HB

664

OPHTHALMOLOGIST
WILLIAM F KINN, M D
BRUCE J WOLF, M D
SAMUEL A McCONKEY, M D

OTOLARYNGOLOGIST
RONALD E TINSLEY, M D
RICHARD P RAUGUST, M D
BRUCE G WHIPPLE, M D

PLASTIC AND RECONSTRUCTIVE SURGEON
WILLIAM W WENNEN, M D

EYE, EAR, NOSE & THROAT CLINIC

February 7, 1978

Mr. Charlie Parr
Chairman
Health, Education and Social
Services Committee
Alaska State House of Representatives
Alaska State Capitol
Room 112
Juneau, Alaska 99811

Dear Mr. Parr:

On behalf of the physicians in the State of Alaska who are concerned with eye care, I would like to again thank you for giving me some time out of your obviously quite heavy schedule in order that I might become better acquainted with House Bill 664, an act relating to optometry. I was able to see several members of your committee on my recent visit to Juneau and hopefully will have an opportunity to introduce myself to the remainder when I get to Juneau in the future. I plan this to be the first of several background papers that you and your committee might wish to consider in your deliberations on House Bill 664.

I think it is appropriate that I give you some background into my education and status within the ophthalmologic community in Alaska. I received an undergraduate degree in premedicine at West Virginia University in Morgantown, West Virginia in 1962. I had my medical school training at the Medical College of Virginia, graduating with a degree of Doctor of Medicine in 1966. I served a year of surgical internship and a year or surgical residency at the same institution, completing that course of study in 1968. In October of 1968, I was inducted into the armed forces as a surgeon with the United States Air Force, stationed at Eielson Air Force Base near Fairbanks, Alaska. Following a 30 month tour of duty, I was in the private practice of general medicine in Fairbanks, Alaska for one year. In 1972, I became associated with the Medical University of South Carolina in an ophthalmology residency program, completing that course of study in June of 1975. From January until March of 1975, I was also a teaching fellow in ophthalmology, concerned with the education of medical students at the Medical University of South Carolina. In July of 1975, I returned to Fairbanks, Alaska and have been in the private practice of ophthalmology with the Eye, Ear, Nose and Throat Clinic since that time. I am a Diplomat of the American Board of Ophthalmology. This accrediting board was the first medical specialty board established in America at a time when optometry was in its infancy and long before licensing boards for optometry existed. The privilege to practice my specialty is the culmination of 13 years of post high school education. This is in contrast to the average six to eight years spent by optometrists in post high school education today and is in greater contrast to the four years or less post high school education of approximately 50% of all optometrists presently practicing in the United States.

1919 LATHROP STREET, P O 1248, FAIRBANKS, ALASKA 99707, PHONE 456-7767

WHAT OTHER STATES HAVE DONE

House Bill 664 is a continuation of a nationwide move on the part or organized optometry to be legislated into the practice of medicine. Since 1971 until 1977, nine states had passed similar laws. In 1977, as of August the 25th, 14 states had denied the use of drugs to 8,275 optometrists. There were five states that passed drug related optometric bills. Four of these states, namely Montana, Wyoming, New Mexico, and Kansas, are certainly in the category of rural states and indicates that the major direction of optometry toward pressing this legislation today is most certainly in rural areas. The defense against that argument that optometrists can provide their care where no ophthalmologists are available, is as follows: In those communities where no ophthalmologists practice, there are physicians with medical "know-how" to deal with eye problems on an urgent basis and refer them for ophthalmologic care to nearby cities. A colleague of mine, Dr. Charles Bobo, Greenwood, South Carolina, studied the population that presented to a small rural community hospital emergency room over the course of one year from July 1, 1975, to June 30, 1976, and in his independent study, showed that 80% of the patients seen in this emergency room sitting were capably treated by the general practice family type physician and only 20% of those needed to be seen by an eye specialist. This certainly refutes the attempt by ambitious optometrists to make a case for being allowed medical functions in rural areas by claiming that there are too few ophthalmologists. The Eye, Ear, Nose and Throat Clinic in Fairbanks, Alaska, of which I am a partner, has, for years, been carrying out not only ophthalmologic but ear, nose and throat clinics in remote areas and in bush communities for the care and welfare of patients that prefer to live in a rural setting. It might be mentioned that our prices for these clinics are exactly the same as they are in our offices in Fairbanks, Alaska.

Find enclosed a copy of some random court rulings as to what other states have had to say in defining optometry and optometric responsibilities.

I will follow this report with others over the next several days, outlining various other points of interest concerning consumer protection and other pertinent data as may be important in your committee's consideration of this bill.

Sincerely yours, I remain,

Sam A. McConkey, M.D.

SAM:ls
cc: Representatives: M.F. Beirne
Don Bennett
Thelma Buchholdt
C.V. Chatterton
Samuel A. Cotten
Alfred C. Nakak
Al Ose
Randy Phillips

ALABAMA (Supreme Court of Alabama)

"Dilation of the pupil...forbidden by law."

"'Optometry' (from Greek. ***optos, visible, plus, ***metron, measure; literally, eye measurement). The science of measuring the accommodative and refractive powers of the eye without the use of drugs. It is defined in various statutory laws regulating the practice as "the employment of any means, other than the use of drugs, for the measurement of the powers of human vision and the adaptation of lenses for the aid thereof.' The practitioner of this art is called an optometrist... While no attempt is made to teach the diagnosis and treatment of eye diseases, dilation of the pupil with drugs is forbidden by law.

"'Optometry,' apart from statutory definition, is defined as the employment of any means other than the use of drugs for the measurement of power of vision and the adaptation of lenses for the aid thereof...the measurement of the range of vision, and does not authorize the diagnosis for treatment of eye disease."

Hampton v. Brackin's Jewelry & Optical Company

DISTRICT OF COLUMBIA (U.S. Court of Appeals of D.C.)

"Empirical rather than learned"

"'Optometry is a mechanical art requiring skill, manual dexterity, and knowledge of use and application of certain mechanical instruments and appliances designed to measure and record errors and deviations from normal which may be found in the human eye, rather than the knowledge and learning appropriate to professions or callings which deal with causes and conduct rather than with conditions and effects, and is in its nature empirical rather than learned.

"'Oculists' and 'ophthalmologists' pursue a calling quite distinct from that of 'optometrists,' having relation to the practice of medicine and surgery in the treatment of diseases of the eye, whereas the calling of 'optometrists' relates to the measurement of the powers of vision and the adaptation of lenses for the aid thereof."

Silver v. Lansburgh & Bro.

"Function...is to measure" (D.C. Code, T. 20, 261-282)

"The District of Columbia statute governing practice of optometry does not contemplate that an optometrist shall be a graduate physician or shall, like an oculist (ophthalmologist), diagnose or treat diseases of the eye, since function of 'optometrists' is to measure the refractional abnormalities of the eye and prescribe, and sometimes grind, the lenses to correct them."

ILLINOIS (Supreme Court of Illinois)

"Other than the use of drugs"

"...'Optometry' to be the employment of any means other than the use of drugs, medicines or surgery for the measurement of the power of vision and adaptation of lenses for the aid thereof, is broad enough to include every measurement of the power of vision and fitting glasses to aid vision."

People v. Griffith

"Measurement of the range of vision"

"'Optometry' means measurement of the range of vision. Also, locsely, measure of other visual powers, hence, scientific examination of the eyes for the purpose of prescribing glasses, etc., to correct defects, without the use of drugs."

Babcock v. Nudelman

MASSACHUSETTS (Supreme Judicial Court of Mass. Suffolk)

"More akin to physical science of optics"

"One who practices optometry exclusively is not commonly to be treated as 'practicing medicine,' 'optometry' in its origin and nature being more akin to physical science of optics than to science of medicine, and its emphasis being upon supplying physical means to aid bodily powers rather than upon cure of disease. 'Ophthalmology' has relation to the practice of medicine and surgery in the treatment of diseases of the eye, and 'optometry' has relation to the measurement of the powers of vision and the adaptation of lenses for the aid thereof."

Sachs v. Board of Registration in Medicine

MISSOURI (Kansas City Court of Appeals)

"Mechanical means"

"...employment of objective mechanical means to determine accommodative or refractive states of eye and range, power, or vision of eye constituted practice of optometry."

State v. Etzenhouser

NEW JERSEY (Supreme Court of New Jersey)

"Other than the use of drugs"

"'Ophthalmologist' has a relation to the practice of medicine and surgery in treatment of diseases of the eye, while practice of 'optometry' relates to the measurement of powers of vision and adaptation of lenses for aid thereof...the employment of any means other than the use of drugs."

N.J. State Board of Optometrists v. S.S. Kresge Co.

NEW YORK (Supreme Court, Appellate Division)

"Calling quite distinct"

"'Oculists' (ophthalmologists) pursue a calling quite distinct from that of 'optometrists.' The first has relation to the practice of medicine and surgery in the treatment of diseases of the eye, and the second to the measurement of the powers of vision and the adaptation of lenses for the aid thereof. It is the primary function of the 'optometrist' to employ means to determine the need for lenses for the correction of defects of eyesight, and the increase of the power and range of vision. He forms a judgment as to the need, and then provides the corrective lens."

Dickson v. Flynn

OHIO (Court of Appeals of Ohio)

"The business of an optometrist"

"The word 'optometrist' made up of 'opto' meaning of or relating to the eyes of vision, and 'meter,' a unit of measure, indicates what the business of an optometrist is."

Kime v. Aetna Cas. & Sur. Co.

PENNSYLVANIA (Supreme Court of Pennsylvania)

"Other than the use of drugs"

"It is substantially correct to define 'optometry' as the employment of any means other than the use of drugs for the measurement of the powers of vision and the adaptation of lenses for the correction and aid thereof."

Martin v. Baldy

TENNESSEE (Supreme Court of Tennessee)

"Optometry...occupation or vocation"

"...ophthalmologists being recognized as learned professions relating to the practice of medicine and surgery in treatment of eye disease, and optometry an occupation or vocation calling for degree of mechanical skill and experience in fitting glasses to eyes."

Saunders v. Swann

UTAH (Supreme Court of Utah)

"Subjective and objective means"

"...defines optometry as the employment of 'subjective and objective' mechanical means to determine the accommodative and refractive conditions of the eye."

State ex. rel. Hallen v. State Board of Examiners in Optometry

WISCONSIN (Supreme Court of Wisconsin)

"Not one of the learned professions"

"Although certain standards of education are prescribed by statute concerning the practice of optometry, 'optometry' is not one of the learned professions and an 'optometrist' may be an employee."

State ex. rel. v. Kindy Optical Co.

STATE OF ALASKA

NOTICE OF ADOPTION OF
EMERGENCY REGULATION

As required by AS 44.62.250, notice is given that the Board of Examiners in Optometry adopted on this date 12 AAC 48.063 and 12 AAC 48.065 and amended 12 AAC 40.070 and 12 AAC 48.080 as emergency regulations relating to advertising of ophthalmic prosthesis devices, routine vision examination and unprofessional conduct.

Copies of these regulations may be obtained by writing to:

Department of Commerce
and Economic Development
Division of Occupational Licensing
Board of Examiners for Optometry
Pouch D
Juneau, Alaska 99811

Date:

Curtis M. Johnson, O.D.
Chairman
Board of Examiners in Optometry

E. E. BACH, O.D.
PHILLIP W. BACH, O.D., PHD.
OPTOMETRISTS
BOX 192
ANCHORAGE, ALASKA 99510

February 14, 1978

The Honorable Thelma Buckholdt
House Education & Social Services Committee
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Mrs. Buckholdt:

I wish to request your support for a bill that you will soon be considering as a member of the House, Health, Education and Services Committee.

This bill amends the Alaska Optometry law to permit the use of Diagnostic drugs by Optometrists. Diagonstic drugs assist in the detection of pathology of the eye, one of the legal repsonsibilites of the Optometrist in the course of his examination of the eyes and vision.

So far twenty two states have adopted this measure in the interest of providing the best safeguards to the public health. That Optometrists will be qualified will be demonstrated to your committee.

I urge your support for the House Bill 664. I would appreciate a response to my request.

Respectfully,

E.E. Bach, O.D.
Suite 204
Denali Professional
Center
3401 Denali Street
Anchorage, Alaska 99503

EEB:pb

DR. ED CRAIG
OPTOMETRIST
348 Main Street
KETCHIKAN, ALASKA 99901

Dial 225-3975

February 6, 1978

Representative Thelma Buchholdt
Pouch V
Juneau, AK 99811

Dear Representative Buchholdt:

I solicit your support of HB664 which will legislate the use of diagnostic drugs by optometrist during the course of eye examination for glasses.

Historically optometry has been a drugless profession. Through modern technology optometry has more sophisticated equipment in the examination room. This equipment enables the optometrist to think in terms of the patient's general health and visual demands. Optometry now has slit lamps, tonometers and retinal cameras, all of which afford a better view of the patient's retina. These procedures require dilation of the pupil to see more of the retina, or an anesthetic to numb the cornea to record the interocular pressure.

These drugs also afford an additional tool for examining the very young child, the retarded adult or the non-English speaking individual.

Optometry is defined as a primary health care profession. The optometrist functions as the principal point of contact within the total health care system for persons seeking relief of visual complaints. If a pathological condition is observed during the course of examination for glasses, referral is made to the proper health care practitioner for treatment.

The safety of these drugs is established in the literature. Because of the small doses, low concentration and limited duration of action, it is established that the small amount absorbed by the body is inactivated in a short period of time and no harmful effects to the patient is found.

In conclusion, I ask your support of this legislation because optometry could do an even better job for the public if we had these additional tools to work with.

I will attempt to answer any questions you may have. I would appreciate your reply.

Respectfully,

Ed Craig, O.D.

E. E. BACH, O.D.
PHILLIP W. BACH, O.D., PHD.
OPTOMETRISTS
BOX 192
ANCHORAGE, ALASKA 99510

February 10, 1978

The Honorable Thelma Buchholdt
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Ms. Buchholdt:

I recently had the pleasure of seeing your son and daughter, Chris and Ti, as patients.

Now I wish to request your support for an item of great importance. The House Health, Education and Social Services Committee, of which you are a member, will soon be considering House Bill 664. This bill amends the Alaska optometry law to permit the use of diagnostic drugs by optometrists. It brings the law into line with optometrists' professional qualifications. Diagnostic drugs assist in the detection of pathology, one of the legal responsibilities of the optometrist in the course of his examination of the eyes and vision. Thus far some 22 states have approved this measure in the interest of providing the best safeguards to the public health.

I urge your support for this important measure.

Respectfully,

Phillip W. Bach

Phillip W. Bach, O.D., PhD
Suite 204, Denali Professional Center
3401 Denali
Anchorage, Alaska 99503

PWB:pb

OPHTHALMOLOGIST
WILLIAM F. KINN, M.D.
BRUCE J. WOLF, M.D.
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OTOLARYNGOLOGIST
RONALD E. TINSLEY, M.D.
RICHARD P. RAUGUST, M.D.
BRUCE G. WHIPPLE, M.D.

PLASTIC AND RECONSTRUCTIVE SURGEON
WILLIAM W. WENNEN, M.D.

EYE, EAR, NOSE & THROAT CLINIC

February 8, 1978

Representative Charlie Parr
Chairman
Health, Education and Social
Services Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Mr. Parr:

This is the second in a series of background reports that I hope will be valuable to you and your committee in your deliberations of House Bill 664.

CONSUMER EFFECTS AND CONSUMER PROTECTION

As regulations evolve to guide the delivery of health care under a federalized system, the role of paraprofessionals in medicine is being defined. A short time ago, most optometrists were "eye examining - glasses fitting" employees of chain and jewelry stores. Now they are a national political effort attempting to legislate themselves into the position of primary eye care practitioners; House Bill 664 is such an attempt, and as presented, this bill is vague, illogical, and unacceptable and is not in the public interest.

Optometry organized for its present effort many years ago and began to implement programs for presenting generally persuasive nonmedical evidence to legislators in many states recently. Before medicine could rally its forces to articulate the logic which is clearly on the side of medicine and the public, several legislatures were persuaded to transform optometrists into quasi-physicians.

Ophthalmologists have been forced to assume responsibility for protecting the public health against optometry. This situation is unfortunate because optometry was once respected for many decades by medicine and the public for having provided vision improvement (not health care) for millions of Americans. The result of their present legislative attempts to intrude upon the practice of medicine could be continuous disharmony and perhaps even the destruction of optometry as a respectable science. Nurses, ambulance attendants, and others who have been trained under the supervision of medicine are appreciated, enjoy a good reputation, and are classified as paramedical personnel, but optometrists insist upon being nonmedical and refuse to accept medical supervision. It is possible for optometry to join the American health care delivery system under qualified medical supervision if vision care is to be included, as is currently done in the U.S. military services and in other countries; but until then, optometry is risking its reputation as a fine profession and the state legislators are being encouraged to transform optometrists into quasi-physicians by legislative fiat which is not in the public's best health interest.

1919 LATHROP STREET P.O. 1248, FAIRBANKS, ALASKA 99707, PHONE 456-7757

A recent poll nationally showed that the public fears blindness second only to cancer. Americans deserve to expect better primary care for possible eye or related bodily disease and not what optometrists are remotely prepared to offer. Despite the claim of their nonphysician educators, optometrists, by background, training, and experience, do not have the capability to diagnose medically related eye problems or eye diseases, drops or no drops. The diagnosis of disease is the practice of medicine. Optometrists are not trained to practice medicine. Many individuals can recognize departures from normal and even make diagnostic guesses, but definite diagnosis and the ability to recognize fine differences between one disease and another rests solely with the physician. It requires understanding, not only of disease but also knowledge of its response to medical and surgical methods of treatment. Ophthalmic diagnosis further requires an understanding of diseases as they effect not only the eye but the body as a whole. Only an ophthalmologist, schooled first in medicine, has this ability. We can not divorce the eye from the human body.

Ophthalmologists and organized medicine have no vendetta against optometry. Optometrists practicing in their traditional role are needed. They are a value testing for glasses and performing those functions for which they have education and experience. The concerted political effort by optometry to become the primary eye care group, however, is not acceptable, logical, or reasonable. Physicians look upon this with alarm. It is a serious threat to quality eye care and patients will suffer. Optometrists are not able to make medical determinations because it is not within the scope of their training. By contrast, legally limiting the profession of optometry to the area of activity in which they are trained to function will not reduce their effectiveness. It will help safeguard their whole profession from the potentially irresponsible action of a few and will promote the health of the public.

If all that I have said is true, then one might reasonably ask why an expansion of the traditional role of optometry is being considered. The answer lies in two areas primarily. First, the desire of legislators to contain the cost of medical care, and second, the need for optometry to improve its collective status.

The legislators have been lead to believe that if optometrists provide basic eye care, the cost might be less than care provided by ophthalmologists. The hypothesis seems attractive on the surface, but in truth, optometrists tend to over prescribe glasses for minimal refractive errors; whereas, ophthalmologists do not. Thus, the total cost of examination and glasses by an optometrist often exceeds that given by an ophthalmologist. If lessened expense is the object, refractive care delivered by trained ophthalmic assistants working under the direct supervision of ophthalmologists costs less and gives the patient better care. Such care now exists in certain prepaid health plans and university eye departments. Duplication of effort and poor referral routes also raise the cost of eye care given by optometrists. Frequently, a patient with a serious eye problem first consults an optometrist for examination, is referred on to the patient's physician for a reexamination, and finally sees the ophthalmologist, who should have been consulted in the first place. Too often, optometrists are reluctant to refer directly to an ophthalmologist, and this custom is expensive.

Optometrists, as well as other paraprofessionals, desire to improve their status. This need is no small factor motivating optometrists to spend large amounts of money and personal effort as they move to "expand the scope of optometry." The way to gain this expansion, as organized optometry sees it, is not through education but by legislation. The public relations experts for optometry have coined phrases for optometrists like "GP's of the eye," "dentists of the eye," and "optometric physicians." Such labeling is fraudulent and misleading. In the Optometric Weekly of July 7, 1977, there was a statement that an expanded definition of optometric services in the Army had been approved. This was not true, has been refuted, and has resulted in the issuance of a mandate from the United States Department of Defense that there shall be medical supervision of optometrists in all branches of the military. Yet optometry has loudly and falsely proclaimed in the state legislatures of this country that civilian optometrists should be allowed the unfettered use of eye drops like their brothers in the military.

Of late, we have seen advertisements in leading newspapers in the country and heard radio ads inserted by state optometric societies using material supplied by the American Optometric Association which are deliberately false and misleading, particularly in those densely populated states whose legislatures have not seen fit to grant optometrists the right to use drops and diagnose or treat eye disease. These ads are now being prohibited by the state attorney's general and departments of consumer protection.

In the summer of 1977, the Washington Society for the Prevention of Blindness successfully stopped an optometric advertisement aired in the guise of a public service announcement: "The Washington Optometric Association reminds you that an eye examination will detect early symptoms of diabetes, arteriosclerosis, and hypertension." Excerpts of a protest to the Consumer Protection Division of the Washington Attorney General's office prompted removal of this fraudulent advertising after the Washington State Attorney General said in part, "This health service message, couched in such broad terms, might have the capacity to mislead a layperson to expect and rely on a wider range of medical services than are actually obtainable from optometrists."

Many optometrists are not enthusiastic about organized optometry's effort to encroach upon the practice of medicine. Recently, Richard Ball, writing in the Optometric Weekly, posed a question to his fellow optometrists when he wrote, "Should we be first class O.D.'s or second class M.D.'s."[1] This stand is supported by the deans and some professors of several colleges of optometry.[2] Also, many optometrists are becoming gun shy because of the mounting resistence to their legislative attempts to encroach upon medical practices. Organizations such as Leagues of Women Voters, labor unions, federations of state, county, and municipal employees, and leading newspaper editorials throughout the land oppose the making of pseudophysicians of optometrists.[3] They recognize that these back door attempts at redefining optometry only serve to further confuse the public as to the capabilities of the two practitioners in the eye care field. A number of ophthalmologists who were formally optometrists and then went to medical school and by way of the ophthalmology residency route became qualified ophthalmologists,

vigorously oppose this legislation because they know better than all others that the medical eye care rendered by eye physicians is the only medical eye care that should be available to the public.[4]

Optometrists and ophthalmologists should compliment and support each other. Disregard for excellence, such as would result from enactment of the proposals put forth in Bill 664, will adversely effect the superior level of eye care currently offered to patients in Alaska.

In closing, I might quote from a thesis entitled, "The Expansion of Optometry into Medical Practice": "The regulation of the practice of optometry is not for the benefit of the licensees but for the benefit of the state and its people...no where does case law state that public protection will be qualified, i.e., that...the risk (may be increased) 'a little bit' but not 'a lot.' The intent is protection...the language is explicit."

Please find enclosed some pertinent editorial comments, as well as some consumer articles that have appeared in other parts of the country as concerns this legislation. Thank you very much for your time in reading through this material.

Sincerely,

Sam A. McConkey, M.D.

SAM:ls
cc: Representatives: M.F. Beirne
Don Bennett
Thelma Buchholdt
C.V. Chatterton
Samuel R. Cotten
Alfred C. Nakak
Al Ose
Randy Phillips

REFERENCES

1. Ball, R., "Should we be first class O.D.'s or second class M.D.'s," Optometric Weekly, volume 67, page 874 through 895, 1976.

   Optometric Weekly, April 3rd, 1976, James C. Miller, O.D., Nappanee, Indiana, "(I) think optometry has too many quasi-physicians now! If these optometrists want to be physicians, they should have gone to medical school...if we believe the end result will be to our benefit or to the benefit of the public, we are inane."

   In Optometric Weekly, April 3rd, 1976, under a column headed "Vox Oculi," over half the optometrists writing in agreed that they could never appreciate the difficulty and intensiveness involved in treating eye disease until he or she is educated to a point of being able to handle it on a daily basis. "There is no present need for the move and the necessary education is not available for optometry to attempt to secure drug utilization." Richard Ball, American Optometric Association, Interprofessional Relationships Committee.

   September 15, 1976, American Optometric Association News, James A. Rakes, optometric resident, V.A. Hospital, Lexington, Kentucky. "The day will come when optometrists can treat disease with the approval of ophthalmology, but they will have to earn it through the same hard work that ophthalmology residents must go through. There is no shortcut to therapeutics."

   Optometrist, Philip C. Lafrance, Laconia Eye Clinic, Laconia, New Hampshire, "Optometrists, in their many years of training, are not adequately trained to correctly define an eye disease."

2. Dean Henry B. Peters of the University of Alabama School of Optometry writing in the Journal of the Americal Optometric Association, June, 1977, said, "not one of our schools is prepared by either faculty resources or available clinical experiences to accept this challenge (of preparing optometrists to treat eye disease) at the present time." "Optometric educational institutions have serious responsibilities within the present practice of optometry and precious few resources to carry them out...the resources necessary to adequately prepare students and practitioners to treat eye disease are simply not available." "It is going to be difficult or impossible...to provide the educational requirements for the expansion of optometry into the area of treatment of ocular disease."

   Meredith W. Morgan, O.D., Dean emeritus of the School of Optometry of the University of California at Berkley, "As far as I know, there is not a school with the curriculum adequately designed to educate students in pharmaceutical therapy and there is not a school with adequate resources to establish such a curriculum."

3. New York Federation of Women's Clubs, Inc., April 30, 1976, a drug bill in New York State. They took a public stand against the passage of this bill. The New York State AFL/CIO, a nonmedical union, advised its constituency that "optometry is not a medical profession and optometrists are not engaged in medical practice. Optometry is confined to a limited area of the measurement for and fitting of eye glasses that traditionally is outside medicine." Please find included copies of several editorials from leading newspapers throughout the country.

4. Five optometrists who furthered their education by going to medical school and became M.D.'s (ophthalmologists) have testified as follows: "Although we had courses in anatomy, physiology, histology, and many other scientific disciplines, including some courses about drugs, our training was superficial compared to medical school training. Furthermore, it was directed with an entirely different perspective in mind, that of examining the eye for vision defects and correction thereof." The five M.D.'s who thus spoke out in unison are Charles Denton, O.D., M.D.; Roger DeShaies, O.D., M.D.; Roger L. Hiatt, O.D., M.D.; Marshall Johnson, O.D., M.D.; and William Roberts, O.D., M.D.

   American Optometric Association News, September 15, 1976, James A. Rakes, O.D., an optometric resident at the V.A. Hospital in Lexington, Kentucky, "An optometrist will never appreciate the difficulty and intensiveness of educating the ophthalmology resident until he sees it on a daily basis." He also noted that the experience that he was having had "opened his eyes to the inadequacy of the average optometry student's background in pharmacology and pathology."

THE ATLANTA CONSTITUTION

For 109 Years the South's Standard Newspaper

James M. Cox, Chairman 1950-1957—James M. Cox Jr., Chairman 1957-1974

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PAGE 4-A, WEDNESDAY, JANUARY 11, 1978

Pulse of the Public

Optometrists and Ophthalmologists

MARIETTA—The controversy over Senate ill 20, which would allow optometrists to use angerous drugs, is an issue very few people an address based on first-hand knowledge and xperience.

I am one of only three people in Georgia a position to do so. Currently, I am an oph-almologist (M.D.) practicing in Marietta. An phthalmologist is an eye specialist. Prior to ecoming an ophthalmologist, however, I was optometrist (non-physician).

After completing medical school to be-ome an ophthalmologist and having attended ptometry school earlier, I can say without eservation the difference in an optometrist's aining and an M.D.'s is overwhelming. The phthalmologist's training is essential to per-rm medical services and to safely use drugs.

I became an ophthalmologist because I anted to be allowed legally to diagnose and eat medical and surgical eye disease. To do requires the use of drugs. As an optometrist was neither trained to use drugs nor did I eed them to perform the services for which I ad been licensed.

The training an optometrist receives does ot compare to the training of a medical doc-r. Although optometric training has been mewhat improved since I was a student, it ill remains inferior to that of an M.D. Anyone ggesting that an optometrist is professionally uipped to use serious drugs is playing a dan-rous game with human lives and precious ye sight.

The drugs involved in S.B. 20 are power-l. They have no place in the optometry ofession. The public should not be subjected use of the drugs by optometrists who are not ined to practice medicine.

There are no short cuts to medical exper-tise. The same option I exercised is available to every optometrist in Georgia. If an optometrist wants to practice medicine, that optometrist should be required to become a medical doctor as I have.

IRVING T. STALEY, M.D.

Opticians Oppose Bill

DUNWOODY—The Georgia Society of Dispensing Opticians, which has over 600 statewide licensed members, strongly opposes Senate Bill 20 which would allow optometrists, who are not medical doctors, to use diagnostic drugs in eye examinations.

Opticians, who are skilled technicians licensed to fit, adjust, and dispense eye glasses from the prescription of an ophthalmologist or optometrist, serve an important and unique role in the delivery of eye care to the public. Because of our position in the area of public eye care, we are compelled to express an opinion regarding S.B. 20. Ophthalmologists are medical doctors (M.D.s) who specialize in the treatment and diagnosis of medical and surgical eye disease. Optometrists are not medical doctors. Optometrists are licensed to evaluate the eyes for visual behavior and prescribe glasses accordingly.

The clincial and patient training of an optometrist is unequivocally inferior to that of the ophthalmologist. To allow these non-physicians to use drugs which are unnecessary in eye screening examinations poses an unwarranted, serious hazard to public health.

Optometrists are not trained sufficiently to treat reactions which can arise in the process of administering drugs; moreover, the public should not be subjected to serious drugs unnecessarily.

The greatest danger to the public should S.B. 20 become law, is mis-diagnosis and delayed recognition of disease. The proper legal role of optometry is not to make specific diagnosis and determine whether a patient is to be treated or not, but to screen for the presence of eye disease in the course of an examination. To do otherwise constitutes the practice of medicine which is not the role of the optometrist.

As president of the Georgia Society of Dispensing Opticians, I, along with our statewide membership, vigorously oppose S.B. 20 in the best interest of public health.

DAVID F. MELDRUM

Letters will be subject to standard editing and must bear the writer's signature and address. Short letters are best. On request the writer's name will be withheld.

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Doctoring the eyes

Public confusion about the distinction between ophthalmologists and optometrists is understandable. Both are called "doctors," although only ophthalmologists actually have medical degrees, and both diagnose and treat eye conditions. But the distinction between the two professions has always been blurred and ophthalmologists fear that a bill allowing Massachusetts optometrists to administer drugs during eye examinations would further confuse the public, lead to missed diagnoses of serious eye diseases and endanger public health.

Optometrists are seeking the legislated right to use drugs, in the form of eye drops, for three kinds of examinations: local anesthetics to aid in measuring pressure on the eye, mydriatics to make the pupil larger and give a better view of the eye's back wall, and cycloplegics to eliminate muscular movements that hamper thorough examinations.

But some of these drugs can be dangerous. In some cases, severe nervous disorders have resulted from examinations in which the drugs have been used. Convulsions are rare but known to occur. Death has also resulted from application of even these mild, surface-applied drugs, although also rarely.

Optometrists argue that they are fully trained today to treat the occasional negative reaction to eye drugs which they wish to use. In Massachusetts, for instance, optometrists undergo four years of schooling after receiving their undergraduate degree, which often is in the sciences. They say that they are taking more drug application training, both in class and in clinics, than is needed for the limited authority they are seeking. They point out that 22 states, including Rhode Island and Maine, have already passed legislation enabling optometrists to apply diagnostic drugs and that serious complications have been negligible.

Nevertheless, serious complications are a possibility and patients have a right to be secure in the knowledge that a medical technique used by a doctor, a paraprofessional, a nurse or anyone else in the health delivery field is safe. They also have the right to know that should a complication arise they will be quickly and properly treated.

The Massachusetts legislation, H6670, has passed the House but received an unfavorable report from the Senate Ways and Means Committee. It is scheduled for a floor vote, possibly today. Senators should be cautious in voting on this legislation because many medical doctors, who are the best-trained authorities in society concerning the application of diagnostic and other drugs, believe the bill contains inadequate safeguards for the public. And where the public's health is in question, the prudent course would be to follow the doctors' advice.

THE POST'S OPINION

Keep Eye Care Standards High

If it does anything in the field of eye care, the Colorado General Assembly should strenghthen further the standards of protection against misuse of dangerous drugs in eye diagnosis, not relax those standards to suit the demands of optometrists.

Colorado optometrists are supporting House Bill 1094 in the current legislative session. If passed, the bill would give optometrists the right to use drugs in diagnostic procedures.

Optometrists are non-medical specialists. They test your eyes for refractive errors and measure their focusing powers. They may provide or prescribe glasses and/or exercise to improve sight.

Now, it would be most convenient for them to use a whole host of drugs to dilate, constrict or anaesthetize the pupil. The procedure would be simplified; the patient might get by a bit cheaper.

The word "might" in that sentence is important, however, because the patient also might have his eyesight impaired by use of those drugs. In some cases, death could result.

At present, the use of drugs is restricted to opthalmologists. Opthalmologists are medical doctors who specialize in defects and diseases of the eye.

While opthalmologists may prescribe glasses or contact lenses, there is considerable interplay in their relationship with optometrists. When serious eye problems are suspected, such as glaucoma, the optometrist sends his patient to the opthalmologist.

There are insufficient numbers of the latter to prescribe glasses for everyone who needs them. Both bodies of expertise thus find work; the optometrist offers a somewhat less expensive option for the person simply in need of glasses.

But under H.B. 1094 the optometrists could extend their service by moving into the use of drugs in diagnosis.

There are several things to keep in mind. One is that drugs don't just wash out of the eye. They go into the tear ducts and are absorbed by the body.

Here are some of the drugs available for eye diagnosis:

- Neosynephrine in 10 per cent solution. This concentration is 80 times stronger than the neosynephrine solution used in nasal drops. It can cause a stroke if improperly used.
- Atropine. One drop of atropine in one per cent solution can keep a patient's pupil dilated for 10 days.
- Phospholine iodide. This is a pupil-constricting agent, used in combination with the dilating drugs. Absorbed in the body, this drug can affect the enzyme system and could—in rare circumstances—cause death if used in combination with anaesthetics.

The anaesthetic drugs are valuable in detecting glaucoma because they help in measuring eyeball pressure. Again, they are potentially dangerous and must be handled by experts.

The bill proposed by the optometrists would require pharmacology training. This is not good enough. The optometrist needs only five years of training, three of which are in professional studies. The opthalmologist spends a minimum of 11 to 12 years in pre-med, med school, internship and residency. Obviously, a medical school offers qualitative advantages as well.

The subject is not one for easy answers. One could not object to a move toward parity if training were parallel and equal. But the public needs total protection where the use of dangerous drugs is involved. The standards should remain high; the only question the assembly should ask in the interests of citizen health is this: are those standards high enough?

Albuquerque Journal
Albuquerque, New Mexico
February 7, 1977

Editorials • Comment

ALBUQUERQUE JOURNAL

Optometrists Win: People Lose

The top-heavy 7-2 vote by which the New Mexico Senate Public Affairs Committee gave its do-pass to the optometrists' diagnostic medicine bill is cause for alarm; it is to be hoped it is not indicative of things to come.

It was simply a case of lawmakers without medical training passing on the medical qualifications of others without medical training.

If a summer short course can qualify two thirds of the state's optometrists to administer and understand all the possible ramifications of diagnostic drugs, then it must follow that the American people are supporting a grossly overtrained and overly qualified medical profession. The latter, of course, is a conclusion that no one with health problems is willing to, or can afford to, accept.

Sentinel Star
Orlando, Florida
December 10, 1976

Sentinel Star

"Not for its sake alone — but for the sake of society and good government — the press should be free" — James A. Garfield

Orlando, Florida, Friday, December 10, 1976

Eye To Eye On Eye Drops

WE DON'T always agree with physicians. In fact, in our years of reporting local medical society news there have been notable occasions when we differed sharply with what has been called that group's "closed shop" policies.

Physicians can be secretive when it suits them, occasionally indifferent to the point of callousness, and frequently too immersed in their own small world to make an appreciable contribution to communities that support them in styles ranging from comfortable to luxurious.

But we see eye to eye with the Florida Society of Ophthalmologists which seeks to amend a questionable statute the State Board of Optometry claims permits optometrists to prescribe drugs and eye drops.

Ophthalmologists are doctors of medicine or doctors of osteopathy whose training in pharmacology has given them an intimate knowledge of the risks and benefits of drugs administered to living tissue. They have completed medical training, served a supervised internship and residency, specialized and passed their state boards.

Optometrists have had classroom training only in correcting faulty vision through mechanical procedures. They are qualified to prescribe lenses for certain eye deficiencies, but they lack the pharmacology and training to treat diseased tissue.

Eye drugs can cure or cripple. They can produce high blood pressure, skin rash, fever and convulsions. They can bring on glaucoma, delirium, mental confusion and blindness. They should be prescribed by qualified physicians exclusively.

Florida ophthalmologists are justified in proposing legislation to restrict their use and the fact that Atty. Gen. Robert Shevin has described the present law as "vague" should alert legislators to its danger.

Chronicle-Herald
Augusta, Georgia
January 30, 1977

Sunday Chronicle-Herald

"The history of liberty is a history of limitations of governmental power, not the increase of it. When we resist, therefore, the concentration of power, we are resisting the processes of death, because concentration of power is what always precedes the destruction of human liberties." — Woodrow Wilson

Kill Senate Bill 20

The Georgia Society of Ophthalmology and the Medical Association of Georgia are acting in the best interest of the people in their opposition to a measure that could, as they claim, "create physicians by legislation rather than education."

The measure is Senate Bill 20. It deserves defeat. It concerns ophthalmologists — who are physicians, specializing in vision problems, with a minimum of 12 years of specialized training — and optometrists, who examine eyes for glasses and receive only six years of training, none of which is in a hospital setting.

Senate Bill 20 would allow the optometrist to use medications without supervision of a physician, such as an ophthalmologist. It is true that in large institutions such as Veterans Hospitals and the Nation's armed forces, optometrists are permitted to use and dispense drugs. Nevertheless, there is always an ophthalmologist nearby who could handle any emergency arising out of the utilization of the drugs.

Experts say that many of the drugs used in the treating of eye disorders affect the autonomic nervous system, and convulsions, lung and heart irregularies as well as accute glaucoma attacks could arise. A basic weakness in the bill, say foes, is the fact that optometrists are not trained in how to counteract adverse effects of drugs.

We think, in light of this, that if an optometrist wants to legally dispense medications a course of action available to him is one an ophthalmologist already has taken: Enroll in medical school and undergo years of specialized training.

The State
Columbia, S. C.
February 12, 1977

The State

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The Eye Of The Storm

A SEEMINGLY innocuous bill pending before the House Medical Affairs Committee has South Carolina's medical profession in a state of apprehension — and optometrists in a state of anticipation.

At issue is a proposal to amend the existing statute relating to optometrists so as to permit their use of "topical ocular diagnostic pharmaceutical agents" in their examination of eyes. They contend, rather plausibly, that their diagnoses of optical conditions can be helped through the use of certain chemical agents in specific cases.

This contention is meeting vigorous opposition from *physicians* who specialize in the diagnosis, care, and treatment of diseases and other abnormal conditions of the eye. These ophthalmologists, to give them their official medical identification, fear that the general public will suffer if optometrists (who are not trained and licensed as doctors of medicine) are authorized to employ potentially harmful drugs in the examining of eyes.

Both the ophthalmologists and the optometrists readily admit that the two groups play essential, although separate, roles in eye care. Under ordinary circumstances, optometrists who come across indications of eye disease will refer their patients to an ophthalmologist. Conversely, ophthalmologists may refer patients to optometrists when visual needs involve only the prescribing and fitting of lenses, whether conventional or contact.

But they part company with respect to the use of drugs by optometrists. Furthermore, the concern over possible ill effects extends not just to the ophthalmologists but to the entire medical profession, as evidenced by the S.C. Medical Association's recent adoption of a resolution urging the legislature, "for the protection of the people of South Carolina," *not* to allow optometrists to assume the medical functions inherent in the use of drugs.

The State agrees with the physicians of South Carolina in this matter. Without in the least derogating the very useful services rendered by optometrists, we nonetheless feel that medical treatment should be limited to those practitioners who have been medically trained. Eyesight is too precious — and too perishable — to be subjected to ministrations which, however well intentioned, might result in permanent loss or impairment of vision.

Both the ophthalmologists and the optometrists have their hands full in meeting the current demand for eye care. Let us hope they can continue working within their respective fields of preparation and competency as currently defined by law and custom.

Tallahassee Democrat
Tallahassee, Florida
February 7, 1976

Tallahassee Democrat

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As our editors see it

Safeguards are needed in eye care business

There is some professional dissent pervading the eye care business.

Dictionary definitions list an optometrist as a practitioner who measures vision and corrects visual defects without the use of drugs or surgery. Florida law, however, puts no prohibition on the profession of optometry. The law defines optometric services "to be the diagnosis of the human eye and its appendages and...determining the refractive powers of the human eyes, or any visual, muscular, neurological or anatomic anomalies ... and the employment of lenses, prisms... and any other means or methods for the correction, remedy or relief of any insufficiencies or abnormal conditions of the human eyes."

This is pretty powerful stuff. Optometry which is a measuring science now sounds like a medical science.

Ophthamologists as medical doctors specializing in the treatment of disease or defects in the eye are understandably concerned over the license given the optometrists by Florida law. They maintain that to "diagnose" the human eye and employ "any means" to correct abnormal conditions is not within the realm of optometry.

They're right. Optometrists serve a need in the community for the measuring of visual inaccuracies and the prescription of corrective glasses. Their training does not include enough pharmacology to safely prescribe drugs, nor enough anatomy to accurately diagnose disease.

Most optometrists are practicing within the logical limits of their profession. They do not attempt to treat diseases of the eye nor prescribe drugs for improvement of eye conditions.

But the potential for jeopardizing health standards is there. The law should be made more specific.

Thus far the legislators have declared that the "professions" should fight it out by themselves. Legislators have also claimed that this isn't their battle, that legislating a more precise definition does not fall within their jurisdiction.

What they neglect to mention is that the state has police powers that may be invoked to provide for the health and safety of its inhabitants. Defining the limits to the profession of optometry will not reduce the effectiveness of optometrists. It will safeguard the profession from the potentially irresponsible actions of a few and promote accurate and effective health care of the many.

Tallahassee Democrat
Tallahassee, Florida
August 5, 1976

Define professional limits

By COLLINS CONNER
Democrat Staff Writer

When you're sick, do you go to a doctor? More to the point, when you go to a doctor, do you go to a doctor?

The health care field is growing by leaps and bounds. Most of us are confused and disoriented enough trying to weave our way through the physician specialties. What adds to the confusion are other categories of health providers that seem to straddle the fence between medical doctors and other health professions.

Like podiatrists, who aren't M.D.s but do provide physician services for problems with the feet. Or naturopaths, or osteopaths or chiropractors. None of these are medical doctors, but all provide health care.

They are all allowed to use drugs in their courses of treatment. And under the list of which professionals are allowed to dispense and prescribe their drugs through the services of a pharmacist, they are all included as "practitioners."

★ ★ ★

WHETHER OR not the public understands the intricate limits to the practices of these health providers, the providers themselves do. And so too do other professionals whose duties intermingle with these providers.

That isn't the case with optometrists. Not only is the public sometimes confused about the limits to optometry, but other professionals, such as the pharmacists, and even the optometrists themselves interpret those limits in varying ways.

According to the state statute defining an "optometrist," he is able to use any means to examine, diagnose and treat impairments to or disease of the eye.

The optometrists asked the Florida Attorney General's office if that statute gave them the right to use drugs in their diagnosis and treatment.

CONNER
. . . Seeking drug use

And the Attorney General's office replied, "well, the statute doesn't exclude that possibility."

Enter confusion.

★ ★ ★

A SOUTH Florida druggist had a prescription telephoned to his store by an optometrist. The druggist informed the optometrist that under the statute governing pharmacists, he was not allowed to fill that prescription.

The optometrist said all that had changed. After all, the Attorney General said it wasn't forbidden for the optometrists to prescribe drugs.

So the pharmacist filled the prescription. And in doing so, according to the Florida Board of Pharmacy, the druggist put himself in a precarious position.

Stuck in the middle, the pharmacist's board must make a compromise between a statute that says optometrists can prescribe drugs and a statute that says pharmacists can't fill their prescriptions.

★ ★ ★

THE PHARMACISTS are advised to supply the optometrist with medicines he wishes to use for diagnostic purposes, but not to fill prescriptions for medicines needed for treatment of eye problems.

It's as though the druggists must say, "I can give him medicine in general which he may use as he pleases, but if I fill his patient's prescriptions, it will indicate that I am cooperating in the treatment of a patient which will reflect on my liability."

The debate, for the most part, is way past the comprehension and interest of the average citizen. That's the whole point in having the Legislature define professional limits — to safeguard the interests of an unknowing population.

In this case, the Legislature hasn't considered the safety of the public. It hasn't even considered the risks to the professionals involved.

From stupid statutes mighty snafus grow.

Ruidoso News
Ruidoso, N. M.
December 9, 1976

Stuph & Junk

. . . by

Cale Dickey

YOUR EYES AT STAKE

New Mexico's opthalmologists are rankled at optometrists . . . 'cause optometrists are pushing for rights to administer drugs in the treatment of eye disorders . . . which is roughly akin to taking a horse suffering from colic to a farrier for treatment.

Simply stated an optometrist is trained to examine your eyes for defects, to prescribe corrective lenses and to suggest exercise therapy.

An opthalmologist is a medical doctor . . . that's M.D. . . . who took additional schooling to specialize in eye disorders and their treatment . . . and there are the delicate eye operations performed by opthalmologists . . . and while a farrier might correct a limp in a horse, an optometrist isn't licensed to practice medicine, because optometrists don't receive a degree as a medical doctor with their degree in optometry that lets them refer to themselves as "doctor".

A good optometrist is a credit to himself his community and his clientele . . . he does he's thing by fitting you with glasses so that you can see well . . . for this service he receives an adequate stipend . . . he's happy . . . and you have good fitting glasses . . . but because a good automobile mechanic can keep your car running smoothly doesn't mean he can fix your clock. And even the best glass eye doesn't do a thing for your peripheral vision.

DeKalb News Sun
DeKalb, Georgia
February 9, 1977

One Man's Opinion

by

William C. Crane

Eyes Are Important

An amendment to Code Section 84-1101 is being proposed in the General Assembly. This amendment pertains to you and your eyes, and should be of paramount importance to you the public.

Basically it would allow an optometrist to use pharmaceutical agents for diagnostic purposes if the optometrist has received pharmacological training and accreditation from an accredited institution of higher learning and certification by the Georgia State Board of Examiners in Optometry.

-0-

IT WOULD seem that as written the bill is too vague as to requirements and drugs allowed.

Remember your eyes are your most valuable asset other than your life.

How wonderful to see a blue bird, a sunny spring morning, Jonquils blooming in the twilight, a beautiful girl running down the street, a group of boys playing soccer. The rainbow after the rain, the mountain valleys and lakes, the ocean at sunrise or sunset. Nothing can surpass the sheer beauty that the eyes convey to your brain.

-0-

THIS WRITER believes in seeing an optometrist for prescription glasses and an opthalmolgist for eye trouble involving the use of drugs or surgery. For your information the following description and training of each profession is printed for your guidance and if after reading this you believe that further thought should be given to passage of this bill, then call your senators and representatives and voice your thoughts.

-0-

"AN OPHTHALMOLOGIST is a primary care physican qualified to provide comprehensive diagnostic eye examinations for both systemic and ocular diseases and the initiation of medical treatment including the prescribing of indicated medication and lenses. He is educated, trained and licensed as a Doctor of Medicine (or Osteopathy) and is the portal of entry for the public into medical care systems. His education usually includes four years of college, plus four years of medical school one year of internship and 3-4 years of ophthalmology residency, for a total of 12-13 years of 'basic training.'

-0-

"AN OPTOMETRIST is a limited practitioner, whose formal education (two years pre-optometry college classroom required study, plus a four-year college curriculum in optometry) limits him to testing for vision problems unrelated to disease. Optometrists test depth and color perception and the ability to focus and coordinate the eyes. When necessary, they prescribe and fit lenses. Some are taking additional classroom training in an effort to expand their services into the practice of medicine. Ocular pharmacologists who are M.D.'s testify that classroom training is inadequate and that this trend is a public health hazard.

(Views expressed by our columnists do not necessarily reflect the editorial opinion of the DeKalb News/Sun.)

The New Mexican
Santa Fe, New Mexico
February 2, 1977

NEW MEXICAN **Opinion**

Santa Fe, N.M., Wed., Feb. 2, 1977

Defeat eye bill

The Senate Public Affairs Committee is scheduled to hear a controversial bill proposed by the state's optometrists which would establish a dangerous precedent in providing eye care.

The measure, Senate Bill 123 introduced by State Sen. Ray Leger, a Las Vegas Democrat, would permit the state's optometrists to prescribe eye treatment drugs.

The bill is being advanced as a consumer oriented proposal which would reduce the cost of care and make more care available throughout the state. National optometrists organizations have launched a nation-wide push for such measures which have been successful in some states.

The state's opthalmologists—licensed medical doctors—bitterly oppose the bill. They argue that an optometrist, who is not a medical school graduate and who does not have medical training, should not be permitted to prescribe drugs—in some cases dangerous drugs which can have harmful side effects.

Optometrists counter by saying that they have already received or will receive more than 70 hours of training from optometry schools in the use of these drugs.

In our opinion, it is impossible to compare 70 hours of training from an optomery school to the four years of medical school, one year of intership, and three to four years of opthalmology residency which each opthalmologist must undergo before he can be licensed.

Permitting optometrists to prescribe drugs would build in a false sense of security for many patients which may cause them to ignore or overlook serious problems.

In literature it has been said that the eyes are the windows to the soul. In medicine the eyes are an important window and indicator to how the rest of the body is functioning.

If there is something wrong with a patient's eyes that requires the use prescription medicines, it should be a doctor looking into those eyes, not an optometrist.

The legislature has the responsibility to protect the public's health and safety by defeating this measure.

The New Mexican
Santa Fe, New Mexico
February 7, 1977

NEW MEXICAN **Opinion**

Santa Fe, N.M., Mon., Feb. 7, 1977

Limit eye drugs

Should the New Mexico Legislature enact a vague law which permits optometrists to use certain drugs for diagnostic purposes even though some of those drugs can cause harmful side reactions?

That is the baaasic problem facing the House of Representatives now that the Senate has passed a controversial bill backed by the state's optometrists.

Last week a New Mexican editorial opposed this bill on the grounds that optometrists should not be allowed to treat eye patients with prescription drugs.

This brought out a flock of optometrists protesting that they were not seeking the use of prescription drugs to treat eyes, but were merely asking for the right to use a limited number of drugs for diagnoses.

The version of the bill which passed the Senate last week, was amended to limit optometrists to using these drugs for diagnostic work. Even now there is still debate between optometrists and opthalmologists and their lawyers over what the bill does nor does not permit or the original bill did or did not permit.

Optometrists say they need to use these drugs, for which they have received special training, to dialate eyes and perform more accurate, complete eye examinatmions. There are 17 states which permit optometrists to use these diagnostic drugs.

New Mexico's optometrists contend the state's prohibition imposes a financial hardship on state residents seeking adequate eye care.

Opthalmologists counter that the optometrists refuse to be specifc on exactly what type of drugs they want to use. Even optometrists admit that some of the diagnostic drugs involved can cause harmful side reactions in some people, although both groups say reactions are rare.

Opthalmologists, who are trained medical doctors, contend that optometrists, who do not have medical training, are not fully prepared to handle these reactions including possible heart and respiratory problems and convulsions.

There is no specific limitations on the drugs which can be used, although optometrists say they do not intend to use all drugs which fall under the category "ocular diagnostic pharmaceutical agents." The final Senate version of this bill is too vague. It should be as specific as possible about what drugs and under what conditions optometrists should be permitted to use.

We repeat our original concern, that some of these drugs can be dangerous, if used on the wrong patient, in the wrong concentrations and under the wrong circumstances. To protect the public's health the legislature has a responsibility to be as specific as possible.

Evening Independent
St. Petersburg, Florida
June 15, 1976

independent thinking

Efficient?

The crack management team that recently gave the City of St. Petersburg such a fine rating for administra-

EVENING INDEPENDENT

Opinion

16-A Tuesday, June 15, 1976

We hope [illegible] and that of every other [illegible] king privileges — got the [illegible] message.

Clear Case

Their position may not be visionary, but Florida ophthalmologists have made it clear: "Diagnosis" of medical eye problems and use of "any means" of treatment are properly the duties of well-trained medical men — not just optometrists.

And most optometrists don't dispute that.

But a few apparently are prescribing drugs for patient eye problems, when chiefly optometrists are to measure vision and correct defects without drugs or surgery.

The Florida law, it turns out, allows optometrists to use "any means" in "diagnosis." Obviously, a further clarification of that statute is in order.

At least, that's how we see it.

Orlando Sentinel Star
Orlando, Florida
June [illegible], 1976

Sentinel Star
Orlando, Florida

Florida

14A
Sat. June 19
1976

EDITORIAL

Limit Prescription Drug Use

THE FLORIDA Society of Ophthalmology is petitioning the legislature to prohibit optometrists from prescribing drugs in its treatment of eye ailments. Favorable legislative action would nullify a recent decision by the Florida State Board of Optometry allowing use of drugs for diagnosis and treatment of disease by optometrists.

The opthalmologists' petition should receive legislative priority.

We have nothing against the optometric practice of prescribing glasses to correct vision if the affliction is not caused by eye disease. Indeed, one editor doesn't mind admitting she chooses her own reading glasses at McCrory's spectacle counter.

But permanently impaired vision and even blindness can result from drugs prescribed by an unqualified practitioner, and optometrists, whose training is limited to fitting corrective lenses by mechanical means, do not qualify as physicians.

Ophthalmologists, on the other hand, are medical school graduates who have served internships and residencies and have specialized in the treatment of eye disease.

In the interest of public health, prescription drugs should be dispensed at the discretion of physicians only.

ALBUQUERQUE JOURNAL

Robert A. Brown, Senior Editor Gerald J. Crawford, Editor

Wednesday, November 24, 1976

Fences Work Two Ways

The pending legislative confrontation between the medical doctors in the New Mexico Medical Society and the optometrist-members of the New Mexico Optometrical Assn. has the earmarks of a showdown between two professional closed-shop monopolies.

But this time we're inclined to side with the Medical Society and its members, primarily because of the health-and-safety risk involved in placing diagnostic drugs in the hands of those not trained in the care of the entire human body and all its parts.

But poetic justice suggests that the optometrists, in their efforts to trespass on the precincts of another privileged sanctuary, should be governed by the same rules with which they have protected their own. No long memory is required to bring back the days when the optometrists enjoyed free rein in New Mexico's legislative halls, even to the point of infiltrating the legislature and, for brief spans, virtually controlling it.

In those days the optometrists were able to impose rules making it a crime for a pharmacist, a jeweler or any other non-optometrist to even look at a pair of eyeglasses. Worse still, they succeeded in imposing and enforcing a muzzle on the free press, prohibiting newspapers and broadcasters in the state's border cities from publishing price-oriented advertisements from optometrists in adjoining states.

The optometrists have worked hard at perfecting the pattern of the professional sanctuary. It would seem only equitable now that they should live within that pattern.

Albuquerque Journal
Albuquerque, New Mexico
November 24, 1976

Jim Bishop

Our Eyes: Only Two For Each Customer

Glaucoma, whether chronic or acute, is treatable. It cannot be cured. The world of medicine has reached a stage where it can stop the threat of blindness in its tracks. It cannot restore sight; merely stop it at whatever level it has attained when treatment begins.

MOST OF US are fairly faithful in having an annual examination. Our brains are imprisoned in fragile structures called the body. Our doctors examine the parts and give us counsel about weight, blood pressure, heart, lungs, kidney function, many things.

He merely peeks into each eye to see if the blood vessels are engorged. He gives it as much attention as his peek into your ears.

An optometrist can prescribe proper glasses. An optician will grind them and fit them. Only the ophthalmologist is qualified to look inside your eyes, study the optic nerves and tell you that your windows on the world are in reasonably good health.

Eyes are rationed. Only two to a customer.

JIM BISHOP, NATIONALLY SYNDICATED COLUMNIST, APPEARING IN OVER 200 NEWSPAPERS, TOTAL CIRCULATION EXCEEDS 20 MILLION

from HESS

HB 664

14 states permit Optometrists drugs to dilate pupils for diag. purpose

2 states permit use drug for treatment of conjunctivitis

HB 664

Bigelow O.D. w/ ANHS

optom. w/ ANHS - 3½ yrs. have used drugs no adverse reactions

beneficial to use - cause reaction in rural areas - 1-10,000 times
Eskimos - narrow anatomically angle - more susceptible to glaucoma

have to be lic. somewhere

265-3348
279-6661 ext. 348

miotics cycloplegics
mydriatics

HB 664
"topical" drugs

~~W. Virginia - Charleston -~~
Delaware
Kansas
Louisiana - Baton Rouge -

~~California~~

Maine Augusta -

~~Montana~~

~~New Mexico~~

Oregon - Salem

Penn. - Harrisburg

Rhode Island - Providence

Tenn. - Nashville

~~Wyoming~~

~~S. Carolina~~
N. "

Alaska Nurses Association
523 West Eighth Avenue
Suite 111
Anchorage, Alaska 99501
(907) 274-0827
. . . a constituent of American Nurses' Association

April 7, 1978

Representative Charles Parr
Pouch V
Juneau, Alaska 99811

Dear Representative Parr:

The AaNa Legislative Committee has reviewed H.B. 664 and has met with representatives of the optometrists. The committee supports the intent of H.B. 664 giving the controls on the use of pharmaceutical agents by only those practitioners who are educated in the diagnostic use of these agents. We believe that citizens deserve health care by persons who are educated to competently provide services and do not believe that services should be denied when there is no increased risk involved. It is also apparent that large numbers of Alaskan's served by the military and the public health service now receive care from optometrists who use the pharmaceutical agents in question without suffering undue risk.

Between 20 to 30 states now permit optometrists the practice in question. It is our understanding that basic education programs in medicine, dentistry and optometry include essentially the same emphasis upon pharmacology. We understand that being permitted to use the pharmaceutical agents in question will promote more effective diagnosis of visual problems and will reduce the number of false referrals.

The AaNa supports H.B. 664.

Sincerely,

Clair Martin

Clair Martin, R.N., Ph.D.
Legislative Co-Chairperson
Legislative Committee

cc: Dr. William Faulkner
Barbara Walker, AaNa Lobbyist

March 31, 1978

Rep. Charlie Parr, Chairman
Pouch V
State Capital
Juneau, Alaska 99801

Dear Mr. Parr,

I am writing in regard to House Bill 664. I do not feel optometrists should be allowed to use certain medications for the eyes. I feel it would be dangerous as they are not physicians and are untrained in the use of drugs for treating eye problems. I feel only trained physicians should be able to use medications and I urge you to defeat House Bill 664.

Respectfully,

Michele A. Bone

Michele A. Bone
Speech and Language Pathologist
P.O. Box 8340
Ketchikan, AK 99901

cc: Rep. Terry Gardiner
Rep. Oral Freeman
Sen. Robert Ziegler

March 21, 1978

To: Rep. Charlie Parr

Re: House Bill #664

Dear Rep. Parr,

I am very concerned about the pending legislation that would allow optometrists the legal permission to use certain drugs. I want you and your colleages to defeat this proposal for the following reasons:

I have had direct experience with optometry in Arizona, Oregon, and in Alaska that has shown me that as a group, optometrists are very resistant and hesitant to refer their patients to physicians when the optometrist observe a medical problem or the signs of a potential medical problem. I have seen this trend activity result in serious conditions for a member of my family and others. I have seen this happen in Ketchikan.

While I believe some optometrists are probably ethical, I fear that many engage in the above described activity. They do this because they don't want to lose patients and therefore business. It only takes a few to endanger many members of our society.

The drugs in question may be relatively harmless or potentially dangerous, I don't really know. I strongly feel that by allowing optometrists the use of some drugs, this will reinforce and promote their tendency to not refer medical problems to the appropriate professionals.

I sincerely hope that you recognize the dangers in what I've described. These are the reasons I'm against this bill and why I want you to vote against it.

Thank you for your consideration,

Stanley J. Bambauer

Stanley J. Bambauer
2141 Third Ave.
Ketchikan, AK 99901

copies to Rep. Terry Gardiner
Rep. Oral Freeman
Sen. Robert Ziegler

Pouch V
State Capitol
Juneau, Alaska 99801

The
ALASKA OPTOMETRIC ASSOCIATION

AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

April 7, 1978

Representative Charles H. Parr
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Representative Parr:

I appreciated your consideration of House Bill No. 664 on Tuesday, April 4, but feel I must make some comments on the remarks made by Dr. Robert Page, ophthalmologist of Juneau. Dr. Page pointed out two situations where ophthalmic drugs caused emergencies in patients. He did not point out, however, that in neither of these cases could this have happened in the office of an optometrist, nor is there any evidence nationwide to show that optometrists have misused or have had emergencies in the use of these agents they could not handle. The instance where the patient was given a bottle of topical anesthetic to treat a scratched cornea was done by someone other than an optometrist in Juneau and it is common knowledge amongst eye practitioners that these agents do soften corneal tissue, retard healing and open the tissue for infections of any and all sorts. It would seem to me this is a misuse of this drug by someone other than an optometrist and has no bearing on the skill or knowledge of optometrists concerning these agents. The other crisis occurred in the emergency room where you can expect to have a patient under stress with a drug of unknown concentration mixed with an irrigating solution, apparently during a procedure to help open up the tear ducts which sometimes causes minor bleeding, which means there would be an opening directly into the blood stream. The eye was probably also inflamed which means the vessels near the surface of the skin would be enlarged and therefore more apt to rapidly absorb more than normal amounts of the agents used. Again, there's no correlation between a reaction under these conditions and any hypothetical reaction that may occur on a calm, uninjured, healthy patient in the office of an optometrist. These kinds of undocumented reports of adverse drug reactions are commonly used by the medical community in their arguments against the optometric use of these agents when there is absolutely no correlation between the misuse of the agent or the stressful condition under which the agent was applied by a physician and the conditions under which they would be used in the office of the optometrist.

I am sure you must realize by now that the optometrist refers his eye emergencies and eye pathologies to the office of ophthalmologists and you can rest assured that if any serious cases or emergencies had occurred as a result of optometrists using these drugs in any of the states, some of which have been using them for years, the medical community would have promptly reported them to you. The reaction to cycloplegic drug taken home by a patient is also another example of exaggeration concerning the possible side effects of the agents. When a youngster has a reaction to a cycloplegic drug, the medical treatment for this reaction is to discontinue the use of the drug. This is a common instruction given to parents where these agents are used and, of course, could be just as easily given by the optometrists as they can by the ophthalmologist.

Dr. Page also stated that he believed optometrists were going to be following marginal cases of high intra-ocular tensions, a conclusion he arrived at from my statement that because of the variability of some electronic tonometers and because of their inability to be used in clinics in rural areas, it would benefit the patient and the optometrist to be able to use a more reliable screening instrument for glaucoma and one that is more transportable, which requires the use of topical anesthesia. I did not say, nor did I intend to infer, that it was the intent of optometry to follow marginal cases. They would be referred just as they always are, but the use of these agents, particularly in rural clinics, will allow the optometrist to more easily identify the marginal or suspicious pressure patient for referral. It is also routine treatment of anterior chamber depth.

You will also be told that the military approach to optometric use of these agents has always been to be under the close supervision of medical personnel which, of course, does not happen in Alaska as shown in the letters you have received from military optometrists. The Surgeon General has recently changed a long standing policy concerning optometrists using these agents to imply that now all optometrists will have a physician looking over their shoulder while they are using these agents. The reason for this change was because of extreme pressure from organized ophthalmology on the Surgeon General, because optometrists in other states have used this argument successfully in rightly convincing legislators that these agents are safe for optometrists to use and beneficial to the patient. There isn't any more record in the military than there is in the private sector to show that optometrist's patients suffer serious adverse reactions to these drugs.

It has also been stressed to you that optometrists can't possibly know how to handle these agents because they do not have medical training. I guess dentists would have the same problem because none of the five dental schools in the state of California, for instance, are affiliated with a medical school. I have no knowledge of whether or not they share professors with any of the medical schools, but I do have what I consider reliable information that dentists learn dental procedures from other dentists as optometrists learn optometric procedures from other optometrists. The same is true of physicians who learn medical procedures from other physicians. It is true that some of the procedures used in optometric practices are similar to those used in ophthalmological practices, but it is ridiculous to hear that these procedures are the property of organized medicine who have worked mightily to preserve their monopoly in the health care delivery system which, of course, has the same effect of any other monopoly in a free enterprise system.

Sincerely,

Roy A. Box

Dr. Roy A. Box
Legislative Chairman

RAB:jj

PHONE 586-2159
OR 586-2901

DR. ROY A. BOX and DR. GILBERT H. KEMP
OPTOMETRISTS
611 WILLOUGHBY AVENUE • JUNEAU, ALASKA 99801

April 4, 1978

Arlene Montano, Chairman
Board of Nursing
1.5 Mile Chena Ridge
SR Box 100033
Fairbanks, AK 99701

Dear Miss Montano:

I have received a copy of your letter to Mr. Parr concerning eye physician McConkee's statement that "I said nurse practitioners prescribe medications" during the hearing for House Bill #664. I have relistened to my tape of these hearings and did not mention nurse practitioners prescribing medication during my comments. Apparently Dr. McConkee was hearing what he wanted to hear and not what I was saying. My comments about people prescribing medication was directed towards village health aides, many of whom do not have working relationship with physicians, and whom I know personally do not contact physicians more than once or twice a month.

I am extremely sorry that my comments were not acurately reported and I would like to assure you that neither I nor the Alaska Optometric Assoc. have any intention of deriding the skill and very important services provided by nurse practitioners nor are we interested in reducing the functions also provided by village health aides, but merely were pointing out the fact that other people who are not physicians routinely handle and prescribe medications that are potentially dangerous, and have very few adverse reactions.

Yours very truly,

Roy A. Box, O.D.

RAB:jc

cc: Charlie Parr

Louisiana

Director of Legal Research: Olive R. Mafey
Director of Governmental Research: Anne Dunn
(504) 389-6141

Maine

Legislative Research Office
Director: David Silsby
(207) 289-2101

Office of Legislative Assistants
Coordinator: Helen T. Ginder
(207) 289-2486

Oregon

Research Coordinator: Lyle Allen Green
Room S-420
(503) 378-8871

Pennsylvania

Joint State Government Commission
Chairman: Rep. Fred J. Shupnik
Research Director: Ronald C. Steele
(717) 787-6422

Rhode Island

General Assembly Research

Research Analyst: Karl Morrissey

(401) 277-2351

Tennessee

Legislative Council Committee

Research Librarian: Julia McCown

(615) 741-4856

(Office of Legislative Services & Office of Legal Services both vacant)

Dr. Winters
Ronald H.

PhD
Pharmacol
O.S.U.

asst dean school par.
assoc. dean Heal Related Prof's w/ st. U.

2 questions:

1) does design of bill ensure adequate ed. & training?
2) is worth doing - to improve care? safe?

(316) 689-3600
(316) 686-4334

Response:

Oregon - Idaho

1) competency evaluated in standardized - must prove comp.
no "grandfather clause"

2) cost & benefit
safety & efectivness

1) what agents
2) dosases
3) how administered

rare incidence of glaucoma
can tell
taught for screening
check 1st
- can constrict pupil to counter act -

1) Short duration of action (minutes)

2) Small dose - 1-2 drops solution

3) not likely more than 20% in blood stream - since dropped in eye - relatively speaking safe

~~effects~~? effectiveness?

increase op. to detect disease

better to refer patient

lrg. gain for patient

safe, effective

appropriate safeguards - proper training

encourages passage

Wil Kamm
97208

ALASKA
STATE LEGISLATURE

MEMORANDUM

How about amending the board of Optometry Statute to include an ophthamologist? That way the test would be fair, for sure.

sub. "detection" for "diagnosis"

20/200 vision
20/40 vision

Introduced: 1/19/78
Referred: Health, Education & Social Services and Judiciary

IN THE HOUSE BY THE COMMERCE COMMITTEE

HOUSE BILL NO. 664

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the practice of optometry."

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

* Section 1. AS 08.72.300(2) and (3) are amended to read:

(2) "optometry" is the employment of means or methods [, OTHER THAN THE USE OF DRUGS,] for the diagnosis of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription or application of lenses, prisms or ocular exercises for the correction or relief of the human eye;

(3) "practicing optometry" means the diagnosis [, BY MEANS OR METHODS OTHER THAN THE USE OF DRUGS,] of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription of lenses, prisms or ocular exercises for the correction or relief of the human eye, or the holding of oneself out as being able to do so;

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

Sec. 08.72.305. USE OF DRUGS FOR DIAGNOSIS. (a) No person practicing optometry may use drugs for diagnostic purposes unless he has

(1) passed the board's examination on the subject of pharmacology as it relates to optometry and the use of topically applied diagnostic drugs; or [AND]

(2) completed a course approved by the board and offered by a recognized school or college and passed an examination, given by that school or college, which relates to topical application of drugs to the eye.

(b) No person practicing optometry may administer drugs except for

a diagnostic purpose.

(c) Topical anesthetics, mydriatics, cycloplegics and myotics, may be used for diagnostic purposes by a person practicing optometry under conditions approved by the board.

miotics

not diagnostic

HB 664

ALASKA PHARMACEUTICAL ASSOCIATION

P.O. Box 1185
Anchorage, AK 99510
March 28, 1978

Mr. Charlie Tarr
Chairman, HESS Committee
Pouch 5
Juneau, AK 99811

Dear Mr. Tarr:

The following is the resolution passed by the Alaska Pharmaceutical Association at their state convention on February 19.

> "Whereas: Optometrists do not possess the pharmacological background necessary to ensure patient safety and moreover since according to current laws, dispensing is not allowed; be it Resolved that the Alaska Pharmaceutical Association unanimously disapproves of House Bill No. 664 and urges the defeat of this bill."

C. A. Decker

C. A. Decker
Secretary-Treasurer

CAD/d

March 24, 1978

Rep. Charlie Parr, Chairman
Pouch V
State Capital
Juneau, Alaska 99801

Dear Rep. Parr,

As a Registered nurse with thirty years experience I ask you to give serious consideration to House Bill #664. Placing drugs in the hands of and allowing them to be administered by untrained persons poses a serious threat to the health of the consumer. Do not be mislead into thinking these drugs mentioned in HB #664 are safe, as they all have potential side effects and it is our duty to protect the people from possible harm by allowing medications to be administered only by trained medical people. I would like to go on record as being opposed to HB#664 and urge you to vote against it.

Sincerely,

Ethelbelle Kondzela

Ethelbelle Kondzela, R.N.

CC: Sen. Robert Zeigler
Rep. Oral Freeman
Rep. Terry Gardiner

OPHTHALMOLOGIST
WILLIAM F. KINN, M.D.
BRUCE J. WOLF, M.D.
SAMUEL A. McCONKEY, M.D.

OTOLARYNGOLOGIST
RONALD E. TINSLEY, M.D.
RICHARD P. RAUGUST, M.D.
BRUCE G. WHIPPLE, M.D.

PLASTIC AND RECONSTRUCTIVE SURGEON
WILLIAM W. WENNEN, M.D.

March 20, 1978

Representative Sam Cotten
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Re: House Bill 664

Dear Representative Cotten:

It was, needless to say, a real education for me to have had the opportunity to see and participate in the legislative process before the House HESS Committee last week. It would appear that you and your colleagues are daily presented with well prepared arguments for and against issues that you, as representatives, must decide upon. This task, obviously, is much more difficult if the legislation concerns technical or professional issues with which you may be unfamiliar. It's unfortunate that House Bill 664 is before you as a legislative action. Issues such as this should be handled medically and obtain appropriate certification rather than by legislative fiat. We are not in the political arena because we want to be, we are in it because medicine is clearly being maligned at the expense of the public health. We did not bring this proposal to you, optometry did. On behalf of the ophthalmologists (medical doctors), let me make quite clear that this is in no way "special interest legislation," in the usual sense. The medical community, and in this case ophthalmology in particular, is the most informed segment of the community at large to present to our elected officials the facts. One wouldn't ask a fuel oil dealer for information on how to build an oil pipeline and expect that this would be the best advice one could obtain.

As you are well aware, this is the fourth year of such effort on the part of organized optometry to pass such a bill in legislatures across the country. Until 1974, there were only eight states where optometrists were using drops for "diagnostic purposes." Six of these eight states had statutes that were inadequate, i.e., did not address the question of drug use (Florida, Indiana, New Jersey, Idaho, Minnesota, and Nevada). Optometry took this to mean that drugs were not prohibited, and so they have been using drops in these states. In 1974, a nationwide effort was undertaken, the effects of which have now reached us.

Ophthalmology was not ready for it and before it could get its "act together," a well funded and aggressive optometric effort got this legislation through several states, among them were California where an early multimillion dollar effort in this "always the first" state succeeded. Oregon passed this legislation by one vote in a legislature whose senate was presided over by an optometrist. It, however, failed in Washington before ever being admitted as formal legislation.

1919 LATHROP STREET, P.O. 1238, FAIRBANKS, ALASKA 99707, PHONE 456-7767

In 1977, "diagnostic drug bills" passed in five states (Montana, Wyoming, New Mexico, North Carolina, and Kansas), while it was defeated in seventeen states. Four of these states were "rural states," the main thrust of optometry being an unequal distribution of ophthalmologists and optometries; thus, our addressing this problem before your committee. No states thus far this year have had such bills made law. It has been defeated in four states this year (Georgia, Missouri, Mississippi, and South Dakota).

The trend should be quite evident - defeat at the rate of four to one in states where there has been an informed legislature and public. I hope this may answer the question of what other states are doing. I must admit to philosophical differences in this approach, but I understand the reasons for doing it.

Please don't consider a compromise position on this legislation. Vote to defeat House Bill 664.

I would appreciate your passing this on to the other HESS Committee members. I plan to write a letter on the topic of Alaska natives to Representative Nakak soon, and I would hope that he will have copies made for you.

Sincerely,

Sam A. McConkey, M.D.

SAM:ls

PRESIDENT OF ALASKA STATE ASSOCIATION

OF OPHTHALMOLOGY

FOR HOUSE BILL 664, MARCH 13, 1978

Alaska Is fortunate to be blessed with an abundance of professional people of all types. The Alaskan way of life seems to appeal to those professions which some areas of the country have difficulties in attracting. Currently our state possesses an extraordinary array of physicians in almost every major city and certainly ophthalmologists are quite generously represented. Because of this generous supply of physicians, Alaskans should feel no great compunction to settle for anything less than first rate medical care, whether it be on the family practice level or on the specialized level. Ophthalmologists are proud that they are quite capable of offering Alaskans first rate medical and surgical eye care. Having come from all parts of the "lower 48", Alaskas ophthalmologists can offer its citizens some of the most innovative ideas from the countries major medical centers. Indeed we are to the point now where we can even offer the people sub-specialties within the field of Ophthalmology.

Given this rather encouraging medical picture one might reasonably ask the question: "How can we improve the Alaskans eye care status by legislation which would expose them to drugs which are dispensed by non-medical professionals?" Given such generous supply of ophthalmic physicians trained for 12 years in all aspects of medicine and surgery, what could possibly be gained by extending the use of drugs to non-medical professionals? I will go over for you some of the arguments offered by optometrists to justify such legislation:

1. Optometrists can provide eye care cheaper than eye physicians (or ophthalmologists) can! I would like to suggest that each of you conduct a study of the relative values given for eye care costs around our state. I would suggest to you that in Anchorage and on the Kenai one can obtain a complete eye exam from an ophthalmologist for the same fee and in many instances for less money than an optometric exam. As an illustration I'd like to submit to you a bill given a patient for a routine eye exam by an optometric clinic in Anchorage. For the stated sum of $64.00 one could easily obtain 1½ exams by an ophthalmologist physician. Concerning costs I'd also like you to consider that during the past 15 years there has never been a bid turned into the public health service by an optometrist for primary eye care that was significantly lower than those bids offered by an ophthalmologist . In fact one optometric clinic in south east Alaska consistantly turns bids 1½ times higher than all other providers! Thus in Alaska there is no cost difference between an optometrist and a physician.

2. Optometrists claim that they can better screen for eye disease with the use of drugs! It is a well known tenent of medical diagnosis taught to all 3rd year medical students that the cornerstone of all screening procedures is the medical history. This is nowhere more true than in the field of eye c re. If the examiner can take an accurate medical history he should be able to decide which cases need referral to an ophthalmic physician and surgeon. An educated exam without the use of drugs should confirm that impression arrived at from the medical history. I'd like to offer two vivid examples which occured in Anchorage ^ last year. which demonstrate this point.

½ Kenai

A middle aged man from Nome went to an Anchorage optometric clinic because of decreasing VA and a history of diabetes. He was examined by one of the optometrists who assured him his problem was one of cataracts and nothing need be done for the time being. The man returned to Nome and was seen one year later by an ophthalmologist, at which time the diagnosis of diabetic eye disease was made and the appropriate Laser treatment given. Because of the delay in diagnosis this man lost valuable time in obtaining proper medical treatment. I'd like you to consider that drops were not needed to arrive at a correct diagnosis, but what was needed was a sound medical background and an accurate history taking. No amount of drugs applied to the eye or elsewhere on the body will ever substitute for these basic medical skills! A second illustrative case I'd like to present is one of a 12 year old boy who first saw an optometrist about 1 year previously because of severe crossed eyes. The boys mother creating a disabling cosmetic blemish was advised that surgery would be of no help and the only hope was to undergo exercises of the eye muscles. The boy was brought to the optometrist religiously for the exercises. All the while the boy suffered in school because of his self consciousness caused by his cosmetic blemish. Finally he was referred by the school nurse to an ophthalmologist, who operated on the boys eye muscles and within a matter of days ~~had~~ the boys eyes were straight. The cosmetic blemish releived, the boys school work improved, his social status soured and the teachers are pleased. Again no amount of drug applied to this boy could substitute for a sound medical and surgical judgement. The problem again is

not one of insufficient drugs but one of mistaken roles in the eye care field. The difference between a measuring decipline such as optometry and a medical and surgical decipline became all too apparant when cases such as these are reviewed.

3. Optometrists remind us that drugs are used by their decipline in other countries! Therefor this practice should be permitted in the United States.
Although America strives to be bigger and better in many areas we should be proud that we are not a world leader in the field of cultivating the use of drugs by unqualified members of society. We should recall that in China one can purchase antibiotic, and other potentially harmful drugs over the counter in herb stores. Most observers in this country feel that such promiscous use of drugs by society is not in the best interests of establishing a health care system which is to be emulated by other civilized countries!

4. Dentists use drugs the optometrists say and they are not physicians! In understanding this statement one should realize that for the first two years of their training the dental student and the medical student undergo the same basic science studies, in the same classrooms, by the same professors and underwritten by the same exams. During the second half of his training the dentist undergoes clinical training in a clinic where he is supervised by not only physicians but by surgeons whose subspecialty is Ear, Nose and Throat. In such a setting the dental student sees patients sick from trauma, and treats them, sick from infections and treats them and sick from general body disease and also treats these. Indeed the medical training of the dentist is so well established that in times of war and natural disaster he

is called upon to act as a "screening officer" so that physicians can work with more acutely ill patients. Thus it can be seen that the dentist is indeed a medical practicionor by education as well as by practice and in no sense of the term by legislative fiat!

5. Optometrists are trained by pharmacists and pharmacologists for over 100 hours in the use of drugs on the human, ~~therefor~~ they are sufficiently trained to expand their practice! professionals in the pharmaceutical trade, PhD's or otherwise are well trained in the chemistry of drugs, the toxicity of drugs and possibly in the use of drugs. These are highly skilled people who serve an essential role in the health care industry. Despite this specialized training such professionals are not versed in other aspects of clinical medicine. They do not understand the problems of sick people, ~~The~~ problems of patient acceptability of drugs and above all they can not be expected to interpret responses in humans to drugs. These professionals are analogous to the mechanic in the airline industry. Despite the aircrafts mechanics expertise in all aspects of engines and fuselage he is not to be entrusted with the responsibility of acting in the capacity of a pilot. So too despite the pharmacists expertise in the chemistry of drugs he can not be entrusted to act as a clinician or a physician and use those same drugs on the human body. Indeed there is not a state in the land which would consider licensing pharmacists to use drugs on humans. If the pharmacist teacher cannot be entrusted with the use of drugs how can the optometrist student be given that priveledge?

6. We must use drugs optometrists say, because there are so many sophisticated pieces of equipment available to us to use! There are retinal cameras, gonioscopes, and slip lamps now available and if we are to use these new tools we must use drugs! While the names of these ophthalmic tools sound impressive to the layman do not be decieved into feeling they should be part and parcel to the optometrists office equipment. Such sophisticated tools, although new to the optometric exam room have been use by ophthalmologists for at least the past 30 years! Such ophthalmic tools are used for medical and surgical diagnosis and are by no means necessary to fit eyeglasses. Indeed one piece of equipment claimed essential by the optometrist is the retinal camera and this tool is used strictly to treat and document eye pathology. It could have no concievable use for the practicing optometrist! To claim the necessity to use drugs because of the sophisticated tools available is tantamount to my claiming the necessity to fly because of the sophisticated tools available for the aircraft. (POINT A) It is truley a sad state for organized optometry since they decided to expand their field of endeavor via legislative fiat rather than the time tested educative process. Such unqualified expansionist attitude can only serve to adversely affect optometric credibility. Examples of the resulting decline in credability are not difficult to find. On the national level one should recall the Quasar TV commercials of a few years ago which purportedly had the backing of the Americal Optometric Association.

Buy Quasar the ads urged because they are better for your eyes. This all sounded strange to me, so I wrote to the optometric association and was advised that the conclusions were based on the work of a prominent professor of optometry in the midwest. I wrote to him and he was perfectly aghast that he was being misquoted because his work never supported such conclusions!

On the local level I refer you to an article which appeared in the Anchorage Times December 3, 1977. The article describes a computor device which one of the optometry clinics in Anchorage purchased and it goes on to describe how the "physicians" can also use the computor to diagnose glaucoma and cataracts. It is a well known fact among all eye physicians that this computor was designed to measure a refractive error and refractive errors only. This machine in no way can diagnose eye pathology! Again such optometric practice indicates not a shortage of drugs available to them but simply a paucity of sound medical knowledge upon which to base any attempts to expand themselves into the field of medical diagnosis and treatment. A sound medical history and an exam without drops can do more to diagnose cataracts and glaucoma than all the computors designed to date!

This legislature can encourage optometry to continue to provide good quality eye care services in the tradition of the past 50 years. You can do so by urging them to excell in those areas they are well trained for and not expand into a decipline which is foreign to them. You can remind them of the plea of one of their most revered professors

(Dr. Peters) who urges them to strive to be first class optometrists as opposed to second class physicians. You can remind them that if they have an insatible urge to use drugs on people then they should do as so many of their rank have done across the country, and that is to re-cycle themselves thru an accredited medical school cirriculum. In this fashion they would truely have earned the priviledge to use drugs and surgery on their fellow man!

TESTIMONY

HOUSE BILL 664

HESS COMMITTEE

ALASKA STATE LEGISLATURE

MARCH 13 - 14, 1978

Mr. Chairman, Members of the Hess Committee:

My name is Sam A. McConkey. I am a Doctor of Medicine, Licensed to practice medicine and surgery in Alaska, and am a certified Diplomat of the American Board of Ophthalmology. I am a partner in the Eye, Ear, Nose and Throat Clinic in Fairbanks, Alaska. The Alaska Association of Ophthalmology, of which I am a member, is authorized to speak for the ophthalmologists in the State of Alaska. I wish to speak in opposition to House Bill 664.

This is a subject that, until recently, might have been more properly dicussed only before medical groups. Physicians, as a whole, and opthalmologists, in particular, have a natural tendency not to speak out publicly until it is clear that a danger to the public health exists, as is the case with Legionarie's Disease in Philadelphia or the threat of a polio epidemic. When health threats become public issues, as is demonstrated by the attempt at the legislation before you (House Bill 664), we have a duty to speak out.

Alaskans deserve to expect better primary care for possible eye or related disease than that which optometrists are remotely prepared to offer. Despite the claim of their nonphysician educators, optometrists, by background, training, and experience, do not have the capibility to diagnose medically related eye problems or eye diseases, drops or no drops. The diagnosis of disease is the practice of medicine. Optometrists are not trained to practice medicine. Ophthalmologic diagnosis requires an understanding of disease as it affects not only the eye but the body as a whole. Only an ophthalmologist, schooled first in medicine, has this ability.

You will be seeing so=called optometric fact sheets and will be hearing optometric testimony as to their capabilities in pharmacology, diagnosis, and pathology. According to the Random House Dictionary of the English Language, pharmacology is the science dealing with the preparation, uses, and effects of drugs; diagnosis is the process of determining by medical examination the nature and cicumstance of a diseased condition; and pathology is the science or study of the origin, nature, and course of diseases. These are all scientific studies associated with general medical studies, and no optometry school is equipped to prepare medical students.

Dean Henry B. Peters of the University of Alabama School of Optometry, writing in the Journal of the American Optometric Association in June, 1977, said, "Not one of our schools is prepared by either faculty resources or available clinical experience to accept the challenge (of preparing optometrists to treat eye disease) at the present time." "It is going to be difficult of impossible to provide the educational requirements for the expansion of optometry into the areas of treatment of ocular disease." Similarly, Meridith W. Morgan, O.D., Dean of the School of Optometry of the University of California at Berkley, said, "As far as I know, there is not a school with the curriculum adequately designed to educate students in pharmaceutical therapy and there is not a school with adequate resources to establish such a curriculum." These comments from var-

ious optometric educators across the land, as well as optometrists in the private sector, could be presented here for hours.

Optometrists have incorrectly implied that their courses in pharmacology compare favorably with those of medical and dental students and nurse practitioners, but they haven't told you that the medical students and dental studenst go far beyond textbook courses in pharmacology and spend many hundreds of hours in courses in therapeutics. This is the application of pharmacologic knowledge to patients with disease and the recognition and management of local and bodily drug reactions. Even pharmacists never consider themselves adequately trained to evaluate drug dosage or adminsiter drugs. It has been stated that optometrists have an equal educational background with nurse practitioners and that nurse practitioners can use drugs without restriction. This is absolutely not true. There are current guidelines being drawn up today by the licensing board for nursing in the State of Alaska to establish rules and regualtions for nurse practitioners. Under these, they will have prescription ability but only under a close collaborative relationship with a physician. These requirements must be met before a nurse practitioner will be licensed in Alaska.

Optometrists certainly won't tell you that the average ophthalmologist, in addition to medical school and internship, has, in his three year residency, spent more than twice the number of hours required in the entire optometric curriculum, devoted soley to ophthalmology lectures and constant clinical exposure to the diagnosis and treatment of disease. Optometrists will fail to mention that optometric clinical exposure is almost totally in the realm of examining eyes for glasses and so-called "visual training" and that this exposure is very scant in numbers of patient contacts. In optometry school, there's no hospital training whatsoever nor are optometry students exposed to sick eyes or sick patients.

In a recent study conducted by the American Board of Ophthalmology and instigated by the Federal General Accounting Office, the results were no only that we have too few ophthalmologists in this country, but the number of optomtrists presently being graduated is "clearly excessive when compared to the amount of work available to them," and therein lies a key factor in the rapidly developing political efforts of optometry, to expand their capabilities by legislative acts' they need to make work for themselves.

According to figures obtained in February of 1978, from the Department of Commerce, Division of Licensing , there are 38 licensed optometrists in Alaska. Their educational background is as follows:

24 attended Pacific University College of Optometry
5 attended Illinois College of Optometry (4 graduated prior to 1960; 1 graduated 1976)
3 attended Southern College of Optometry
2 attended University of Houston College of Optometry
1 attended Southern California College of Optometry
1 attended Los Angeles College of Optometry (which is no longer listed as an optometric school)
1 attended Northern Illinois College of Optometry (which is no longer listed as an optometric school)
In one case, it's unknown to the Department of Commerce where he went to school.

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

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

Illinois College of Optometry prior to 1960 had NO M.D., PhD., or anyone with a masters or bachelors degree in pharmacology teaching. The one graduate of 1976 may have been exposed to one professor in the category of PhD. or masters or bachelors degree.

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

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

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

It follows that, at least from all the available evidence, the MAXIMUM number of optometrists in the state that had any textbook pharmacology training from any qualified instructor at all is TWO, one from the Illinois College of Optometry who graduated in 1976 and the one graduate of Southern California College of Optometry. It is apparent that the MAXIMUM number of optometrists in the state that had any pharmacology training from any M.D. or PhD. in pharmacology is ZERO. Also, the MAXIMUM number of optometrists in this state that had any instruction at all from any full time M.D. is ZERO. It would seem reasonable that there would be an ophthalmologist either in the teaching staff or in the clinical training portion of optometric education, but from the available evidence, it seems that NO optometrist currently licensed and practicing in Alaska had any full or part-time instruction, either by lecture or in a clinical atmosphere by an ophthalmologist. In the Blue Book of Optometry which was last issued in 1976, only TWO of the six board members of the State Board of Optometry are listed as even having a bachelors degree from any school. House Bill 664 is unreasonable in assuming that a hurry-up course in pharmacology could render the optometrist capable of using drugs, especially when the Bill places in the hands of

the Board of Examiners in Optometry the right to determine the educational and professional competence of its own practitioners. How can members of a board, who themselves have never had training in the use of drugs and the diagnosis of disease, be given the power to pass in the qualifications of their own people in these medical areas?

We are given to understand that the necessity for amending the statutes as currently written is to prevent the continued breaking of the law by optometrists. You will hear that inclusion of the word "diagnosis," coupled with the exclusion of drops, is continuing to make optometry liable to misdemeanor charges under the law, and that drops, as requested by House Bill 664, would then allow optometrists to diagnose properly. This is comparing apples and oranges. Education cannot be legislated. Physicians argue that our license is not given, but earned; 13 years of dues paid to protect the public from paraprofessions who have had a minimum of classroom pharmacology training and no exposure in a clinical situation, sick patients, or "real life" pharmacologic consequences of drug administration.

In the Alaska statutes, there are four key words relating to optometry. They are: Diagnosis, deficiency, deformity, and anomaly. From Dorland's Medical Dictionary, diagnosis is defined as "the art of distinguishing one disease from another, the determination of a case of disease. Deficiency is defined as "a lack or defect, i.e., taste deficiency, an hereditary defect in the sense of taste, analogous to color blindness in vision..." Deformity defined as "distortion of any part or general disfigurement of the body." Anomaly as "a marked deviation from a normal standard." With these definitions in mind, the HESS Committee, who has been thrust into the forefront as defenders of the public health and well being, may well want to consider, rather than House Bill 664, statutory changes such as:

1) Eliminating the word "diagnosis" from the statute with substitution of the word "detection." The American Law Reports, annotated, gives numerous references to the practice of optometry and what constitutes the practice of optometry. In reference to the term diagnosis, it says, "It would be applying a severe rule and stretching language beyond its natural force if we should say that such an action on the part of an optometrist is diagnosing diseases...the quoted phrase must involve the act of determining what disease exists. This, the optometrist does not attempt to do."

2) The lay public and the medical profession as a whole accepts the fact that 20/20 means normal visual acuity. By definition, it follows that anything less than 20/20 corrected vision would be the absence of health; therefore, disease. It might be quite appropriate that the HESS Committee consider legislation making it mandatory in the optometric statutes that any patient seen by an optometrist who can not be refracted better than 20/40 be referred to an ophthalmologist for determination of his visual incapacity and determination of the cause of his decreased visual acuity. Ophthalmologists are qualified to accept this responsibility, optometrists are not!

In summary, I should say that my wish is for cooperation, not competition, in health professions. Optometrists do not need to use drops to practice good optometry. You, as legislators, must guard the public welfare for there can be no compromise in the quality of medical care to which Americans and Alaskans are entitled. The role of the optometrist is a vital one and can be expanded through the use of new optics technology and ideally by working as members of the eye care team under ophthalmologic direction. This is working in the armed forces and large teaching institutions and in large multispecialty clinics, such as the Kaiser groups. Optometrists and ophthalmologists should compliment and support each other. Disregard for excellence, such as would result from enactment of the proposals put forth in Bill 664, will adversely effect the superior level of eye care currently offered to patients in Alaska.

In closing, I would like to leave you with a quote from a thesis entitled, "The Expansion Of Optometry Into Medical Practice." "The regulation of the practice of optometry is not for the benefit of the licensees but for the benefit of the state and its people. Nowhere does case law state that public protection will be qualified, that the risk may be increased a little bit but not a lot. The intent is protection. The language is explicit."

Thank you for your patience. I will certainly leave you with copies of my presentation and various other data to support my position in opposition to House Bill 664.

Position Paper, House Bill No. 664 Division of Public Health

An act relating to the practice of optometry.

This bill would permit the use of selective drugs, including topical anesthetics, mydriatics, cycloplegics and myotics by optometrists, and as such would delete from the definition of optometry in AS 08.72.300 (2) and (3).

(2) "optometry" is the employment of means or methods, other than the use of drugs for the diagnosis of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription or application of lenses, prisms or ocular exercises for the correction or relief of the human eye. It would also change (3) "practicing optometry" by means or methods other than the use of drugs, of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription of lenses, prisms or ocular exercises for the correction or relief of the human eye, or the holding of oneself out as being able to do so.

The intent of the bill would be to permit optometrists to use prescription drugs. This significantly increases the scope of optometry as presently defined. The Division of Public Health recognizes that there is pressure to permit the use of medications and drugs by physicians other than medical doctors and dentists. While sympathetic to the optometrists in their wish to increase the scope of their activities, we are concerned that this precedent may be unwise. The Division of Public Health has reviewed House Bill No. 664 with the recommendation of do not pass.

POSITION PAPER/Department of Health and Social Service

HOUSE BILL NO. 664

"An Act relating to the practice of optometry."

This bill would permit the use of selected drugs including topical anesthetics, mydriatics, cycloplegics and myotics by optometrists, and as such would delete from the definition of optometry the restriction against the use of drugs.

The intent of the bill would be to permit optometrists to use certain prescription drugs. This significantly increases the scope of optometry as presently defined and poses some increased risk and complications. The use of mydriatics is occasionally associated with the development of acute narrow angle glaucoma which may necessitate emergency surgery. The use of topical anesthetics are occasionally associated with acute, allergic reactions and some risks of danger to the cornea by foreign bodies. Recognizing the unusal, but definite risks and complicating reactions, the Department of Health and Social Services feels the use of prescription medications by optometrists would not be in the best interests of the public.

Recommended by: Robert I. Fraser. 3/13/78
Robert I. Fraser, M.D., Director — Date
Division of Public Health

Approved by: Helen D. Beirne 3/13/78
Helen D. Beirne, Commissioner — Date
Department of Health and Social Services

1.5 Mile Chena Ridge
S.R. Box 10033
Fairbanks, Alaska 99701
March 7, 1978

Representative Charlie Parr
Chairman HESS Committee
Pouch V
Juneau, Alaska 99811

Dear Mr. Parr,

Dr. Sam McConkey has asked me for information on the status of nurse practitioners prescribing medications. Apparently, a statement was recently made by an Optometrist that nurse practitioners prescribe medications. This was intended to justify the proposal in Bill #664 that Optometrists, who work independantly of physicians, be allowed to do the same.

The Board of Nursing (i.e., the licensing board) is currently working with the Board of Medical Examiners to jointly promulgate rules and regulations governing the practice of nurse practitioners. The preliminary draft stipulates that before a nurse practitioner is licensed she must substantiate a collaborative relationship with a physician(s). There are currently nurse practitioners in the State who are prescribing medications, but they all have working relationships with physicians. I hope this clarifies the situation.

Yours truly,

Eileen Montano

Eileen Montano, Chairman,
Board of Nursing

EM/ldb

cc: Sam McConkey
Ruth MacMahon, Executive Officer,
Board of Nursing

EYE CLINIC OF KETCHIKAN
RONALD L. TOKAR, M.D.
Eye Physician and Surgeon
Post Office Box 8636
Ketchikan, Alaska 99901
Telephone
(907) 225-2656

March 9, 1978

Representative Charlie Parr
Pouch V
State Capital
Juneau, Alaska 99801

Dear Representative Parr,

As one of two ophthalmologists in Southeastern Alaska, I would like to reveal and explain my opposition to HB 664.

I recently finished my training as an ophthalmologist last June and now practice in Ketchikan. Below is a review of my training.

4 years undergraduate school--------B.S. Degree
4 years medical school--------------M.D. Degree
1 year internship
2 years general practice in Alaska
3 years residency in ophthalmology
8 months private practice

I have completed and passed a written examination of the American Board of Ophthalmology and later this year will take a two and one half day oral examination. The above is typical of an ophthalmologists training. Please compare it to an optometrists.

I believe that the use of the drugs discussed in HB 664 by a non physician will be hazardous to the public for two principle reasons. First, all of the drugs may have side effects. The optometrists lack the experience and training to safely control these reactions when they do occur. Enclosed is a sample of the inserts required by the Food and Drug Administration to be distributed with each drug. Please read these.

During my ophthalmology training program, a patient experienced a serious reaction after receiving dilating eye drops. The patient, an apparently healthy male in his twenties, underwent a cardiac arrest in the eye clinic after receiving the eye drops. Fortunately, the examining ophthalmologist was capable of caring for the patient who did recover. This is unusual, but can happen. I myself was examining a patient last year when he underwent a seizure which we felt was triggered by the use of dilating drugs.

My second objection is that both the optometrist and the patient will be lured into a false sense of security with the use of drugs by non physicians. Optometrists were traditionally trained to treat the eye with glasses and have no medical training enabling them to recognize serious pathology.

Enclosed is a copy of a letter sent to me by a Ketchikan optometrist. There are numerous defects in the reasoning of this letter. I would like to use an important one to illustrate a point. The statement that if a pathological condition is observed, it would be referred to a proper health care practitioner. Since I have been in Ketchikan (8 months) the writer of this letter has never referred a patient to me for evaluation of pathology.

One can then make several assumptions and I will leave these to the committee to discuss. One could go much further elaborating other arguments against HB 664. I am sure my colleagues will testify to these.

The opposition to HB 664 as you know is opposed by most Alaska Physicians. I would like it to go on record that each and every physician in Ketchikan is opposed to HB 664. You will soon be receiving a letter from the Ketchikan Medical Society stating this fact.

I would appreciate this letter be offered as testimony to your committee Thank you.

Respectfully yours,

Ronald L. Tokar, M.D.

MARIETTA EYE CLINIC, P.A.
653 CHEROKEE STREET
MARIETTA, GEORGIA 30060

Telephone 427-8111

IRVING T. STALEY, M.D.
RICHARD M. BROWN, M.D.

GERALD E. SANDERS, M.D.
JOHN F. BIGGER, M.D.

January 30, 1978

Charles Bobo, M. D.
Vice President
South Carolina Society of Ophthalmology
Post Office Box 369
Greenwood, South Carolina 29646

Dear Dr. Bobo:

Regarding the controversy over House Bill 2158 which would allow optometrists to use dangerous drugs, this issue is one that very few people can address based on first hand knowledge and experience.

I am one of only three people in Georgia in a position to do so. Currently, I am an ophthalmologist practicing in Marietta, Georgia. Prior to becoming an ophthalmologist, I was an optometrist.

After completing medical school to become an ophthalmologist and having attended optometry school earlier, I can say without reservation the difference in an optometrist's training and that of a medical doctor is overwhelming. The ophthalmologist's training is essential to perform medical services and to safely use drugs.

I became an ophthalmologist because I wanted to be allowed to legally diagnose and treat medical and surgical eye disease. To do so requires the use of drugs. As an optometrist, I was neither trained to use drugs nor did I need them to perform the services for which I had been licensed.

The training an optometrist receives does not compare to the training of a medical doctor. Although optometric training has been somewhat improved since I was a student, it still remains inferior to that of an M.D. Anyone suggesting that an optometrist is professionally equipped to use serious drugs is playing a dangerous game with human lives and precious eye sight. The drugs involved in House Bill 2158 are powerful. They have no place in the optometry profession and the public should not be subjected to the use of drugs by optometrists who are not trained to practice medicine.

There are no short cuts to medical expertise. The same option I exercised is available to every optometrist. If an optometrist wants to practice medicine, that optometrist should be required to become a medical doctor as I have.

Sincerely,

Irving T. Staley, M. D.

ITS:er
cc

ISOPTO® HOMATROPINE

(Homatropine Hydrobromide)

Ophthalmic Solution

SCRIPTION: A sterile ophthalmic ution. Each ml contains: Active: matropine Hydrobromide 2.0% or %. Preservatives: Benzalkonium oride 0.01% (in 2% strength), zethonium Chloride 0.005% (in strength). Vehicle: Hydroxypropyl thylcellulose 0.5%. Inactive: So- m Chloride, Polysorbate 80 (in 2% ngth), Hydrochloric Acid and/or dium Hydroxide (in 2%) (to adjust), Purified Water. DM-03

CTIONS: A parasympatholytic nt.

DICATIONS: A moderately long ng mydriatic and cycloplegic for loplegic refraction and in the treat- nt of inflammatory conditions of uveal tract.

NTRAINDICATIONS: Contrain- ated in persons with glaucoma or a tory to angle glaucoma and in per- with hypersensitivity to belladonna aloids.

ARNINGS: Excessive use in chil- n or certain individuals may pro- e symptoms of atropine poisoning.

(Cyclopentolate Hydrochloride)

Sterile Ophthalmic Solution

DESCRIPTION: A sterile borate buffered ophthalmic solution. Each ml contains: Active: Cyclopentolate Hydrochloride 0.5%, 1%, or 2%. Preservative: Benzalkonium Chloride 0.01%. Inactive: Boric Acid, Disodium Edetate, Potassium Chloride (except 2% strength), Sodium Carbonate and/or Hydrochloric Acid (to adjust pH), Purified Water. DM-01

ACTIONS: This anticholinergic preparation blocks the responses of the sphincter muscle of the iris and the accommodative muscle of the ciliary body to cholinergic stimulation, producing pupillary dilation (mydriasis) and paralysis of accommodation (cycloplegia). It acts rapidly, but has a shorter duration than atropine.

INDICATIONS: For mydriasis and cycloplegia in diagnostic procedures.

CONTRAINDICATIONS: Should not be used where narrow-angle glaucoma is present.

PRECAUTIONS: In the elderly and others where increased intraocular pressure may be encountered, mydriatics and cycloplegics should be used cautiously. Tonometric examination prior to drop instillation is advisable. Systemic absorption may be minimized by compressing the lacrimal sac for a minute or two during and following instillation of the drops. Sac compression blocks passage of the drops to the wide absorption area of the nasal and pharyngeal mucosa. This is more advisable in the use of the 2% solution and especially in children.

MYDRIACYL®

(Tropicamide)

Sterile Ophthalmic Solution

DESCRIPTION: A sterile anticholinergic agent. Each ml contains: Active: Tropicamide 0.5% or 1.0%. Preservative: Benzalkonium Chloride 0.01%. Inactive: Sodium Chloride, Disodium Edetate, Hydrochloric Acid and/or Sodium Hydroxide (to adjust pH), Purified Water. DM-01, DM-02

ACTIONS: This drug blocks the responses of the sphincter muscle of the iris and the ciliary muscle to cholinergic stimulation, dilating the pupil (mydriasis), the stronger preparation (1.0%) also paralyzing accommodation. These preparations act rapidly and the duration of activity is relatively short.

INDICATIONS: For mydriasis and cycloplegia for diagnostic purposes.

CONTRAINDICATIONS: Contraindicated in narrow-angle glaucoma and in persons showing hypersensitivity to any component of these preparations.

WARNINGS: For topical use only — not for injection. Reproductive studies have not been performed in animals. There is not adequate information on whether this drug may affect fertility in human males or females or have a teratogenic potential or other adverse effect on the fetus.

PRECAUTIONS: In the elderly and others where increased intraocular pressure may be encountered, mydriatics and cycloplegics should be used cautiously. Tonometric examination prior to instillation is advisable. Dilation of iris and accommodative paralysis may be shortened by instillation of pilocarpine solution when advisable. Systemic absorption may be minimized by

(proparacaine HCl) 0.5%

sterile ophthalmic solution

DESCRIPTION

Contains:

proparacaine HCl 0.5%

with: benzalkonium chloride, glycerin, sodium chloride and purified water.

ACTIONS

A rapidly acting topical anesthetic with induced anesthesia lasting 15 minutes or longer

INDICATIONS

For procedures in which a topical ophthalmic anesthetic is indicated: corneal anesthesia of short duration, e.g., tonometry, gonioscopy, removal of corneal foreign bodies, and for short corneal and conjunctival procedures.

CONTRAINDICATIONS

Should be considered contraindicated in patients with known hypersensitivity to any of the ingredients of this preparation.

WARNINGS

Prolonged use of a topical ocular anesthetic is not recommended. It may produce permanent corneal opacification with accompanying visual loss.

ADVERSE REACTIONS

Occasional temporary stinging, burning, and conjunctival redness have been reported after use of proparacaine, as well as a rare, severe, immediate-type, apparently hypersensitive allergic corneal reaction, with acute, intense and diffuse epithelial keratitis, a gray ground glass appearance, sloughing of large areas of necrotic epithelium, corneal filamonts and sometimes, iritis with descemetitis.

Allergic contact dermatitis from proparacaine with drying and fissuring of the fingertips has been reported.

DOSAGE AND ADMINISTRATION

Usual Dosage: Removal of foreign bodies and sutures, and for tonometry; 1 to 2 drops (in single instillations) in each eye before operating.

Deep Ophthalmic Anesthesia: 1 drop in each eye every 5 to 10 minutes for 5-7 doses.

Note: Do not use if solution is discolored (amber).

HOW SUPPLIED

15 cc plastic dropper bottles On Prescription Only

ALLERGAN PHARMACEUTICALS Irvine, California 92713, U.S.A.
Printed in U.S.A. 7048N 31-2/F

May cause pressure increase in normal eye.

PRECAUTIONS: To avoid excessive systemic absorption particularly in children the lacrimal puncta should be occluded by digital pressure for one minute after instillation.

ADVERSE REACTIONS: Conjunctival vasodilatation occurs following instillation. Sensitivity infrequently results; however, if it does, discontinuance and routine therapy will ordinarily be effective.

DOSAGE AND ADMINISTRATION: For refraction: one or two drops topically in the eye(s), may be repeated in 20 minutes if necessary. For therapy: one or two drops topically every three to four hours.

HOW SUPPLIED: In 5ml and 15ml plastic Drop-Tainer® dispensers.

ALCON LABORATORIES, INC.
Fort Worth, Texas 76134 USA
September 1974 29001 Printed in USA

Homatropine

ocular pressure. Use of Cyclopentolate has been associated with psychotic reactions and behavorial disturbances in children especially with 2% concentration. Ataxia, incoherent speech, restlessness, hallucinations, disorientation as to time and place, failure to recognize people, and tachycardia have been reported.

DOSAGE AND ADMINISTRATION: Adults: One drop, followed by a second drop in 5 minutes. Although complete recovery usually occurs in 24 hours, 1 or 2 drops of 1% or 2% pilocarpine reduces recovery time to 3 to 5 hours in most eyes. In patients with darkly pigmented irises, the use of 2% solution is recommended; the 1% solution also has produced satisfactory results. Subsequent instillation of 2% pilocarpine reduces recovery time to 6 hours or less. Children: Pretreatment with Cyclogyl on the day prior to examination usually is not necessary. One drop of 0.5%, 1% or 2% solution is instilled in each eye, followed 5 minutes later by a second application of 0.5% or 1% solution if necessary. On rare occasions, atropine-like symptoms have been produced in children as a result of overdosage with the 2% solution.

HOW SUPPLIED: ½%, 1% and 2% each in 2ml, 5ml, and 15ml multiple-dose plastic Drop-Tainer® dispensers.

Alcon

ALCON LABORATORIES, INC.
May 1976 29003 Printed in USA

Cyclogyl

gentle compression of the lacrimal sac for a minute or two following instillation. Sac compression blocks passage of the drops to the extensive absorption area of the nasal and pharyngeal mucosa. This is most advisable in children and with the stronger solution. Possibility of occurrence in children of psychotic reaction and behavioral disturbance due to hypersensitivity to antimuscarinic drugs should be borne in mind.

ADVERSE REACTIONS: Increased intraocular pressure. Psychotic reactions, behavioral disturbances, and cardiorespiratory collapse in children with this class of drugs have been reported. Transient stinging, dryness of the mouth, blurred vision, photophobia with or without corneal staining, tachycardia, headache, parasympathetic stimulation, or allergic reaction may occur.

DOSAGE AND ADMINISTRATION: For refraction, one or two drops of 1.0% solution in the eye(s), repeated in five minutes. If patient is not seen within 20 to 30 minutes, an additional drop may be instilled to prolong mydriatic effect. For examination of fundus, one or two drops of 0.5% solution 15 or 20 minutes prior to examination.

HOW SUPPLIED: 0.5% and 1.0% solutions in 15ml plastic Drop-Tainer® dispensers.

STORAGE: Store at 46° to 75° F. Do not refrigerate or store at high temperatures. Keep container tightly closed.

Alcon

ALCON LABORATORIES, INC.
Fort Worth, Texas 76134 USA
June 1975 29004 Printed in USA

Mydriacyl

before intraocular surgery, the 10 per cent ophthalmic solution (plain or viscous) or 2.5 per cent ophthalmic solution may be applied topically from 30 to 60 minutes before the operation.

Refraction

Prior to determination of refractive errors, Neo-Synephrine hydrochloride 2.5 per cent ophthalmic solution may be used effectively with homatropine hydrobromide, atropine sulfate, or a combination of homatropine and cocaine hydrochloride.

For *adults*, a drop of the preferred cycloplegic is placed in each eye, followed in five minutes by 1 drop of Neo-Synephrine hydrochloride 2.5 per cent ophthalmic solution and in ten minutes by another drop of the cycloplegic. In 50 to 60 minutes, the eyes are ready for refraction.

For *children*, a drop of atropine sulfate 1 per cent is placed in each eye, followed in 10 to 15 minutes by 1 drop of Neo-Synephrine hydrochloride 2.5 per cent ophthalmic solution and in five to ten minutes by a second drop of atropine sulfate 1 per cent. In one to two hours, the eyes are ready for refraction.

For a "one application method," Neo-Synephrine hydrochloride 2.5 per cent ophthalmic solution may be combined with a cycloplegic to elicit synergistic action. The additive effect varies depending on the patient. Therefore, when using a "one application method," it may be desirable to increase the concentration of the cycloplegic.

Ophthalmoscopic Examination

One drop of Neo-Synephrine hydrochloride 2.5 per cent ophthalmic solution is placed in each eye. Sufficient

mydriasis to permit examination is produced in 15 to 30 minutes. Dilatation lasts from one to three hours.

Diagnostic Procedures

Provocative Test for Angle Block in Patients with Glaucoma: The 2.5 per cent ophthalmic solution may be used as a provocative test when latent increased intraocular pressure is suspected. Tension is measured before application of Neo-Synephrine hydrochloride and again after dilatation. A 3 to 5 mm. of mercury rise in pressure suggests the presence of angle block in patients with glaucoma; however, failure to obtain such a rise does not preclude the presence of glaucoma from other causes.

Shadow Test (Retinoscopy): When dilatation of the pupil without cycloplegic action is desired for the shadow test, the 2.5 per cent ophthalmic solution may be used alone.

Blanching Test: One or 2 drops of the 2.5 per cent ophthalmic solution should be applied to the injected eye. After five minutes, examine for perilimbal blanching. If blanching occurs, the congestion is superficial and probably does not indicate iritis.

HOW SUPPLIED

In Mono-Drop® (plastic dropper) bottle:

Low surface tension solutions

2.5 per cent ophthalmic solution—Neo-Synephrine hydrochloride 2.5 per cent in a sterile, isotonic, buffered, low surface tension vehicle with sodium phosphate, sodium bi-

phosphate, boric acid, and, as antiseptic preservative, Zephiran® Chloride (brand of benzalkonium chloride, USP) 1:7500. The pH is adjusted with phosphoric acid or sodium hydroxide.

Bottles of 15 ml.

10 per cent ophthalmic solution—Neo-Synephrine hydrochloride 10 per cent in a sterile, buffered, low surface tension vehicle with sodium phosphate, sodium biphosphate, and, as antiseptic preservative, Zephiran Chloride 1:10,000. The pH is adjusted with phosphoric acid or sodium hydroxide.

Bottles of 5 ml.

Viscous solution

10 per cent ophthalmic solution—Neo-Synephrine hydrochloride 10 per cent in a sterile, buffered, viscous vehicle with sodium phosphate, sodium biphosphate, methylcellulose, and, as antiseptic preservative, Zephiran Chloride 1:10,000. The pH is adjusted with phosphoric acid or sodium hydroxide.

Bottles of 5 ml.

Winthrop

Winthrop Laboratories Division of Sterling Drug Inc.
New York, N.Y. 10016

PRINTED IN U.S.A. Revised November 1970 (7469-K)

NEO-SYNEPHRINE®
HYDROCHLORIDE

Brand of

phenylephrine hydrochloride ophthalmic solution, USP

Vasoconstrictor and Mydriatic

SOLUTIONS 2.5% AND 10%

VISCOUS SOLUTION 10%

For Use in Ophthalmology

WARNING: PHYSICIANS SHOULD COMPLETELY FAMILIARIZE THEMSELVES WITH THE COMPLETE CONTENTS OF THIS LEAFLET BEFORE PRESCRIBING NEO-SYNEPHRINE.

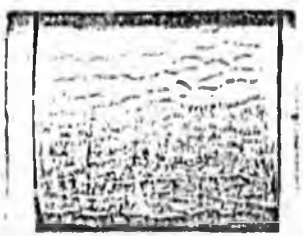
DESCRIPTION

NEO-SYNEPHRINE hydrochloride is a synthetic sympathomimetic compound structurally similar to epinephrine and ephedrine.

ACTION

Neo-Synephrine hydrochloride is used for disorders of the eye because of its vasoconstrictor and mydriatic action.

The ophthalmologic usefulness of Neo-Synephrine hydrochloride is due to its rapid effect, moderately prolonged action, and effectiveness even when administered repeatedly, as well as to the fact that it produces no compensatory vasodilatation. In addition, undesirable systemic side effects are extremely rare.



The action of different concentrations of ophthalmic solutions of Neo-Synephrine hydrochloride is shown in the following table:

Strength of solution (%)	Mydriasis		Paralysis of accommodation
	Maximal (minutes)	Recovery time (hours)	
2.5	15-60	3	trace
10	10-60	6	slight

INDICATIONS

Neo-Synephrine hydrochloride is recommended for use as a decongestant and vasoconstrictor and for pupil dilatation in uveitis (posterior synechiae), wide angle glaucoma, surgery, refraction, ophthalmoscopic examination, and diagnostic procedures.

CONTRAINDICATIONS

Ophthalmic solutions of Neo-Synephrine hydrochloride are contraindicated in persons with narrow angle glaucoma. Neo-Synephrine hydrochloride 10 per cent solution (plain or viscous) is contraindicated in infants.

WARNINGS

As with all other adrenergic drugs, when Neo-Synephrine 10 per cent ophthalmic solution (plain or viscous) or 2.5 per cent ophthalmic solution is administered simultaneously with, or up to 21 days after, administration of monoamine oxidase (MAO) inhibitors, careful supervision and adjustment of dosages are required since exaggerated

adrenergic effects may result. The pressor response of adrenergic agents may also be potentiated by tricyclic antidepressants.

PRECAUTIONS

Ordinarily, any mydriatic, including Neo-Synephrine hydrochloride, is contraindicated in patients with glaucoma, since it may occasionally raise intraocular pressure. However, when temporary dilatation of the pupil may free adhesions or when vasoconstriction of intrinsic vessels may lower intraocular tension, these advantages may temporarily outweigh the danger from coincident dilatation of the pupil.

Elevated blood pressure is rare but has been reported after conjunctival instillation of customary doses of Neo-Synephrine 10 per cent ophthalmic solution (plain or viscous). Since each drop of medication contains approximately 5.0 to 7.5 mg. of phenylephrine, the blood pressure of those patients in whom absorption of a significant part of this dose would be undesirable should be carefully monitored. Caution, therefore, should be exercised in administering the 10 per cent solution (plain or viscous) to patients with marked hypertension, advanced arteriosclerotic changes, children of low body weight (see Contraindications), or as a topical application to any vascular area of the body where considerable absorption can be anticipated.

Rebound miosis has been reported in older persons one day after receiving Neo-Synephrine hydrochloride ophthalmic solutions, and reinstillation of the drug produced a reduction in mydriasis. This may be of clinical importance in dilating the pupils of older subjects prior to retinal detachment or cataract surgery.

Due to a strong action of the drug on the dilator muscle, older individuals may also develop transient pigment floaters in the aqueous humor 30 to 45 minutes following the administration of Neo-Synephrine hydrochloride ophthalmic solutions. The appearance may be similar to anterior uveitis or to a microscopic hyphema.

To prevent pain, a drop of suitable topical anesthetic may be applied before using the 10 per cent ophthalmic solution.

DOSAGE AND ADMINISTRATION

Prolonged exposure to air or strong light may cause oxidation and discoloration. Do not use if solution is brown or contains a precipitate.

Vasoconstriction and Pupil Dilatation

Neo-Synephrine hydrochloride 10 per cent ophthalmic solution (plain or viscous) is especially useful when rapid and powerful dilatation of the pupil and reduction of congestion in the capillary bed are desired. A drop of a suitable topical anesthetic may be applied, followed in a few minutes by 1 drop of the Neo-Synephrine hydrochloride 10 per cent ophthalmic solution on the upper limbus. The anesthetic prevents stinging and consequent dilution of the solution by lacrimation. It may occasionally be necessary to repeat the instillation after one hour, again preceded by the use of the topical anesthetic.

Uveitis: Posterior Synechiae

Neo-Synephrine hydrochloride 10 per cent ophthalmic solution (plain or viscous) may be used in patients with uveitis when synechiae are present or may develop. The formation of synechiae may be prevented by the use of the 10 per cent ophthalmic solution

(plain or viscous) and atropine to produce wide dilatation of the pupil. It should be emphasized, however, that the vasoconstrictor effect of Neo-Synephrine hydrochloride may be antagonistic to the increase of local blood flow in uveal infection.

To free recently formed posterior synechiae, 1 drop of the 10-per cent ophthalmic solution (plain or viscous) may be applied to the upper surface of the cornea. On the following day, treatment may be continued if necessary. In the interim, hot compresses should be applied for five or ten minutes three times a day, with 1 drop of a 1 or 2 per cent solution of atropine sulfate before and after each series of compresses.

Glaucoma

In certain patients with glaucoma, temporary reduction of intraocular tension may be attained by producing vasoconstriction of the intraocular vessels; this may be accomplished by placing 1 drop of the 10 per cent ophthalmic solution (plain or viscous) on the upper surface of the cornea. This treatment may be repeated as often as necessary.

Neo-Synephrine hydrochloride may be used with mioties in patients with wide angle glaucoma. It reduces the difficulties experienced by the patient because of the small field produced by miosis, and still-it permits and often supports the effect of the miotic in lowering the intraocular pressure. Hence, there may be marked improvement in visual acuity after using Neo-Synephrine hydrochloride in conjunction with miotic drugs.

Surgery

When a short-acting mydriatic is needed for wide dilatation of the pupil

HB664 3-14-78 Dr. Marvin Brendahl

I. EYE HEALTH CARE PROVIDERS OF THE CONSUMING PUBLIC

The American Optometric Association defines an optometrist as:

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

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

1. "optometry" is the employment of means or methods, other than the use of drugs, for the diagnosis of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription or application of lenses, prisms or ocular exercises for the correction or relief of the human eye;

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

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

The ophthalmologist is a medical doctor who has completed a 3-5 year residency program after one year internship[2] preceeded by 4 years of college and 4 years of medical school. He is trained in the diagnosis and treatment of ocular dysfunction and disease and in the use of all techniques or treatment including drugs, surgery, laser photocoagulation, radiation, etc. Because he has

been trained as a general physician first, his perspective of the eye is broader than the optometrist. He views the eye and its diseases within the context of the whole body physiology and pathology.[3] Further, refraction to the ophthalmologist is viewed as only one necessary step in a differential diagnosis of the patient's complaint, Table 1 demonstrated the overall education and numbers of optometrists and ophthalmologists. From Table 1 it is evident that ophthalmologists have much more training in pharmacology and pathology than the optometrists. Still the optometrists continue to compare their curriculum hours to dental school curriculum hours. This is like comparing apples to oranges. They are not asking to use the drugs dentists use or to diagnose oral pathology. They are asking to do what the ophthalmologist does. Therefore, it is more accurate to compare ophthalmologists curriculum hours to optometric curriculum hours.

Table 2[4] gives a comparison of consumer services offered by ophthalmologists and optometrists. It is quite apparent that there is considerable overlap. This is most apparent with respect to refractions. The optometrist obviously can do some of the things the ophthalmologist can do; the ophthalmologist can do all of the things the optometrist can do, has the education to better interpret the data acquired, and provide medical/surgical treatment. The ophthalmologist is trained to provide complete eye care and to evaluate ocular dysfunction in the context of total body physiology and pathology. Although the overlap of professional services is greatest for refractions, this is a source of considerable consumer spending in both professions.

II. ECONOMICS (AND PRACTICE)?

Table 3[5] shows the substantial number of public dollars which are expended for eye care. A total of approximately $3,135 million dollars were spent in 1975 for vision care services.[6] The national consumer spending for ophthalmic surgery is not listed. This would make the total ophthalmologic dollar spent on eye care far greater than the optometric dollar. If optometrists are allowed to expand the scope of their practice through the use of diagnostic drugs, the price of the basic eye examination would undoubtedly rise. Proposed national health care legislation

can be expected to impact heavily upon these figures. For example, if the Kennedy-Mills proposal were to include coverage of sight correction services, total spending for these services would rise by 21% or $866 million dollars per year. It is obvious that there will be considerable effort by vision care providers to ensure their fullest possible participating in this program. The economic stakes are very high.[7] This makes it very clear why optometry has put on an aggressive nationally organized push to legislate themselves into a better position to compete for this consumer dollar. Even though the optometrists in the State of Alaska suggest that this is not a "money bill" it is. It is merely the first step toward the national optometric goal to become the primary eye care provider. We should expect that in the future the Alaska optometrists to follow the attempt of other states optometric associations to next try for the priveledge to use these same diagnostic drugs as theraputic agents. An attempt was made in West Virginia to legislate the privelage of eye surgery but this was defeated.

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

Table 1, indicates the total number of practitioners in each group.[8] The median number of patients seen per week by optometrists was 43.2; the median seen by ophthalmologist was 102.[9] The ophthalmologist sees more than twice as many patients as the optometrist while he comprises only 30% of the work force. It is, therefore, clear that the ophthalmologists care for half the patients, while the optometrists, comprising 70% of the national work force, care for the other half. The statistics in Alaska show that their is a total of 40 optometrists[10] and 25 ophthalmologists.[10] Thus the