fine. The measure, SB 5807, sponsored by Sen. Kent Pullen (R-Kent), takes effect July 1.

The penalty was sought by Washington tribes, whose leaders said grave robbing and vandalism are on the rise.

Gardner vetoed a bill that would have permitted manufacturers, importers and wholesalers of alcoholic beverages to wine and dine retailers and their employees.

The bill would have repealed sections of the state's "Tied House" law that prohibits any connection between distillers and distributors of alcoholic beverages and retail establishments.

Several other bills were sent to the governor Tuesday for his signature. Those included:

■ A proposal that would have the state hold developmentally disabled offenders in special facilities and more carefully monitor their furloughs.

The measure drew impetus from the state's inability to deal with a developmentally disabled sex offender named Gary Lee Minnix. The man, described by authorities as having the intelligence of a 5-year-old, has been held since 1984 in Western State Hospital for a series of rapes in Seattle's Beacon Hill neighborhood. During a Christmas furlough, he raped a Steilacoom woman, authorities say.

■ A proposal to let voters decide next fall whether to constitutionally guarantee rights for crime victims, under a measure approved by the Senate on Tuesday.

Among other things, the amendment would provide that the victim has as much right as the defendant to be informed of trial and all other court proceedings.

■ A measure aimed at protecting elderly, developmentally disabled, and mentally ill adults from sexual and economic predators.

The House-amended Senate measure, sponsored by Sen. Linda Smith (R-Hazel Dell), would expand a system now in place permitting businesses and government agencies to learn criminal backgrounds of people hired to work with children.

■ A proposal to allow judges the freedom to give lighter sentences to victims of abuse who injure or kill their long-time tormenters, under a bill sent to the governor on Tuesday.

The Senate measure, amended by the House before winning unanimous Senate approval, was inspired by the case of Delia Alaniz, a Sedro-Woolley woman who hired a man to kill her husband after she and her children suffered what was said to be 17 years of severe abuse.

OPTOMETRISTS

Gov. Booth Gardner has signed into law one of the most controversial bills of the legislative session, one that pitted optometrists against the medical profession.

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The measure, SB5193, will allow optometrists to treat eye problems with drugs. Currently they can use drugs only for diagnostic purposes.

Under the bill signed by the governor Tuesday, the Optometry Board will determine what drugs optometrists can use.

Jeff Keller, O.D.
is one of the leaders
of Utah's optometry bill

LEGISLATURE 1991

Panel OKs Bill Allowing Optometrists to Prescribe Drugs

A bill allowing optometrists to prescribe a limited range of drugs received the Senate Business, Labor and Economic Development Committee's endorsement Wednesday.

The committee voted 9-5 to send House Bill 168 to the full House for consideration. The bill is sponsored by nearly two dozen legislators, including several on the committee.

The lengthy debate before the committee pitted optometrists against ophthalmologists.

Optometrists contend the extension of powers would allow them to provide better and less expensive care to patients, particularly those in rural areas, and that they have received enough training to prescribe certain drugs for the treatment of common diseases and minor injuries.

Optometrists also maintain ophthalmologists want to defeat the bill to limit economic competition.

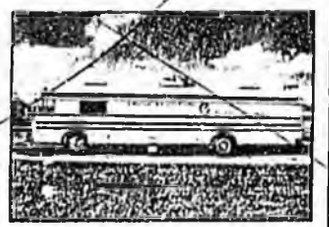
Ophthalmologists said money has nothing to do with their opposition and that their primary interest is protecting public health. They insist that optometrists have not received sufficient training to justify the right to prescribe medicine, increasing the potential for errors.

CATARACT SURGEONS HIT THE ROAD

Some Florida cataract surgeons are hitting the road to search for prospective patients.

Several large cataract surgery centers have purchased specially-outfitted screening vehicles, which make the rounds of the retirement communities, mobile home parks and shopping malls.

Inside the vans, technicians—and sometimes optometrists—perform free cataract and glaucoma screenings. When they find problems, they refer patients first



Eye Center of Florida's 40-foot screening vehicle.

to their own eye doctors for complete eye exams. If the patient doesn't have an eye doctor, they refer to area O.D.s friendly to the van's owner. And they offer the surgeon's services as well.

The idea is to find cataract patients, and reap the $1,549 to $1,821 per eye Medicare pays for surgery in Florida.

"It's a gimmick designed to find patients for surgery. The more cataracts, the better," says Fort Myers O.D. Donnie Dance.

Those who manage the vans admit to ulterior motives. "It's a marketing thing," says Richard A. Nixon, director of professional services for the Ft. Myers-based Eye Center of Florida. He is responsible for the comings and goings of a specially-equipped 40-foot vehicle that cruises throughout six counties, five to six

(Continued on p. 9)

IN THE NEWS: U.S. VISION SETTLES SUIT

U.S. Vision has settled out of court with Indianapolis O.D. Christopher OBeime, who sued the optical chain last September for "wrongfully" terminating an unwritten lease he had with the company and for refusing to return his patient records. Details of the settlement were not released.

□

Carl Zeiss, Inc. has denied an accusation by some newspapers and TV stations that it is among a group of German firms that sold military equipment to Iraq and supported the production of chemical weapons. Zeiss did sell medical equipment and surveying instruments to Iraq during the 1980s, a company spokesman said.

□

Blindness in rural areas nearly doubles the national rate, according to a study by researchers at Johns Hopkins. The researchers found that haif the cases of blindness and impaired vision in thei study could have been prevented with proper treatment. ■

DRUGS BECOME A GREATER PART OF PRACTICE

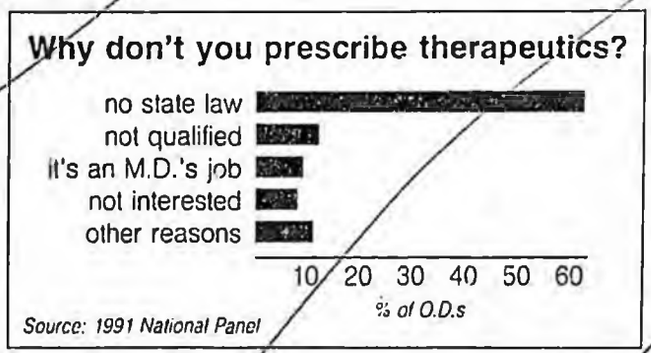
Using drugs to diagnose and treat eye diseases could soon be the norm rather than the exception in optometric practice. O.D.s are more likely to use diagnostic and therapeutic drugs today than they were in 1989, and they're handling nearly twice as many treatment-based office visits.

So says our latest National Panel, Doctors of Optometry, survey. Forty-four percent of our 500 panelists responded.

More O.D.s today are licensed to use diagnostic and therapeutic drugs than in 1989. Today, nine in 10 panelists may use DPAs; three in 10 may use TPAs. With these privileges, one California O.D. proclaims, "Patients no longer have an excuse to see an ophthalmologist for primary eye care."

It appears that O.D.s with licensure are more likely than two years ago to use drugs in daily practice. In 1989, only 6 percent of our

(Continued on p. 9)



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