HB

215

ALASKA STATE LEGISLATURE

Representative Lisa Murkowski Chair
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HOUSE LABOR AND COMMERCE COMMITTEE

Sponsor Statement
HB 215
Optometrists and Pharmaceuticals

Optometry is a primary health care profession that examines, diagnoses, and treats conditions of the human eye and visual systems using methods and procedures in accordance with professional training and competency.

Similar to other limited licensed health care professions such as optometrists, dentists, podiatrists, and nurse practitioners, the methods and procedures used by optometrists are determined in regulation by their respective state boards. Over the years, as technology and training has advanced, optometry has had to return to the legislature to update statutes to practice at the highest standard of care.

In 1988, Alaska was the last state to enact statutes allowing optometrists to use diagnostic drugs. In 1992, Alaska was the 32nd state to authorize prescriptive privilege of topical therapeutic drugs to treat eye diseases. There have been no complaints to the Alaska board concerning drug prescriptions by optometrists since that privilege was granted. Currently, all 50 states authorize optometrists to prescribe drugs, with 34 states allowing for oral or systemic drugs, while 16 states, including Alaska, further restricted to topical drugs only.

In 2000, SB 73 allowed for qualified optometrists to prescribe and use medications related to the eye and for emergency anaphylaxis. SB 78 was passed by the legislature, but vetoed by the governor, citing possible inadequate board oversight of training and testing, and concern regarding eye injections to the eye.

HB 215 addresses the governor's concerns by providing for board authority to ensure competency. It will change the scope of board-endorsed optometrists to prescribe the additional medications beyond topical for treatment related only to the eye and prohibits injections into the globe of the eye. It further allows the board to require additional education for endorsement and to apply limitations to a licensee's endorsement.

HB 215 allows optometrists to practice at the currently accepted standard of care, and provide improved access to quality, cost-effective eye care throughout Alaska.

Staff Contact: Amy Erickson 465-4954
Last Updated April 5, 2001

Sponsor Statement

SITE: OFF-NETS

COMMITTEE: HHES

DATE: 4/24/01

SUBJECT OF MEETING:

HB 215

HB 112

Update#:

PLEASE SIGN IN

PLEASE PRINT: NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY? Y or N
CARL ROSEN			Y HB 215
BOB PALMER DL A C	OPTOMOLOGY		Y HB 215
DR. COLLEEN MURPHY			Y HB 112

SITE: OFF-NETS *COMMITTEE:* *DATE:*	*SUBJECT OF MEETING:* HB 215 *Update#:*

$10,000 year
$5/Hour

PLEASE SIGN IN

PLEASE PRINT: NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY? Y or N
DR. CASSER			Y HB 215

The Medical Board recently voted to send a letter to the Optometry Board inviting them to talk at a future Medical Bd meeting

– Catherine Reardon
Director of Occupational Licensing

Testimony for HB 215

Linda Casser, OD, FAAO

April 24, 2001

Chair Dyson and Members of the House Health Education and Social Services Committee:

My name is Dr. Linda Casser. I am an optometric physician and the Associate Dean for Academic Programs at the Pacific University College of Optometry in Forest Grove, Oregon. I am pleased to have this opportunity to testify in support of House Bill 215 by briefly providing specific information on the extensive training and education received by optometric physicians. My testimony today is based upon the following perspectives:

- In my current position as Associate Dean, I am responsible for the curriculum at the College, including content and development.
- I have nearly 25 years of experience in faculty and administrative positions in four different schools and colleges of optometry.
- I have served as an instructor in numerous classroom courses, clinical courses, and continuing education courses.

My testimony will briefly summarize several important areas:

- Classroom Education
- Training and Education in Pharmacology
- Clinical Education
- National Standardized Testing/Assessment
- Program Accreditation
- Continuing Education

Classroom Education:

The Doctor of Optometry degree program at Pacific University is comprised of 4,315 contact hours (180 semester credits: please see the "2000-2001 Curriculum"). This course of study is a four-year graduate level program. Enrollment in the program follows completion of an undergraduate degree that encompasses the prerequisites, or a minimum of 90 semester hours of prerequisite courses in Biological Sciences, General Physics, Chemistry, Mathematics, Statistics, General Psychology, and English. This prerequisite course of study is not only a rigorous and comprehensive one but is comparable to that completed by pre-medical and pre-dental students.

Pre-optometry students are also required to successfully pass the Optometry Admission Testing (OAT) examination, which is comparable to the MCAT examination required of medical students. The Admissions process is competitive and thorough: approximately 20% of the candidates who apply are actually admitted to a given entering class.

Those students who are admitted to the program experience a curriculum that is broad in scope and diverse in content, reflecting contemporary practice of the optometric physician. The process of curriculum development is a very dynamic and ongoing one to ensure that state-of-the-art optometric practice is reflected in our curriculum and to help set the future direction of our profession.

Students in the Doctor of Optometry program are thoroughly educated in the basic sciences in preparation for clinical diagnosis, treatment, and management of the eye and its associated structures, including the use of therapeutic medications. The breadth and depth of the basic science background is designed so that diseases and disorders of the eye are understood and treated in their proper context---as affecting an organ system contained within the body as a whole. Unique to the optometry curriculum are courses on optics, examination techniques, visual perception, the care of special populations, specialty optometric care, patient communication, legal and professional aspects, ethics, and public health, to name just a few.

Training and Education in Pharmacology:

In the 2000-2001 Curriculum, 255 classroom hours are assigned to the specific area of pharmacology, including the use of topical, oral, and injectable medications in the treatment of the eye and associated structures. This cited figure does not include the additional 165 classroom hours of courses pertaining to the diagnosis, treatment, and management of ocular disease, as well as the extensive patient care clinical experience in which these pharmacological concepts are actively applied.

Studies indicate that optometry students as a whole receive the same number of course hours in pharmacology as do medical and dental students. Students in the Doctor of Optometry degree program receive added specialty training in ocular pharmacology.

A brief comparison of the education and training of dentistry and optometry:

	Dentistry *(Review of materials from OHSU)*	**Optometry** *(Pacific University College of Optometry)*
Prerequisites:	3 years (90 semester hrs)	3 years (90 semester hours)
Admissions Examination:	Dental Admissions Test	Optometry Admissions Test
Graduate studies:	4 years	4 years
Degree:	DMD (Doctor of Dental Medicine)	OD (Doctor of Optometry)
National Examination:	Yes	Yes
Accreditation:	Yes	Yes
Pharmacology:	260 contact hours	255 contact hours

Clinical Education:

The College has excellent clinical facilities located on campus as well as an outstanding network of community-based clinical centers in the Portland metropolitan area. Many of these facilities provide care to the under-served. Our students begin their clinical activity in the first year of the professional program; this patient care experience increases in complexity and intensity throughout the program. The fourth year is spent in full-time patient care activity, and two of the three semesters are spent in off-campus clinical preceptorships in a variety of health care settings. In total, our students spend at least 2,000 patient contact-hours in a variety of optometric clinical settings examining diverse patient populations.

National Standardized Testing/Assessment:

Graduates of the four-year Doctor of Optometry professional degree program are required to pass a series of rigorous standardized national examinations administered by the National Board of Examiners in Optometry. The major areas of testing include:

Part I Basic Science
Human Biology
Ocular/Visual Biology
Theoretical, Ophthalmic, and Physiological Optics
Psychology

Part II Clinical Science
Systemic Conditions
Ocular Disease/Trauma
Refractive/Oculomotor/Sensory Integrative Conditions
Perceptual Conditions
Public Health
Legal and Ethical Issues

Part III Patient Care, including the Treatment and Management of Ocular Disease
Clinical Skills Examination (practical examination)
Patient Assessment and Management Examination

Program Accreditation:

The curriculum at the Pacific University College of Optometry is very representative of programs at our sister institutions. All of the 19 schools and colleges of optometry in North America are accredited by the Council on Optometric Education (COE). The Council, and the standards against which the programs are assessed, are recognized by the United States Department of Education (USDE). The activities and policies of the Council on Optometric Education are regularly reviewed by the USDE to ensure that valid and reliable accreditation processes are conducted.

An extensive accreditation review of each program by COE generally occurs once every seven years following an exhaustive self-study review. In addition, each program is required to submit an annual report to the profession's accrediting body.

Continuing Education:

Optometric physicians are required to meet significant continuing education (CE) requirements for relicensure. Depending upon the course offered, a lecture format, hands-on workshop, web-based interactive format, or video format may be conducted. Course offerings are submitted to state boards of optometry to qualify for credit in meeting requirements for license renewal.

In summary, graduates of the Doctor of Optometry professional degree program complete an intensive curriculum that includes rigorous classroom studies, as well as an intensive and extensive clinical experience. This thoroughly prepares optometric physicians to provide safe and effective eye and vision care services for the patients they serve.

Thank you for your kind attention. I will be glad to answer any questions that members of the Committee may have.

CASE IN POINT:
ELEMENTS REPRESENTATIVE OF CURRICULAR CHANGE

The Pacific University College of Optometry has a long and rich history of a strong curriculum of which our faculty, students, and alumni deserve to be very proud. Curricular changes at the College are active, ongoing, and forward-looking: they serve to appropriately broaden the scope and diversity of the curriculum while retaining its traditional strengths and emphases.

Two aspects in the training and education of the optometric physician illustrate this dynamic evolution of the curriculum very clearly: general/ocular pharmacology and the use of injections in the management of ocular disease. Our students have continually received a comprehensive education in the diagnosis, treatment, and management of conditions and disorders of the eye and associated structures, the visual system, and related systemic diseases; as the scope of the profession has changed, so, too, has the curriculum. Curricular changes over the course of a decade illustrate this:

Case in Point: Education in Pharmacology

- In the 1988-89 Curriculum, 84 classroom hours were assigned to the specific area of pharmacology, including Diagnostic Pharmaceuticals, Therapeutic Pharmaceuticals, and Systemic Disease and Management.

- Ten years later, in the 2000-2001 Curriculum, 255 classroom hours are assigned to the specific area of pharmacology, including the use of oral medications in the treatment of the eye and associated structures. This cited figure does not include the additional 165 classroom hours of courses pertaining to the diagnosis, treatment and management of ocular disease, as well as the extensive patient care clinical experience in which these pharmacologic issues are actively applied.

Case in Point: Education in Injections

- In the 1988-89 Curriculum, no classroom hours were assigned to covering the topic of the use of injections in the assessment and management of ocular disease

- Ten years later, in the 2000-2001 Curriculum, the use of injections in the assessment and management of ocular disease is included in the curriculum, including hands-on training. One of our fourth year students, who completed a preceptorship in Pennsylvania, forwarded this correspondence to a faculty member:

"Way back in 1996 when I took the disease lab, I was one of those who got so queasy even when pretending to do a stick that my ears begin to buzz. I have to admit that I still get that way when someone sticks me. But last semester I was able to do these injections and am glad to have had the early exposure to the procedure. My preceptor feels that new optometrists need to be very flexible and well trained to survive in the managed care environment, and is pleased that Pacific has an injections lab. He was just as pleased that I was well versed in vision therapy techniques."

PACIFIC UNIVERSITY COLLEGE OF OPTOMETRY

Doctor Of Optometry Degree
2000-2001 Curriculum: Class of 2004

FIRST PROFESSIONAL YEAR

OPT #	Fall Semester:	Credits	OPT #	Spring Semester:	Credits
501	Geometric Optics with Lab	4.0	502	Physical Optics with Lab	3.0
516	Clinical Experience I	0.5	503	Visual Optics and Ocular Motility with Lab	4.0
531	Ocular Anatomy, Physiology and Biochemistry with Lab	4.5	517	Clinical Experience II	0.5
535	Functional Neuroanatomy and Neurobiology	3.0	532	Anatomy of the Visual System with Lab	3.0
536	Pharmacological Principles and Autonomic Agents	3.0	533	Microbiology, Genetics and Immunology; Pharmacology of Anti-Infective Drugs; Diseases of the Lid and Lacrimal System	3.0
546	Clinical Procedures: Non-refractive Diagnostic Tests with Lab	3.0			
562	Behavioral Optometric Science with Lab	4.0	534	Laboratory Procedures for Assessment of Ocular Disease	1.0
			537	Etiology, Diagnosis and Management of Systemic Diseases; Pharmacology of Systemic Medications I	4.0
			547	Clinical Procedures: Binocular Testing and Optics with Lab	2.0
	Total Semester Credits	22.0		Total Semester Credits	20.5
				Total First Year Credits	42.5

SECOND PROFESSIONAL YEAR

OPT #	Fall Semester:	Credits	OPT #	Spring Semester:	Credits
601	Ophthalmic Optics	3.0	617	Optometric Case Analysis	4.0
602	Sensory-Motor Interactions in Vision with Lab	4.0	618	Theory and Practice of Spherical Rigid and Soft Contact Lenses with Lab	3.0
616	Theory and Methods of Refraction	3.0			
620	Clinical Experience III	0.5	621	Clinical Experience IV	0.5
631	Diagnosis and Treatment of Anterior Segment Diseases	2.0	633	Diagnosis and Treatment of Posterior Segment Diseases	3.0
632	Detection, Assessment and Treatment of Anterior Segment Diseases	1.0	634	Detection, Assessment and Treatment of Posterior Segment Diseases	1.0
637	Etiology, Diagnosis and Management of Systemic Diseases; Pharmacology of Systemic Medications II	2.0	638	Etiology, Diagnosis and Management of Systemic Diseases with Lab; Pharmacology of Systemic Medications III	2.0
646	Clinical Procedures: Refractive Error Measurement with Lab	2.0	648	Clinical Procedures: Phorometry and Ocular Health with Lab	4.0
647	Ophthalmic Dispensing Procedures with Lab	2.0	682	Visual Information Processing and Perception with Seminar	4.0
661	Physiological, Psychological and Cognitive Changes During the Lifespan	2.0			
	Total Semester Credits	21.5		Total Semester Credits	21.5
				Total Second Year Credits	43.0

THIRD PROFESSIONAL YEAR

OPT#	Summer Semester:	Credits	OPT#	Fall Semester:	Credits	OPT#	Spring Semester:	Credits
715	Patient Care: First Session	1.0	718	Advanced Optometric Case Analysis with Lab	4.0	723	Patient Care: Third Session	2.0
716	Theory and Practice of Specialty Contact Lenses with Lab	4.0	720	Vision Therapy for Binocular and Oculomotor Dysfunction with Lab	4.0	725	Assessment and Mgt of Strabismus and Amblyopia with Lab	4.0
721	Clinical Experience V	0.5	722	Patient Care: Second Session	2.0	727	Evaluation and Mgt of Patients with Perceptual Problems with Lab	3.0
726	Normal and Abnormal Visual Perception	2.0	724	Pediatric and Developmental Optometry	2.0	735	Applied Ocular Therapeutics	1.0
751	Public Health Optometry	2.0	728	Assessment and Mgt of the Partially Sighted Patient	2.0	762	Communication in Optometric Practice with Lab	2.0
763	Environmental, Occupational and Recreational Vision	2.0	733	Assessment and Mgt of Ocular Disease Patients	2.0	764	Optometric Economics and Practice	4.0
791	Optometric Thesis: Orientation and Planning	1.0		Electives*			Electives*	
	Electives*							
	Total Semester Credits	12.5		Total Semester Credits	16.0		Total Semester Credits	16.0
* = Students are required to complete at least 4 credit hours of electives during third year.							Total Third Year Credits (Including Electives)	48.5

FOURTH PROFESSIONAL YEAR

OPT #	Summer/Fall/Spring:	Credits	OPT #	Summer/Fall/Spring:	Credits
	Preceptorships:			Internal Clinic Rotation:	
815	Primary Patient Care: Preceptorship Rotation #1	15.0	817	Primary Patient Care: Internal Clinic Rotation	7.0
			818	Vision Therapy Patient Care	3.0
816	Primary Patient Care: Preceptorship Rotation #2	15.0	819	Low Vision Patient Care	1.0
			820	Contact Lens Patient Care	1.0
892	Optometric Thesis: Completion (Fall Semester Only)	1.0	821	Clinical Rounds	1.0
			822	Pediatric Patient Care	1.0
			832	Ocular Disease and Special Testing Patient Care	1.0
Preceptorship Rotation #1 = 15 Credit Hours • Preceptorship Rotation #2 = 15 Credit Hours • Internal Clinic Rotation = 15 Credit Hours					
				Total Fourth Year Credits	46.0

TRAINING AND EDUCATION IN PHARMACOLOGY
PACIFIC UNIVERSITY COLLEGE OF OPTOMETRY

In the 2000-2001 Curriculum, 255 classroom hours are assigned to the specific area of pharmacology, including the use of topical, oral, and injectable medications in the treatment of the eye and associated structures. An additional 165 classroom hours of courses pertain to the diagnosis, treatment and management of ocular disease. These pharmacologic concepts are applied in an intensive and extensive patient care clinical experience, including primary and specialty care (a portion of which is represented below). Studies indicate that optometry students as a whole receive the same number of course hours in pharmacology as do medical and dental students. Students in the Doctor of Optometry professional degree program then receive added specialty training in ocular pharmacology.

Opt 536 Pharmacological Principles and Autonomic Agents
3 credit hours; 45 contact hours

Opt 533 Microbiology, Genetics and Immunology; Pharmacology of Anti-infective Drugs; Diseases of the Lid and Lacrimal System
3 credit hours; 45 contact hours

Opt 534 Laboratory Procedures for Assessment of Ocular Disease
1 credit hour; 30 contact hours

Opt 537 Etiology, Diagnosis and Management of Systemic Diseases; Pharmacology of Systemic Medications I
4 credit hours; 60 contact hours

Opt 637 Etiology, Diagnosis and Management of Systemic Diseases; Pharmacology of Systemic Medications II
2 credit hours; 30 contact hours

Opt 638 Etiology, Diagnosis and Management of Systemic Diseases with Laboratory; Pharmacology of Systemic Medications III
2 credit hours; 45 contact hours

Opt 631 Diagnosis and Treatment of Anterior Segment Diseases
2 credit hours; 30 contact hours

Opt 632 Detection, Assessment and Treatment of Anterior Segment Diseases
1 credit hour; 30 contact hours

Opt 633 Diagnosis and Treatment of Posterior Segment Diseases
3 credit hours; 45 contact hours

Opt 634 Detection, Assessment and Treatment of Posterior Segment Disease
1 credit hour; 30 contact hours

Opt 735 Applied Ocular Therapeutics
1 credit hour; 30 contact hours

Opt 832 Ocular Disease and Special Testing Patient Care (This is a specialty care clinic dedicated to ocular disease assessment, treatment, and management. This patient care activity is in addition to primary care settings in which these conditions are also treated and managed.)
1 credit hour; 60 contact hours

THE
FOLLOWING
DOCUMENT(S)
ARE
POOR
ORIGINAL
COPIES

Optometry Educational Program for the Diagnosis, Treatment and Management of Ocular Disease

Linda Casser, O.D., and Sally Hegeman, Ph.D.
Indiana University School of Optometry

During the recent passage of Senate Bill 281,[1] which clarifies the authority of doctors of optometry to prescribe legend drugs, we had an opportunity to share with legislators and other interested parties background information documenting the professional educational program of optometry students here in Indiana. It is a pleasure to have an opportunity in this article to present a brief summary of this material for Indiana pharmacists.

Doctors of Optometry are trained and educated to diagnose diseases of the eye and its associated structures, and are fully qualified to prescribe legend drugs. This brief synopsis of the various facets of the professional optometric program highlights the following four areas:

The Admissions Process
The Pre-Clinic Educational Program
Patient Care Activity/Clinical Education
State and National Standardized Testing

The Admissions Process

Students accepted into the four-year optometry program have successfully completed a rigorous undergraduate course of study that actually exceeds that of pre-medical and pre-dental students in the areas of biology, mathematics, physics, and statistics.[1]

Entering optometry students must complete a broad range of science-oriented prerequisite courses. The mean GPA for undergraduate work for students in the doctor of optometry class of 1994 (entered in Fall, 1990) is 3.35.[3] Mean GPA for the Class of 1994 dental students, as reported by the IU Health Professions and Prelaw Information Center is 3.10; that of medical students is 3.50.[3]

Pre-optometry students are also required to successfully perform on the Optometry Admission Testing (OAT) examination which assesses aptitude in Biology, General Chemistry, Organic Chemistry, Reading Comprehension, Quantitative Reasoning, and Physics. The OAT examination is comparable to the MCAT examination required of medical students.[4]

Pre-Clinical Educational Program

Optometry students are thoroughly educated in the Basic Sciences in preparation for clinical diagnosis, treatment and management of the eye and its associated structures, including the use of legend drugs. The Basic Science optometry curriculum is designed so that diseases and disorders of the eye are understood and treated in their proper context . . . as affecting an organ contained within the body as a whole. The Pharmacology training is comparable to that of the medical student both in depth and breadth of subjects covered. For example, studies show that optometry students as a whole receive the same number of course hours in pharmacology training as do medical and dental students.[1,4] Optometry students then receive added specialty training in ocular pharmacology (Fig. 1). At Indiana University, optometry students receive 5 credit hours of systemic pharmacology plus 5 credit hours of ocular pharmacology and therapeutics; medical and dental students each receive 6 credit hours (1 credit hour = 15 contact hours).

The 1991-93 IU School of Optometry Bulletin describes the established Basic Science courses that pertain to the training of optometry students for the diagnosis, treatment and management of eye diseases and associated disorders.[1] A study of this listing reveals that optometry students complete 3 Basic Science tracks:

- Basic Science pertaining to the body as a whole (eg, Gross Anatomy, Medical Microbiology, Physical Diagnosis)
- Basic Science pertaining to the eye (eg, Ocular Anatomy, Ocular Microbiology, Neurophysiology of Vision)

Pharmacology Preparation of Optometrists

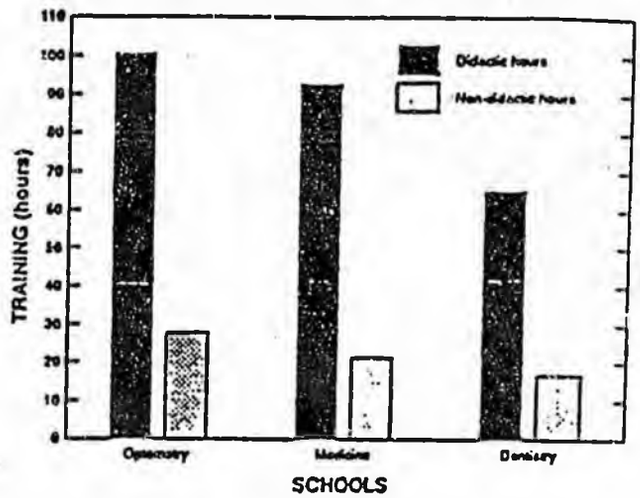

Figure 1 Didactic and non-didactic pharmacology training hours for schools of optometry, medicine, and dentistry.

- Basic Science pertaining to optics (eg, Physiological Optics, Geometrical Optics)

Added to the didactic courses listed in this section are those on optics, examination techniques, legal and professional aspects, and public health, to name just a few.

Patient Care Activity/Clinical Education

The first two years of the 4-year graduate optometry curriculum are spent in intensive didactic and laboratory course work. In the summer before the third professional year, optometry interns begin their clinical patient care activities, which include the diagnosis, treatment and management of diseases of the eye and associated structures utilizing legend drugs in conjunction with licensed faculty members. Over a two year period, in excess of 2000 patient contact hours are spent in a variety of clinical settings examining patients, and diagnosing and treating eye diseases in each of the major clinical experiences:

- The Bloomington Patient Care Program
- The Indianapolis Patient Care Program
- The External Clinical Rotations

The Bloomington Patient Care Program

The Campus Clinic in the School of Optometry in Bloomington houses the following service units: Primary Care, Pediatrics, Contact Lens, and Ocular Disease. Each student is assigned to patient care activity in each of these service units.

Optometry interns participate in 24-hour emergency call along with the faculty members. They also care for patients needing acute eye care at the IU Student Health Center in Bloomington. Patients are referred to this urgent eye care clinic by the Health Center Physicians. Optometry interns examine general medical patients alongside Health Center physicians. Interns participate in first day status post-operative cataract surgery patients at a local ophthalmologist's office.

Indianapolis Patient Care Program

Optometry interns are assigned to one of two IU School of Optometry external clinics located in Indianapolis: the Walker Eye Clinic (located in the Walker Theatre Building)

or the Illinois Street Eye Clinic (near Methodist Hospital). The inner city location of these two facilities attracts a patient population that has a high incidence of ocular disease requiring treatment with legend drugs. The Course Syllabus and the Patient Examination Protocols manual document intern activity in diagnosis, treatment and management of eye diseases, including the use of legend drugs. Interns also participate in cataract patient pre- and post-operative care, as well as acute eye care, at a local eye referral center.

External Clinical Rotations

In addition to the Bloomington and Indianapolis clinic educational program, optometry interns are assigned to a minimum of two External Clinical Rotations. Most of these clinic sites are located out-of-state and include VA Hospitals, Public Health Service Hospitals, military bases, community co-management centers, and ophthalmic secondary/tertiary care centers. Optometry interns work with optometrists and ophthalmologists at these External Clinics. The External Clinic sites provide clinical experiences that concentrate in the area of ocular disease diagnosis and treatment. Surveys recently completed by each of the External Clinic sites indicate that:

- 100% of these External Clinics report "routine" use of Therapeutic Pharmaceutical Agents (TPA's)
- Directors of the External Clinics report that, on average, 58% of the patients seen by the optometry interns involve the diagnosis and treatment of ocular disease

State and National Standardized Testing and Examination

Graduates of the four-year optometry professional program are required to pass a series of standardized national board examinations, administered by the National Board of Examiners in Optometry (NBEO). The major areas of testing include:

- Basic Science
- Clinical Science
- Treatment and Management of Ocular Disease (TMOD)

The 1991 NBEO Candidate's Guide describes the content outline of the questions comprising the Basic Science component of the examination, designed to test and measure "a candidate's fundamental knowledge base of the scientific principles upon which optometric practice is built." The Clinical Science component of the NBEO Examination tests and measures "a candidate's application of the fundamental knowledge base to the prevention, diagnosis, management, and treatment of clinical conditions within the scope of optometric practice."

Also included in the NBEO examination is the examination in the Treatment and Management of Ocular Disease (TMOD). The TMOD Examination is designed as an entry-level examination since "therapeutic drug use is part of the practice repertoire of graduating optometry students".

Before the new graduate is granted a license to practice optometry in Indiana, he/she must also pass an examination conducted by the Indiana Optometry Board. New graduates must demonstrate clinical skills in general health evaluation and management, as well as ocular health evaluation, diagnosis, and management.

Conclusion

Some 70 percent of Doctors of Optometry practicing in Indiana are graduates of IU School of Optometry, one of only 16 in the country. Optometrists prescribe proper medications based on their clinical findings, assessing patient history aspects such as medication allergies, as well as the presence of any systemic illnesses. Once treatment is begun, optometrists then manage their patients through appropriate follow-up care.

The use of legend drugs for treatment and management of diseases of the eye and its associated structures is an integral part of the optometry curriculum, and comprises a substantial portion of the patient care activity provided in each of the School of Optometry Clinics. Senate Bill 281 provides an opportunity to clarify what Indiana optometrists have been doing for decades, so that, without obstacle, they can continue caring for the needs of their patients, and training IU students to be the best eye care providers possible.

Dr. Casser is Associate Professor of Optometry, Department of Clinical Sciences, and Director, Indianapolis Clinics

Dr. Hegeman is Associate Professor of Optometry, Department of Visual Sciences, and Adjunct Associate Professor of Pharmacology, Medical Sciences Program

References

1. Wilson GT. Indiana optometrists granted legend drug prescribing authority. Indiana Pharmacist 1991; 12:8-9 (No. 7).
2. "Preoptometry Requirements," "Preparing for Medical School: A Guide for Freshmen and Sophomores," and "Predental Requirements: A Guide for Freshmen and Sophomores," Health Professions and Prelaw Information Center, Indiana University, Bloomington, IN.
3. "O.D. Profile, Class of 1994," Office of Student Affairs, Indiana University School of Optometry, Bloomington, IN.
4. "1991 Optometry Admission Testing Program," Association of Schools and Colleges of Optometry, Chicago, IL.
5. Waigandt M, Waigandt A. An analysis of pharmacology training in schools of optometry, medicine and dentistry. Journal of Optometric Education 1985; 10:20-25.
6. Hegeman S. Comparison of pharmacology courses for optometry and medical students, Indiana University, Bloomington. Journal of Optometric Education 1983; 8:22-23.
7. 1991-1993 School of Optometry Bulletin, Indiana University, Bloomington, IN.
8. 1991 Candidate Guide, National Board of Examiners in Optometry, Chevy Chase, MD.

STATE OF INDIANA

EXECUTIVE DEPARTMENT

INDIANAPOLIS

PROCLAMATION

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 215
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Community & Econ Dev.
Title: An Act relating to the use of pharmaceutical agents in the practice of optometry....
BRU: Occupational Licensing
Component: Occupational Licensing
Sponsor: House Labor and Commerce
Requester: House HESS
Component Number: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1156 Receipt Supported Services						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2001) cost: 0.0

Check this box (X) if funding for this bill is included in the Governor's FY 2002 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*
New funds are not required to implement this bill.

Prepared by: Jennifer Strickler, Administrative Manager
Phone (907) 465-2144
Division Occupational Licensing
Date/Time 4/23/2001 3:30 p.m.
Approved by:
Date
Agency Dept. of Community and Economic Development

For distribution information, call the Governor's Legislative Office

(Rev 2/7/2001 OMB)

Re: HB 215, HEARING TODAY

American Academy of Ophthalmology
1101 Vermont Avenue NW
Washington, D.C. 2005-3570 Tel. 202-737-6662 Fax 202-842-5854
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April 24, 2001

The Honorable Fred Dyson
Chair, Health, Education and Social Services Committee
Alaska State House of Representatives

Re: H.B. 215

Dear Representative Dyson and Committee Members:

Thank you for the opportunity to comment on H.B. 215. I very much appreciate the Committee taking the time from its busy schedule to begin this review process. Although this bill is short, the policy ramifications of this proposal on the Alaska health policy care system, specifically in regards to eye health care, is complex. Due to the time constraints that you are now facing, you may find it necessary to complete a review of H.B. 215 during the interim.

H.B. 215 gives optometrist a "blank check" to prescribe oral and injectable drugs with little supervision and pharmaceutical training. I believe H.B. 215 if enacted would increase potential health risks to Alaska citizens. Last year legislation with this "blank check" scope of practice provisions were rejected in other states including, Florida, Georgia, Hawaii, Maryland, Mississippi, New York, Pennsylvania, South Dakota, Vermont, and Washington State. This year, state legislatures again in Georgia, Mississippi, and Washington State, and also Iowa, have already rejected optometric drug expansion proposals. I think you would agree, State Legislators across the United States are seriously questioning the wisdom of enacting additional legislation that would further expand optometric drug prescribing authority.

The question that you must address is: Why is this bill before you? The citizens of Alaska are not calling for enactment of this type of broad drug prescribing authority, only the optometry profession. To our knowledge, there have been no claims of delay in getting an appointment with an ophthalmologist where symptoms of disease are present. If there are such problems, Alaska ophthalmologists want to know and would gladly work with you to remedy any such delay. This can be easily accomplished without a change in the law. For example, ophthalmologists from the Alaska State Society are examining rural eye health care delivery, the objective being to further improve the quality of rural eye care services at less cost to Alaska citizens.

H.B. 215 contains far-reaching health policy implications that may not be in the best interest of the citizens of Alaska. H.B. 215 ***does not*** improve access to health care. It ***does not*** open new clinics. It ***does not*** make new services available to the citizens of Alaska. Finally, this bill would not lower health care costs for Alaskans.

For these reasons, I ask you to vote against H.B. 215.

Sincerely,

Bob Palmer

Bob Palmer
Director
State Governmental Affairs
American Academy of Ophthalmology

Tongass Regional Eye Clinic

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April 24, 2001

Alaska State House of Representatives
Health, Education and Social Services Committee

RE: HB 215

Dear Committee Members:

I am writing to express my opposition to HB 215, which extends to non-physician optometrists unrestricted authority to utilize all agents of medication by all routes including injection and oral usage as determined by the authority of the optometric board itself.

At the turn of the last century the United States became publicly aware that medical education was a diffuse and mixed collection of university-based training in Europe ranging down to practical forms of apprenticeship in frontier America. The claims and specifications that allowed an individual to describe himself as a physician were poorly understood and inconsistent in practice. The Simon L. Flexner Report authored by a researcher of the same name set the stage for a wide spread standard of uniform training, certification, and licensing through the United States. It set into motion processes of procedures for establishing medical schools, set standards for training and curriculum, and clarified the role and place of medical practice and its practitioners in our nation.

Though medical practice has evolved and expanded in many ways with many new roles to play created and developed for non-physician healthcare providers, we have been well served by the uniform standards of training, education and licensing established for the practice of medicine. I feel HB 215 opens a gaping hole in the historic standard for medical expertise and authority required of a practitioner.

Any fair minded ophthalmologist will admit that optometric training has improved its standard and expanded the range of training that has been utilized in optometric schools in the past several decades but no conscientious practitioner believes that the essentially academic exercise utilized in optometric school substitutes for the extended academic, clinical and practical based experience that is an essential and required element of medical training for physicians.

Physicians have long criticized the attempts to short cut the acquisition of authority for medical practice on the part of optometrists. Indeed, there is an entire population of former optometrists who have returned to medical school to obtain the experience and authority necessary to allow them the fuller form of medical practice. My partner and I did our residency with such a gentleman, Colonel James Beeson of the United States Army Medical Corp. It was his unchanged opinion freely and frequently expressed that the experience and training he underwent in optometric school was a pale shadow of even the very basic experience that we started in the first year of our residency training and had no comparison to the subsequent specialized training of our advanced years and had no counterpart in our broader training as interns in our first post-graduate year.

Please do not degrade standards of education and experience that have served the public in the United States so well for this past century. Advocacy for this alteration is misguided and inappropriate and does not create any improvements for our residents in either access or expertise. Thank you for your attention.

Sincerely,

Gordon R. Preecs, M.D.

GRP:mjo

EDITOR'S PAGE

Encore! Encore!

Rich Kirkner
Editor-in-Chief

About 30 years ago, a handful of optometric visionaries hammered out an agenda for the profession. At the top of that agenda: gain diagnostic agents, then therapeutics.

Today, you can say mission accomplished. Because of that, our special report, "The State of Optometry," finds that state is solid.

It begs the question: What's next now that the DPA-TPA curtain has dropped?

The vanguards of optometry will have to sort that out, but here's a wish list they can work with:

- **Eye exams for infants.** Operation Bright Sight is onto something here (see "Pilot Program Takes Eye Care to the Cradle.) Cradle-to-grave eye care has to start somewhere. The cradle seems like a logical place.

- **Eye exams for school children.** Kentucky has the right idea passing a law that mandates these. Besides, hasn't anyone yet figured out that our children who see well can learn well?

- **Eye exams for licensed drivers.** The eyes can change a lot between license renewals. Imagine how much they change between the 16th and 65th birthdays. The DMV can't.

- **Promote medical comanagement.** Surgical fees are in a free-fall, so organized ophthalmology is squabbling over your role in managing these patients. To them, it's about money, not sound medical practice. Every patient deserves to have his or her family doctor quarterback care, whether it's brain surgery, foot surgery or eye surgery.

- **Continue to expand the scope of practice.** Optometry now has an excellent track record in disease management. Time to move to the next

level: universal privileges for glaucoma meds, orals and injectibles. Then go for laser privileges for all O.D.s. Today Oklahoma, tomorrow America!

- **Raise awareness of computer-related eye problems.** Most people who use a computer have some kind of eye-related symptom-and that's a lot of people, about 75 million on the job and almost as many at home. A good pair of glasses and some expert consultation can fix just about all those aches and pains.

Indeed, this is a public health agenda. Some items are legislative efforts—something the profession can proudly say it is quite skilled at. All would require big-time public awareness campaigns.

The group of visionaries who laid out optometry's DPA and TPA movements 30 years ago scored a rousing success. Now, that the profession finds itself in a pretty good state, it's time for an encore.

Rich Kirkner

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Q&A on Optometric Scope of Practice Expansion

Q: What is the expansion of optometric scope of practice?

A: The expansion of optometric scope of practice in Alaska is an attempt to repeal the safeguards in existing law to authorize optometrists to treat more diseases with systemic drugs and with little or no oversight by medical doctors. ***It's like writing a blank check!*** Legislation with these blank check scope of practice provisions were rejected last year in other states including South Dakota, Florida, Georgia, Hawaii, Maryland, Mississippi, New York, Pennsylvania, Vermont, and Washington.

Q: Don't we already have Eye M.D.s (ophthalmologists) in ALASKA trained to treat complex eye diseases?

A: ***YES.*** An Eye M.D. has completed 4 years of medical school and has received a medical degree; *PLUS* an Eye M.D. has completed a 1 year, 60 hour per week hospital residency (an internship) in the 5th year of study; *PLUS* an Eye M.D. has returned to medical school for a 3 more years of study for closely supervised, advanced medical training by leaders in the field of medical eye care. This advanced training includes a 2nd residency program. Ophthalmologists have as much training as a cardiologist, neurologist, or oncologist.

However, optometrists do not undergo the thorough grounding in medicine and disease that Eye M.D.s complete. Only about 10 percent of the patients that optometry students see in their clinical training suffer from serious eye disease. In addition, only 10 percent of optometrists opt to do what is called an "optometric residency." And most of these "optometric residencies" do not even focus on the treatment of eye disease. Moreover, optometrists do not return to school for advanced medical training and do not undergo the 2nd residency which Eye M.D.s must complete in their medical discipline.

Q: Why won't the expansion of optometric scope of practice reduce the costs of medical eye care in ALASKA?

A: ***The fee schedule that Medicare and Medicaid uses is the same for optometrists and Eye M.D.s.*** Moreover, participating Medicare providers are not allowed by law to charge private patients a lower fee than Medicare patients. The expansion of optometric scope of practice would create two tiers in the quality of medical eye care but at the same reimbursement level. Indeed, many patients would seek a second opinion from an Eye M.D., requiring duplicate testing and incurring additional costs.

Q: What is so dangerous about the treatment of serious eye diseases by optometrists?

A: One cannot treat serious eye disease separate from understanding the whole body. Eye complaints have led medical doctors to accurately diagnose AIDS, multiple sclerosis, diabetes, arthritis, kidney ailments, high blood pressure, heart disease, hardening of the arteries, thyroid disease, brain tumors, and some types of cancer. Moreover, systemic drugs themselves can have very powerful effects on the body. Extended use of steroids, for example, can lead to permanent damage of the joints and other parts of the body. Steroid use must be managed properly to avoid serious withdrawal effects. Further, if taken by individuals who have certain chronic diseases, such as diabetes, steroids can cause an increase in glucose (sugar) levels sufficient to cause the patient to suffer a diabetic coma. The overprescribing of antibiotics has already contributed to the significant problem of resistant microorganisms, resulting in infectious disease that is more difficult to treat. This occurs even with fully trained medical doctors, and extending prescriptive privileges to inadequately trained allied health personnel will only aggravate this problem. Controlled substances can be habit-forming and subject to abuse. Moreover, even Eye M.D.s in clinical practice rarely have to prescribe narcotic pain medications and then mostly in the post-operative period. Indeed, many Eye M.D.s never prescribe any narcotics over an entire year. Finally, since seniors often have serious eye medical conditions as well as chronic illnesses and less tolerance to drug side effects, careful evaluation and close coordination by an Eye M.D. with other medical treatments is essential.

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Why Should Optometrists be Authorized to Prescribe Meds to Treat Eye Disease?

In Alaska, the practice of optometry has been severely restricted by public policy that reflects a bygone day of ancient history. It was only recently that the Alaska Legislature authorized an optometrist to remove a foreign body (a piece of metal) embedded in the cornea of the eye. Today, in Alaska, an optometrist still may not write more than an eyedrop prescription to treat his patient's eye infection, nor prescribe a pain medication. In many locations, a doctor of optometry must refer the patient to a PA or a nurse practitioner (who is authorized) to write a prescription!

This restriction on optometry is out of step with the level of clinical training and education that today's doctor of optometry receives. What's more, it is inconsistent with what other comparably trained medical professionals (such as the dentist or the podiatrist) are authorized to practice.

Last year, with SB78, the Alaska State Legislature tried to correct that. After examining the quality of education and clinical training, the Legislature agreed that Alaskan optometrists were qualified to use advanced training to write expanded prescriptions. Stipulating that only after appropriate education and examination, Board-endorsed optometrists would be authorized to write full prescriptions for therapeutic pharmaceutical agents. Unfortunately, the Outside national Academy of Ophthalmology didn't agree with the Alaska State Legislature. After the Legislature adjourned, they staged an eleventh hour campaign to misrepresent optometric education and mislead the Alaska State Medical Board and the Governor, which resulted in the veto of SB78. (see the story behind the Governor's veto.)

This year, it's up to members of the 22nd Alaska Legislature to re-examine the credentials of optometry all over again. It is a fact that an optometrist's level of clinical and pharmacology training is comparable to that of a dentist, podiatrist, and a general medical practitioner. It is also a fact that they are restricted because of the turf opposition by the medical profession to any expansion of the scope of practice by any profession other than an MD. These battles have waged for over 30 years in all 50 States against optometrists (OD), advanced nurse practitioners, etc.

The Academy of Ophthalmology argues that an ophthalmologist is more qualified to treat diseases of the eye. This is partially true, as they are trained in tertiary care and surgery of the eye as a specialist, just as a heart surgeon is specialized. But the optometrist is specialty trained for primary and secondary care and limited surgery, including the prescribing of pharmaceuticals for treating the eye. The question is not "who is more qualified?" But rather, "Should qualified optometrists be allowed to practice at the highest level of their training with the current standard of care?" After carefully examining the facts, we are confident that you can trust the Board endorsed Alaska doctor of optometry to provide competent primary and secondary eye care for their patients, and refer to the ophthalmologists when needed for advanced specialty care, no different than family doctors that refer to specialists.

Over forty years ago, leaders in optometry discussed the future of their profession. They concluded that in order for their profession to grow and adequately serve their patients, they must expand beyond the old "detect and refer" model and change to the medical model of "diagnose and treat". Changes were implemented in the colleges of optometry and the old curriculum was expanded to a full 4-year professional program using the current medical model of training, starting about 1965. The scope of optometric education and clinical practice changed from what was an old traditional "eyeglasses" mode, to one of a primary eye care professional, diagnosing and treating eye diseases using medications and limited surgery such as foreign body removal and laser treatment as allowed by each individual state law. In every state, the older practitioners were required to update their training to use any new privileges, there was never any "grandfathering" allowed. Those older doctors that chose not to receive additional training are of course restricted from prescribing medications. In Alaska, only about 4 older optometrists are left in this restricted category.

It cannot be emphasized enough, that this came about only because of a revolution in the optometrist's training. Specifically, enhanced clinical training and education, including the study of eye conditions, clinical medicine as it relates to eye disease processes, and pharmacology. While an optometrist is trained to expertly serve as a primary eye care provider, the level, quality, and hours of professional education is equivalent to that of other health care professional programs, including medicine, dentistry, and podiatry. A 4-year undergraduate degree, followed by a 4-year professional degree (MD,DDS, DPM, OD), and often an additional residency program in an advanced clinical setting.

One of the least known facts about optometry today is how much clinical training the optometrist actually undergoes. Before graduation, optometric students have experienced approximately 3,000 hours of clinical and laboratory training, comparable to the number of hours in medical and dental training and far greater, in eye care specifically, than that of the family MD or any other type of

doctor or nurse practitioner currently authorized to treat the eye, with the exception of the specialty ophthalmologist. And Alaska's 90+ optometrists are located in over 18 towns and travel to many villages, while the ophthalmologists are located mostly in Anchorage (18), with a few in Fairbanks (4), Juneau (2), and the Kenai Peninsula (2).

The average optometry student will examine approximately 1,000 patients over the course of his or her clinical training. By comparison, the student of general medicine will see a few patients with eye problems, but in much smaller numbers than the optometrist due to the time spent on other organ systems. The Legislature offers full authority to MD's to perform anything they wish, trusting that they will not practice above their highest level of training and refer to specialists to do so. The same applies to dentists and nurse practitioners in Alaska, with their scope of practice determined by their State Board and the Alaska Legislature TRUSTING them to practice only as qualified. Why then are OD's so untrustworthy, with MORE EDUCATION, in applying the same standards of the other health professions ???? (Simple answer: Economic turf competition with the ophthalmologists.)

Since the training expansion starting 40 years ago, optometry's scope of practice has been carefully examined and expanded in the United States and around the world. Optometrists today diagnose, manage and treat their patients' eye conditions and eye diseases. This includes evaluating the eye with dilated exams, prescribing corrective lenses, removing embedded foreign objects from the eye, and all 50 states now authorized qualified optometrists to write prescriptions for therapeutic pharmaceutical agents (TPAs), with 37 states plus Wash. DC including oral drug authority. But not Alaska.

Optometrists are now recognized as "physicians" under Federal Medicare Law, and as primary eye care providers by health care consumers, primary care physicians, and benefit plan administrators. They serve as integral health care providers in numerous HMO, PPO, and other managed care plans, serving effectively as both vision and medical eye care practitioners. Today, we respectfully ask the Alaska Legislature to revise the outdated statutes so that doctors of optometry can practice their learned profession at the level that they are trained. This will provide much better access to quality eye care for Alaskans, especially in our rural areas.

For more on the Scope of Practice issue see:
Trustoptometry.com

Subject: FW: Falconer Sr, OD Letter
Date: Wed, 4 Apr 2001 09:27:30 -0700
From: "Linda Sylvester" <lindasylvester@gci.net>
To: "Amy Erickson" <Amy_Erickson@legis.state.ak.us>

-----Original Message-----
From: Jeff Gonnason, O.D. [mailto:jeff@alaska.com]
Sent: Tuesday, April 03, 2001 8:52 PM
To: Linda Sylvester
Subject: Falconer Sr, OD Letter

To whom it may concern,

As an optometrist in Anchorage, Alaska, practicing here for 36 years I have seen changes in medications make treatment of eye disease much more effective.

Without the use of oral medications I am unable to treat many eye diseases to the extent that my training would allow. Many chronic diseases and acute diseases of the lid and eye require oral medications for treatment or supplemental treatment. Often I send these patients to their general practitioner telling the MD what to prescribe, as they don't know the proper diagnosis and treatment of many eye diseases. This incurs extra expense for the patient and the State of Alaska (Medicaid), and delays treatment.

Since optometrists have the training and the patients expect us to solve their problems it is time for Alaska to allow us to use these additional medications. Alaska is one of the few states in the U.S. to not allow qualified optometrists the use of these medications.

James C Falconer Sr, OD
1345 W 9th
Anchorage, Alaska 99501

Subject: FW: Dr. Shank Letter
Date: Wed, 4 Apr 2001 09:27:31 -0700
From: "Linda Sylvester" <lindasylvester@gci.net>
To: "Amy Erickson" <Amy_Erickson@legis.state.ak.us>

-----Original Message-----
From: Jeff Gonnason, O.D. [mailto:jeff@alaska.com]
Sent: Tuesday, April 03, 2001 4:59 PM
To: Linda Sylvester
Cc: John Shank
Subject: Dr. Shank Letter

April 3, 2001

Dear Alaska Legislator,

My practice is in Kodiak, AK. I see most of the eye infections and problems in town and am the referral center for our physicians (MD's). Often patients need to be treated with systemic medication, in addition to topical ophthalmic medications. It is a waste of my time, the patient, and the physician for me to have to call or send the patient back to their practitioner or the ER for the routine medications I am fully qualified to prescribe. I am often requested to follow up on the MD's patients. This costs our patients and their insurance, whether state or private, more money and wasted time

I urge you to pass HB 215 / SB 173

Thank your for your support.
John T. Shank, O.D., F.A.A.O.

Subject: FW: Kosterman OD Letter
Date: Wed, 4 Apr 2001 09:27:30 -0700
From: "Linda Sylvester" <lindasylvester@gci.net>
To: "Amy Erickson" <Amy_Erickson@legis.state.ak.us>

-----Original Message-----
From: Jeff Gonnason, O.D. [mailto:jeff@alaska.com]
Sent: Tuesday, April 03, 2001 8:28 PM
To: Linda Sylvester
Subject: Kosterman OD Letter

I work in an ophthalmologist's office. On many occasions, I have had occasion to prescribe oral medicines for patients, only to have to locate one of the MD's in the office to sign the prescription. Normally, this is just a waste of time, but frequently, I am the only doctor in the office. There have been occasions when a patient was experiencing a pressure spike (a dangerous increase in pressure inside the eyeball, which can cause acute glaucoma and blindness). After taking a careful health history and determining the proper course of medication, I have had to try to contact one of the MD's to "OK" the prescription. Meanwhile, the patient is waiting while nerve fibers are being killed off by the dozen. It has taken up to two hours to make contact, and finally begin the medication. On other occasions, I have been the only doctor on duty when patients returned for post-surgical follow-ups in severe pain. I have been unable to prescribe the strong pain relievers they need, offering the weak substitute of temporary topical anesthetic, which is not always in the patient's best interest, since it delays the healing process.

I don't intend to treat the patients' diabetes, colds, flu, high blood pressure, or whatever other systemic diseases they may have. But I am well-trained to begin an appropriate course of oral medications when that is the best indication for the eye problem I am treating. In most cases, I am able to complete the therapy without oversight. If at any time I feel the patient's sight is threatened, and I am not confident that I know the right treatment for the condition, I have no reservations about referring that patient to a higher-level specialist. But there is no need to refer if I understand the disease, the treatment and its contraindications, and there is a good prognosis.

Daniel J. Kosterman, O.D