ophthalmologists make up 39% of the state work force and the optometrists 61%. Applying the same national ratio of eye consumers seen by optometrists and ophthalmologists, it is evident that the ophthalmologists see 56% of the eye care consumer, but makes up 39% of the state work force. The accuracy of the ratio of two to one was checked in the city of Anchorage by comparing the number of eye consumers seen by the most active ophthalmologist in town-40-50 eye consumers-as compared to the most active optometrist in town-20-25 eye consumers-seen in one day. These figures would seem to indicate that although ophthalmologists are a smaller group than optometrists, the public will work out their services given a free market choice.[11] On this point, the eye consumer in the State of Alaska has ready access to the ophthalmologic eye care providers. Some of the states in the lower 48 are mainly rural and ophthalmologists are congregated in the metropolitan areas and the optometrists are distributed over the rural areas. However, much of Alaska is "bush country", so that the ophthalmologists and optometrists are congregated in Anchorage, Fairbanks, Kenai Peninsula and the southeast. There are only two areas-Kodiak and Bethal-that have a full time optometrist and no full time ophthalmologist, Table-Map 5,6. However, there are other medical doctors in these communities with "medical know how" and there are airports for evacuation in the case of eye emergencies. Furthermore, Kodiak and Bethel are visited on a regular basis by itinernat ophthalmologists. In fact, most areas in Alaska are served by itinerant ophthalmologists both by the Alaska Native Service and by private practicing ophthalmologists, Table-Map 6. In the 14 other states where a similar bill was passed, these states were mainly rural with a maldistribution of ophthalmologists. In these states this was the main reason for passing this legislation. Therefore, this argument for passing house bill 664 does not apply to the State of Alaska, because the distribution of ophthalmologists is essentially identical to that of the optometrists. Thus, the health services of ophthalmologists are readily available to

people in all sections of the state and in many small communities through the itinerant program.

In the states where optometric drug laws are in effect, optometrists who wish to use drugs must take short slide and lecture courses on pharmacology. This has or will create two classes of optometrists, which can only lead to additional consumer confufsion about a profession already shrouded in confusion. In addition, the use of drugs by optometrists could falsely lead patients to believe diagnostic expertise is available from optometrists. It is misleading to the consumer and legislature to imply that any drug is purely diagnostic. Each of the classes of drugs asked for by optometry also are theraputic drugs. Will the optometrists resist the temptation to use these drugs to treat conditions beyond their knowlege and skill?

III. LEGISLATIVE DUTY FOR THE EYE CARE CONSUMER:

As practitioners of an occupation which deals with the integrity of eyesight, optometrists have been recognized by the Washington Legislators as members of a "learned profession".[12] Professionals who deliver health care may be regulated by the state via its police powers to oversee those activities which are involved with health, education and welfare.[13] The healing arts particularly have been the subject of regulatory legislation which specifies strict requirements for the practice of such perfessions.[14] The intent of such restrictive legislation is avowadly the protection of the public against injuries it may suffer from the conduct of such business or calling.[15] The state may reasonably impose any condition precedent to the grant of its consent to practice a healing art, which has a real and rational relation to that objective.[16] The usual means taken by the state in applying these conditions as quality standards has been by imposing licensing requirements and by carefully defining the particular professions involved.[17] Constitutional challenges to this power of the state have been universally defeated when that power has been reasonably exercised.[18]

Licensing requirements usually specify minimum standards of professional competence for the profession covered and frequently the definition of the profession gives braod areas of practice which will be considered appropriate for the practitioner seeking licensure. Additional restrictions upon the practice can be found in state statutes which define unprofessional or unethical conduct. [19]

The above state powers are broad and greatly influence the scope and freedom of practice by the health care provider. Although the right to follow a profession is recognized as a valuable property right which is constitutionally protected,[20] such a right is not absolute; there is no natural or vested right to practice within the healing professions. Any such right is a conditional one.[21]

The justification for such regualtions lies in a perceived right and duty of the legislature to protect the citizens of the state from incompetants and fraudulent health practitioners.[22] The Washington Constitution specifically vests exclusive authority in the legislature to:

> "...regulate the practice of medicine and surgery and the sale of drugs and medicines."[23]

From this, courts have construed legislative authority to regulate, by means of separate statutory licensing requirements, all of the various professions and o cupations engaged in health care delivery. This includes many professions which are not obviously included in "...the practice of medicine..."[24] Further, the state has the power to define what constitutes the practice of any profession and may then confine practitioners of various health disciplines to the particular system of practice in which they have been educated.[25]

This is a logical stance for the legislature to take. If the legislature has an avowed interest in protecting the public [26] it must make some attempt at defining the scope of appropriate practice which each class may safely employ and to license those within each class to practice upon the public

only those skills for which they have demonstrated competant training. That includes courses, testing and most important of all, clinical experience under supervision. This is the manifest legislative intent in enacting licensing statutes.[27] This reasoning is followed with consistency in cases involving almost every viewpoint and aspect of health care.[28]

Great latitude is given by the courts to the legislature in defining its public health goals. However, the goal is universally stated to be the protection of public health. Health legislation is not passed to promote the personal ends of individuals or to enhance the status or prestige of any given class of practitioners.[29] Although the legislature may enact such regulatory legislation as it may consider necessary, there must be a rational basis upon which the legislative determination rest.[30] This cannot be interpreted as meaning anythin less than that such legislation must appear to be rationally directed toward the achievement of the stated legislative goal and to be reasonably rational in the means which it seeks to achieve that goal.

a) Goal- As noted above, the frequently given objective for regulation of health care providers is the protection of the public from incompetant practitioners.[31]

This goal is stated to exist even if it deprives a citizen of a right he otherwise might enjoy in the pursuit of his profession.[32]

This reasoning leads to the conclusion that the legislature has the duty to ensure that its acts and statutes do not tend to increase public exposure to health risk.[33] The stated legislative goal is increased public protection, not increased public risk. Nowhere does case law state that public protection will be qualified-ie, that the legislature may increase the risk "a little bit", but not "a lot". No such slippery subjective terms appear. The intent is protection. The language is explicit.

b) Means - The means by which the legislature attempts to arrive at its stated goal must be reasonable and rational.[34] The means which have been used by all states to regualte the professions have been noted above. The states have attempted to ensure the competency of each practitioner and then limit each to the area of practice embraced within the training which that practitioner has received.[35] If this means anything, it must mean that before the provider is allowed to administer to an uninformed public, (45% of the public does not know the difference between an ophthalmologist and an optometrist)[48] he must provide evidence of training sufficient to ensure the public from health care which is inadequate. Such inadequacy can range from innocuously imporper diagnoses which are nonetheless economically costly, to disabling or fatal mistakes in clinical judgement - either diagnostic or the end result therapeutic.

In so far as it can ever be sure of the quality of professional performance, the state has two related ways to oversee clinical performance.

The state may require evidence of formal professional training which has as its foundation and primary goal, a strong commitment to an understanding and clinical application of those methods, techniques and material to which the public will be exposed and which will place it at risk. Such training must satisfactorily convince the legislature that when it certifies the practitioner, the legislative duty to prevent risk of public harm has been met.

Using the data presented in the first portion of this testimony, it is apparent that optometric training as it now exists in the State of Alaska is not directed toward a broad understanding of human pathology/physiology/pharmocology with supervized clinical experience.[43] Training is limited to a superficial, most theoretical, presentation of data concerning ocular dysfunction with inadequate clinical supervised experience. Not only do the data show that the instruction given the optometric student is very limited but little or no integration of visual disease/function

is made with 'whole body' disease/function. The eye is studied in isolation as an optical instrument. To use an analogy, an operating room nurse could teach an optometrist about eye surgery, just as a pharmacologist Ph.D. can teach an optometrist about pharmacology. However, no one would want an optometrist to perform surgery with an education based only on lectures and theoretical familiarity with the sutject. The prescribing and using of drugs, just like the performance of surgery, must be founded on a broad-based curriculum involving many hours of supervised clinical experience using drugs. To allow any health care provider to practice with only limited classroom experience and testing violates the legislative duty to protect the public from risk of incompetency from lack of clinical experience.[43]

As a second step. the legislature can require continuing education for those practitioners who have already completedbroad formal training upon which additional, up-dated information may be rationally correlated. This type of post-graduate instruction always preseumes in-depth background knowledge. It is used to present newly altered clinical concepts or additional practical experience (e.g., using operating microscopes, intraocular lens implant, etc.) for those practitioners with clinical experience sufficient to allow them to understand the usefulness or pitfalls, to see the advantages or clear disadvantages, to comprehend the clinical reliability or dangers of the material which the course is presenting. Crash courses which involve totally new material, presented to practitioners without that clinical judgement or experience necessary to actually grasp the real impact of the data presented, let alone the nuances, can be expected to create clinicians who will test their newly acquired knowlege in the public sphere. The hazards of such an appraoch are obvious. Again, such an approach does not satisfy the legislative duty to reduce public risk.

I must conclude that for the state to allow graduates of optometric schools, who are unarguably well-trained in the limited sphere of practice which optometry has exercised to date, to extend their

clincial practice to include the application of drugs to the eye would be an irrational approach toward the protection of public health.[43] If the curricula of optometric schools demonstrated sufficiently integrated instruction in human anatomy/pharmacology/physiology/pathology to provide the optometric graduate with an adequate basis for making appropriate clinical decisions of diagnosis, then such a legislative extension of clinical opportunity, and responsibility would be reasonable. Crash courses are not an adequate substitue[38] for many hours of supervised clinical experience.[43]

It should be repeated that the strong interest of the state in protecting the public, has traditionally and appropriately placed rigid conditions and restrictions upon the right to affect public health.[39] It should also be repeated that this power to restrict health care practice is recognized as proper regardless of its effect upon the economic interests of those regulated.[40]

It is doubtfull that an informed public would voluntarily accept a role as an on-the-job training clinical practice model so that the optometrists can gain the clinical experience needed to use drugs. The consumer public currently has expectations which include a higher standard of knowledge by the medical service provider than ever before. These expectations directly flow from the public's increased understanding that they each, as individual complex biologic units, are biochemically affected in manifold ways via the environment, foods and drugs. Any legislative change which would franchise greater administration of drugs and which simultaneously does not require firm, convincing evidence of a profound understanding of the disease to be detected, its effect on the human body, the biochemistry of the drug to be used, ignores the public right to be protected from incompetency and the public right to make decisions concerning its health care. The public has a right to understand that any practitioner, presuming to diagnosis ocular disease that usually have total body manifestations, is making diagnostic decisions based upon training which comprehends all of the above principles.

IV. AGENCY ACTION FOR ASSURRANCE OF THE HIGHEST QUALITY EYE CARE FOR THE CONSUMER.

The public should be able to rely upon state certification of competency. Legislation which does not demand evidence of such competency before certification fails in its duty to provide public protection in matters of health.

Currently, states have little control over the calibre of training which optometrists acquire prior to licensure. An optometrist may have trained in an optometric school unaffiliated with any medical center, he may have obtained the minimal training necessary to qualify for graduation, but once having graduated, he can apply for and obtain a license with ease.[41]

The State Board of Optometry certifies the competency to use drugs of those optometrists which it approves for licensing.[42] Two problems are immediately apparent:

1) The members of the Board of Optometry have little personal experience in ocular pharmacology, ocular pathology, and diagnosis. They are themselves graduate of optometry schools which have offered limited training because the board members took their training when little time was devoted to course work in pharmacology, and now have little experience with drugs. It is difficult to see how such a Board can adequately evaluate such clinical ability in optometric applicants for licensure, nor is it clear how such a Board can construct any 'refresher' course that would adequately prepare the optometrist for his broadened responsibilities. What is usually used is a 'canned' course, prepared elsewhere.

2) The ability of the Board to carry out its mandate to protect the public from those few individuals that would use these diagnostic drugs also as theraputic drugs would find themselves in a frustrated position. The Board can do nothing to prevent this and the fine for practicing medicine without a medical license is only $100.00.

The regulation of the profession by the Optometric Board will be considered appropriate so long as it is reasonable and necessary in the interest of health, safety of the people.[44] Licensing of optometrists by a Board itself lacking in the necessary qualifications to evaluate clinical performance and knowledge, is manifestly unreasonable. To grant the right to optometrists to use diagnostic drugs who are poorly qualified to do so, is not a reasonable, or an appropriate, or a necessary means of 'protecting'the public health.

The regulation of the practice of optometry is not for the benefit of the licensee, but for the state and its people.[45] Certainly, if the practice of medicine and surgery is a proper subject for careful and precise legislation, so also should be legislation which concerns eye care and those who provide it to the public.[46]

V. CONCLUSION

Having looked critically at the past trend toward the expansion of optometr .c sercies into medical care, and with the present trend of more and more states defeating this kind of bill, it is proper that some statement be made regarding an appropriate role for this vision care professional.

If the optometrist will be expected to diagnose eye disease, then one of two events must occur:

1) optometric training must be upgraded substantially enough to provide him with clinical expertise sufficient to satisfy appropriate public expectations of high competencey; or

2) optometrists must work in an association with ophthalmologists close enough to provide for the day-to-day transmission of diagnotic information from the M.D. to the O.D., and allow the latter to obtain practical involvement in treatment rationals and administration. This would be similar to the military, Veterans Administration and Alaska Native Service, where the optometrist use these drugs under the direct supervision of the ophthalmologists.[47]

Having once recoginzed the above solutions two problems immediately present themselves. The first solution would require the relocation of optometric schools to permit integration with medical training and include a complete restructuring of optometric training. So much change would be needed that any difference between the ophthalmologist and optometrist would evaporate. However, if any group of practitioners presumes to medically minister to the public it must accept the rigorous training which must preceed such responsibility. There is no quick and easy path to competent understanding of a subject becoming increasingly complex year-by-year. This is particularly true when the results of error or incompetency can be blindness.

The second solution, close day-to-day association of optometrist/ophthalmologist, creates a psychological hurdle - perhaps an economic one as well. Optometrists would be required to visualize themselves in a supportive role. This is difficult for any professional to do, especially if he has historically been conditioned to see himself as a member of a separate group, practicing independently. So long as he can offer only limited eye care, he is in a supportive role to those who offer complete eye care. This cooperative association is currently working well in the Veteran's Administration System, the military and the Alaska Native Service It could work well in private care.

Finally, if state legislatures believe that it is proper to expand the medical opportunities of this health-care group of practitioners via redefinition and short-course catch-up lectures without restructuring fundamental educational requirements and experience, there can be little rationale for not doing the same for <u>all</u> paramedical groups, e.g. naturopaths, acupuncturists, chiropractors, faith healers.

Rationally, the legislature must either strictly require very high state-of-the-art medical training standards to protect its citizens or it should minimize that responsibility and lower its standards to permit each group to economically advance at the public expense. The latter practice would also reduce the educational time and

experience required to produce specialist M.D.'s- but, of course, such physicians would be recognized as marginally or totally incompetent. Should the standard be any different for optometrists who wish to medically diagnose eye disease that is so closely linked with the body as a hole functioning unit?

Thank you for your time and the opportunity to present this view indorsed by the State Ophthalmologic Association.

TABLE I

SYMPOSIUM ON LEGISLATION

Comparison of Optometry and Ophthalmology

	Optometrists	Ophthalmologists
1 - License	In all staes as optometrists	In all states as Physicians and Surgeons
2 - Prerequisite	2 yrs of college (60% if beginning students have baccalaureate degree or higher	Graduation from Medical School(M.D.)
3 - Curriculum	School or college	Medical school internship, Postgraduate (residency)
Pharmacology	64 hours	187 hours general with 18 months clinical and 120 hours ocular with 3 years clinical.
Pathology	20 hours	200 hours general with 3 years clinicl and 148 hours ocular with 3 years clinical
4 - Period of training	4 yr(34-36months)	3-5yr.(36-60months)
5 - Time for education after high school	6-10 yr(54-72 months)	11-14yr(120 months)
6 - Number of active practitioners	21,900	9,322
7 - Number of students	4,985	1,914(residents)
8 - Total number of practitioners and students	24,933	10,496
9 - Total number of eye professionals	24,800(70% of total)	10,629 (30% of total)

TABLE 2

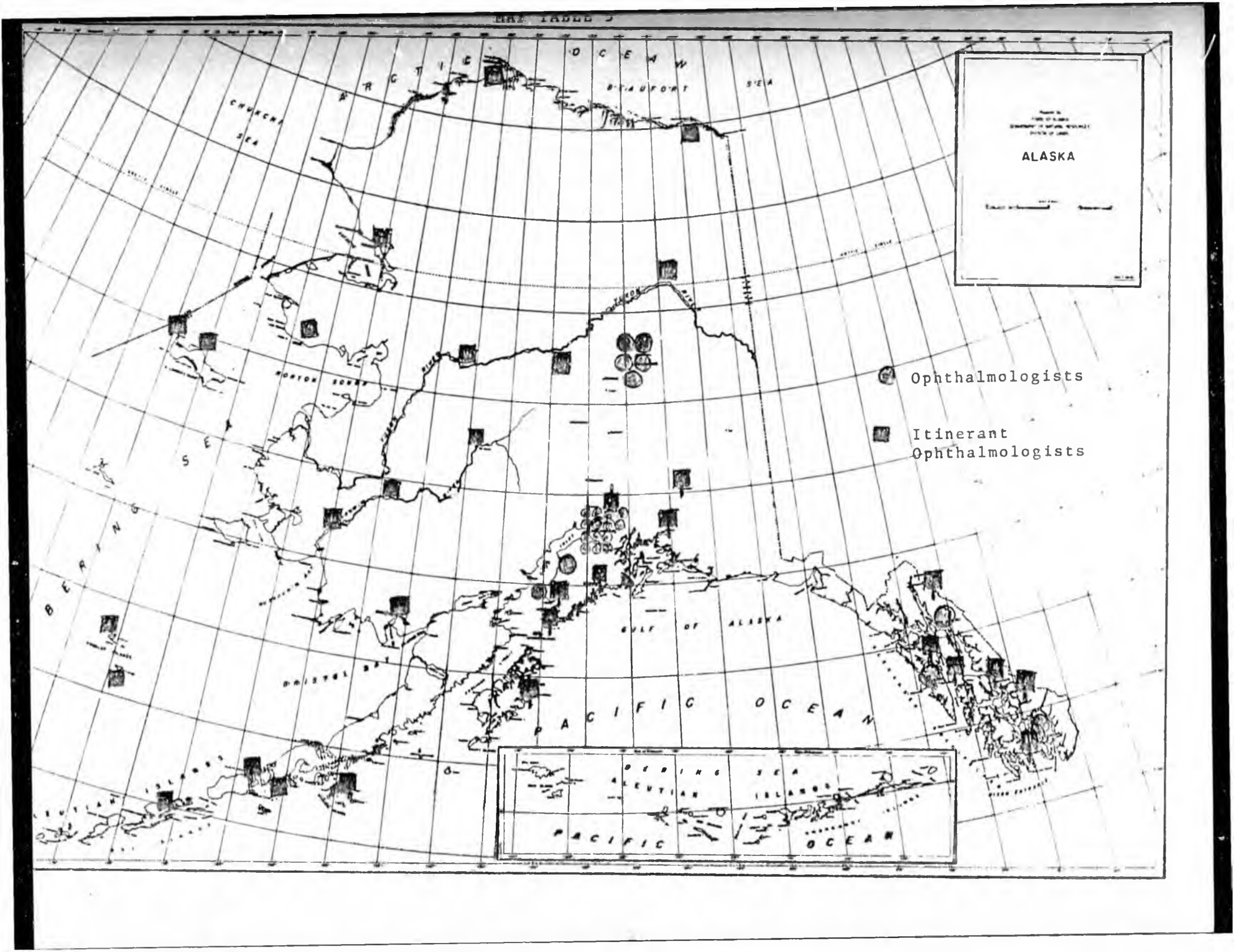
Service offered by Optometrist and Ophthalmologist

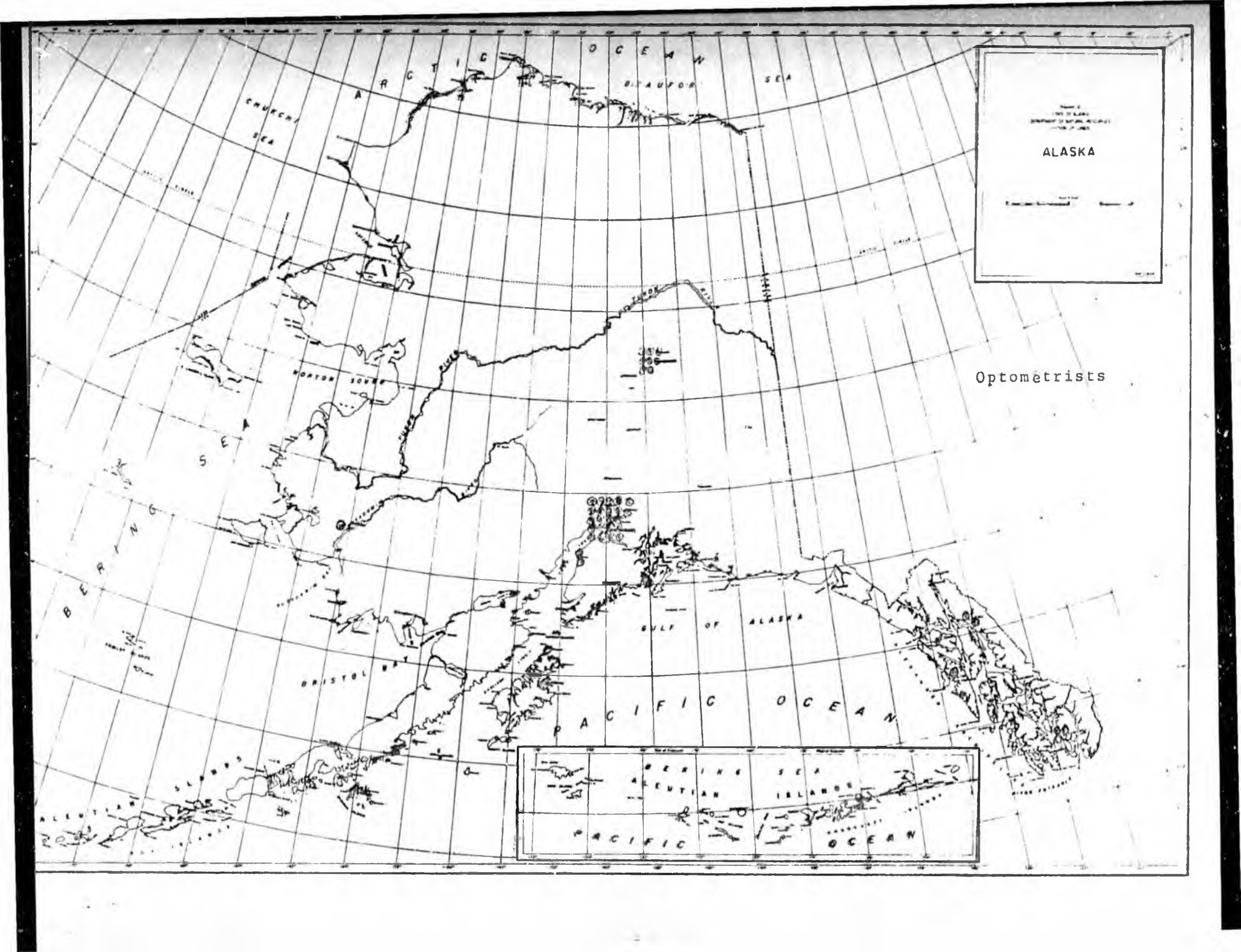
Service	Optometrists	Ophthalmologists
Refraction	99%	99.5%
Ophthalmoscopy	92%	99.5%
Contact Lenses	79%	58%
Visual Fields	75%	94%
Tonometry	66%	99.5%
Orthoptics	50%	53%
Low-vision aids	40%	55%
Biomicroscopy	32%	99.5%
Aniseikonic Testing	8%	9%
Treatment of eye disease	1-2%	100%
West Virginia and North Carolina		
Surgery	0%	99%

TABLE 3

CIVILIAN CONSUMER SPENDING FOR VISION CARE AND SIGHT CORRECTION SERVICES IN 1975

	OFFICES OF OPTOMETRISTS	OFFICES OF OPHTHALMOLOGISTS
A. Expenditures		
General examinations	$525	$510
Medical treatment and therapy	40	500
Ophthalmic Services:		
Corrective Eye glass Lenses	865(49.6%)	180(14%)
Contact Lenses	285	60
Other	30	
	1,745	1,250


ALASKA
Ophthalmologists
Itinerant Ophthalmologists
ARCTIC OCEAN
BEAUFORT SEA
CHUKCHI SEA
NORTON SOUND
BERING SEA
BRISTOL BAY
GULF OF ALASKA
PACIFIC OCEAN
ALEUTIAN ISLANDS



Optometrists

FOOTNOTES:

1 - Worthen: The Ophthalmologic-Optometric Interface. Transactions of American Academy of Ophthalmology and Otolaryngology *3:OP-155, 1977

2 - Representativ of most ophthalmology residency programs, it is that of the University of Minnesota, Mayo Clinic Graduate School of Medicine. Following graduation from Medical school and a general or specialty internship, the resident enters a program which requires 65 hours a week of ophthalmologic instruction; of this, approximately 8 hours a week is devoted to formal, diadactic lecture, the remainder is clinical or laboratory activity. This weekly schedule continues over a twelve month academic year, for three years. Some of a nine month written home study course administered by the Academy of Ophthalmology. Some programs require an additional one year of ophthalmology. Department of Ophthalmology, University of Minnesota, Mayo Clinic Resident 1974-1977.

3 - Curriculum,University of Minnesota College of Medicine. The basic curriculum required of any candidate for an M.D. degree includes 128 credit hours of 'medical' subjects; this does not includ clinical studies which are specifically directed toward a specialty interest. Although optometrists may agrue that these requirements are not appropriate for them, such an analysis ignores the fact that in expanding their role into the practice of medicine optometrists should be subjected to the same educational requirements. Unfortunately, there is no short-cut to professional competence. This is particularly ture in the rapidly expanding and complex field of medicine. The public has a right to demand strict legislative requirements before practitioners are certified as competent.

4 - Worthen, note 1, OP-158, supra.

5 - Trapnell, The Impact of National Health Insurance on the Use and Spending for Sight Correction Service, 1976. (This study was underwritten by the American Optometric Association, and the Optical Manufactures Association.) It reveals that optical device sales represent 66% of the funds expended for optometric services and 19% of funds expended for ophthalmologist services, at Tabel 1 of the Trapwell Study.

6 - This figure includes $920 million spent for optician and $220 spent by institutions. Those categories of service providers are not included in this discussion since they are not involved in patient care.

7 - This economic impact will be divided not only by optometrist and ophthalmologists, but also by opticians and lens/fram/contact lens manufacturers.

8 - Worthen, note , Op-157, supra.

9 - On Blue Shield Survey: In 1975, actuaries for Blue Shield in Connecticut requested of optometrists data necessary to project the cost of insurance covering optometric examinations. One hundred sixty six out of 266 active optometrists responed listing their age, number of years in practice, and number of eye examinations performed each year, and the cost of an eye examination, exclusive of the cost of glasses, so called service charges or visual training. Similar data was gleaned from ophthalmologists, It was concluded that the average optometrist see 23.3 patients per week. Exclusive of patients seen for medical surgical problems or for follow-up care, the average ophthalmologist, of whom there are 160 in Connecticut, sees 56 patients per week for complete eye examinations. Also, if this patients per examiner data is carried over to fit national figures for the number of practicing O.D.'s and ophthalmologists it indicates that about 60% of the primary eye care is rendered by ophthalmologists in the United States right now.

A report prepared for the Optical Manufacturers Association by a consulting actuarial firm (Trapnell Report-1975) presented data based upon national surveys conducted in 1975. The reporters estimated that approximately one-half of 50 million professional eye examinations were done by ophthalmologists and one-half by optometrists. This report dealt only with persons seeking entry into the eye services field for so-called "sight correction" services and did not count all of the services provided by ophthalmologists otherwise for persons who seek out an ophthal-mologists otherwise for persons who seek out an ophthalmologist for treatment of medical and surgical problems. (Ophthalmologists obviously do 100% of significant eye surgery and treatment of major eye disease) It is remarkable to note that even though there were approximately 10,000 practicing ophthalmologists, as compared to 20,000 optometrists in the United States, that half of the 50 million so-called "routine eye exams" were performed by ophthalmologists during the year 1976.

10- Department of Commerce and Occupational Licensing

11- Obviously, where ophthalmologists are rare, optometrists see the bulk of patients. However, public education, assistance with payment of medical bills via Medicare and Medicaid, the high mobility of todays population, and the trend toward urban population clustering near ophthalmologists and other specialists certainly influence this bias toward ophthalmologists.

12- R.C.W. 18 53.005 Legislative Declaration: "The legislature finds and declares that the practice of optometry is a learned profession and affects the health, welfare and safety of the people of the this state, and should be regulated in the public interest and limited to qualified persons..." (Amendment 1975)

13 - Ellstad v. Swayze, 15 Wash. 2d281, 130 P2d 354 (1942). See also, Ketchum v. King Co. Medical Service Corp., 81 Wash 2d 565, 502 P2d 1197, 1200 (1973)

14 - Swayze, note 13, 353, supra.

15 - Kelly v. Carroll, 36 Wash 2d 482, 219 P2d 79, 90. (1950)

16 - Campbell v. State, Id., at 462

17 - Gellhorn has recently argued that state licensing statutes are in fact attempts by the profession or occupation involved to control competition by means of restrictive admission to practice. Even Professor Gellhorn would admit that the licensing of health professions is necessary and probably rises above such critisism. Gellhorn, The Abuse of Occupational Licensing, 44 University of Chicago L.R.6, 1976.

18 - Semmler v. Oregon State Dental Examiners, 294, U.S.608, 611, (1934);State v. Wilson, 11 Wn. App. 916, 528 P2d 279 (1974)

19 - R.C.W. 18.53.140

20 - Laughney v. Maybury, 145 Wash. 146, 259 P.17 (1927)

21 - Ellstad v. Swayze, note 47, 353, supra, Accord. Dantzler v. Callison, 230 S.C. 75, 94 WE 2d 177, app. dismd. 352 U.S. 939(1956)

22 - Kelly v. Carroll, note 15, 85, supra.

23 - Art. 20, 2

24 - Ellstad v. Swayze, note 13, 353, supra.

25 - State v. Bonham, 93 Wash 489, 161 P 377, 379 (1916)

26 - Kelly v. Carroll, note 22, supra.

27 - State ex rel Fleming v. Cohn, 12 Wash 2d 425, 121 P2d 954 (1942) Accord, State v Hauk, 32 Wash 2d 68;. 203 P2d 693(1949)

28 - 61 Am Jan 2d, Physicians, Surgeons, and other Healers, 19;86 ALR 623, 624

29 - Ex parte Whitly, 144 Cal. 167, 77 P 879 (1904)

30 - "It is enough that...it might be though that the particular legislative measure was...rational..." Williamson v. Lee Optical Co., 348 U.S. 483, 488 (1955), Douglas, J., majority opinion)

31 - See note 15, supra.

32 - Campbell v. State, note 15, supra.

33 - "A law which reduces or prevents any increase in an ...evil tends to safequard the public welfare..." Id. at 462. (emphasis added).

34 - Williamson v. Lee Optical, note 29, supra.

35 - State v. Houck, note 27, 700, supra.

36 - Worthen, note , Op-160, supra.

37 - "...the legislature was careful to require definite knowledge

38 - West Virginia Statute 30-8-5 requires those optometrists who wish to use drugs to complete those requirements which the board of optometry may see fit to extablish. The board of optometry requires attendance at a pharmacology course similar to that described in note 43, infra.

39 - Ellstad v. Swayze, note 13, supra.

40 - Campbell v. State, note 15, supra.

41 - R.C.W. 18.54070

42 - R.C.W. 18.54.070 - In fact, the statute excludes from board membership any optometrist "...who has any connection with any school...of optometry..." It could be presumed that optometrists teaching at optometric schools would be best qualified to judge the qualifications of optometric candidates and possess the most currency in clinical information.

43 - A letter from Leon Candenb, O.D., Director Pennsylvania College of Optometry describes the lecture outling in pharmacology used by Kentucky, Florida, Pennsylvania and New Mexico. This course involves participation by the optometrist in six weekend sessions (Saturday and Sunday) and ends with a three hour examination covering the presented material. A letter from Sam A. McConkey,M.D to the Honorable Charles Parr:

ON OPTOMETRISTS PRACTICING IN THE STATE OF ALASKA

According to figures obtained in February of 1978 from the Department of Commerce, Division of Licensing, there are 40 licensed optometrists in Alaska. Their educational background is as follows:

24 attended Pacific University College of Optometry (1951-1976)
5 attended Illinois College of Optometry (ICO)
4 from 1948 to 1960 and 1 graduated in 1977
3 attended Southern College of Optometry
2 attended the University of Houston College of Optometry
1 attended Southern California College of Optometry
1 attended Los Angles College of Optometry (No longer listed as an optometric school)
1 attended Northern Illinois College of Optometry (No longer listed as an optometric school)
In one case, it is unkown 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 1977 may have been taught by 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 teaching 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 institution.

Southern California College of Optometry has NO M.D. teaching in pharmacology; 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 optometrist in the state that had any pharmacology training from any qualified instructor at all, is two; one from the Illinois College of Optometry who graduated in 1977 and the one graduate of Southern Calidfornia College of Optometry. It appears that the maximum number of optometrists in the state that had any pharmacology training from any M.D. or M.D./PhD. in pharmacology is zero.

The maximum number of optometrist in the state that had any instruction at all from any full-time M.D. on the staff of the school is zero.

The maximum number of M.D.'s in even a part-time capacity on the staff of any school attended by 37 of the 40 optometrists in Alaska, is two. From a survey of the Blue Book of Optometry which was last issured in 1976, it appears that the maximum number of members of the State Board of Optometry that even have a bachelors degree from any school is two of the six board members that are listed. It would seem reasonable that there would be an ophthalmologist either in the teaching or in the clinical aspect of optometric education, but it appears from the available evidence, that the maximum number of optometrists currently practicing in Alaska that had any full or part-time instruction, either by lecture or in the clinical setting by an ophthalmologist is zero.

44 - State v. Spino, 61 Wash 2d 246, 377 p2d 868, 870 (1963)

45 - Pennington v. Benelli, 15 Cal App 2d 316, , P2d 448

46 - Campbell v. State, note 15, 466, supra.

47 - The AAO Nove-Dec. 1977. "AGREEMENT REACHED ON DEFINITION OF MILITARY OPTOMETRIST- The army, Navy and Air Force have agreed on a common definition limiting the services optometrist may render to military personnel. Prior to the new definition, the three military branches had differing definitions which the AAO mailed to all state ophthalmological societies earlier in the year. On June 15th James W. Foristel, AAO Congressional Liason, met with Robert Smith, M.D., Assistant Defense Secretary for Medicine, who was attempting to have all three of the service's Surgeons General agree on a common definition. In September, they reached agreement on the following single definition.

'The optometric clinic provides optometric patient services under medical supervision. Optometrist examine the eyes and

adnexa to include refraction and other procedures, prescribe lenses to correct refractive errors and imporve vision. They refer patients to physicians for diagnosis and treatment of suspected disease. Optometrists use appropriate drugs to perform optometric procedures. When using these drugs, immediate medical care is available in the event of adverse reaction.'"

March 13, 1978

The Honorable Charles Parr
Chairman, Health, Education and
Social Services Committee
House of Representatives
State of Alaska
Juneau, Alaska

Dear Representative Parr:

This is to inform you that my appearance before your committee on House Bill 664 is solely on behalf of the Alaska Optometric Association. Please be informed that I am not in any way representing RCA, Alaska Petrochemical Company, the Alaska Dental Society or the Certified Public Accountants of Alaska on House Bill 664.

Very truly yours,

Henry S. Pratt
Alaska Optometric Association

AAOO RESOLUTION ON DRUG LEGISLATION

At its Las Vegas business meeting, the American Academy of Ophthalmology and Otolaryngology passed a resolution opposing use of drugs by non-physicians. It reads as follows:

"Whereas, The AAOO has for 80 years directed its activities to the public interest, health and welfare of the citizens of this country, and

"Whereas, The AAOO is of the opinion that the use of prescription legend drugs by individuals not trained and licensed to practice medicine and surgery in all of its branches is detrimental to the health and welfare of the citizens of this country; therefore, be it

"Resolved, That the AAOO is opposed to all legislative authorization of individuals not licensed to practice medicine and surgery in all of its branches to use prescription legend drugs for either diagnostic or therapeutic purposes, or both."

AMERICAN ASSOCIATION OF OPHTHALMOLOGY EXECUTIVE OFFICES • 1100 - 17th STREET, N.W., WASHINGTON, D.C. 20036 • TELEPHONE (202) 833-3447

RESOLUTION

"WHEREAS, This Association is of the opinion that any legislative authority granted to independent non-medical practitioners to prescribe or to apply drugs is contrary to the public interest and a detriment to the health and welfare of the citizens of this country; be it

RESOLVED, That this Association is opposed to the legislative authorization of independent non-medical practitioners to prescribe or apply drugs for either diganostic or therapeutic purposes or both."

Adopted by the Board of Trustees of the American Association of Ophthalmology at its Annual Meeting held October 5, 1976 - Las Vegas, Nevada.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 169
(A-73)

Introduced by: Section on Ophthalmology
Harold F. Falls, M. D., Delegate

Subject: Reaffirmation of Position Relative to Legislation Authorizing Diagnosis of Disease

Referred to: Reference Committee B
(John J. Hughs, M. D., Chairman)

Whereas, There continue to be legislative proposals which would extend the definition of the practice of optometry beyond the application of optical principles to embrace the use of drugs and medical diagnosis; therefore be it

Resolved, That the American Medical Association reaffirm that any legislation that would authorize optometrists to engage in the diagnosis or treatment of disease or injury, or the diagnosis of the absence of disease or injury, or to use drugs or medications in any form for any purpose is in conflict with the public interest, and that the Association urge constituent societies unequivocally to oppose and to seek the defeat of any legislation that would extend the scope of optometry into these areas of the practice of medicine; and be it further

Resolved, That the constituent state societies be promptly informed by special communication of this action of the House, and that state societies where such legislation is now pending be officially informed without delay of this supportive action of the House.

****

Adopted by the House of Delegates, American Medical Association, Annual Meeting, June 1973, New York City.

****

Past House Action: A-66:107; A-72:36

(19) RESOLUTION 169 - REAFFIRMATION OF POSITION RELATIVE TO LEGISLATION AUTHORIZING DIAGNOSIS OF DISEASE

This resolution asks the American Medical Association to reaffirm that any legislation authorizing optometrists to engage in the diagnosis of or treatment of disease or injury, or the diagnosis of the absence of disease or injury, or to use drugs in any form is in conflict with the public interest, and that the AMA urge constituent societies to oppose and seek to defeat such legislation. In addition the resolution asks that the constituent state societies be promptly informed of this action.

This resolution was introduced by the Section on Ophthalmology and presents a clear statement of the legislative proposals being made in the various states with regard to optometry. Your Reference Committee is fully in accord with the statement made by this resolution.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 169 be adopted.

TAB 5

SUMMARY OF PROCEEDINGS

1976 ANNUAL CONVENTION

RESOLUTION 76 — PRESCRIBING EYE MEDICATIONS

Resolution 76 asked that the AMA adopt the policy that only physicians licensed to practice medicine and surgery are qualified to prescribe or use eye medications and that they should be the primary entry point for eye care, and also asked that the AMA vigorously oppose any legislative or administrative attempt to give optometrists a license to prescribe or use medications or to serve as a primary entry point in the provision of eye service.

The House considered the following amended Substitute Resolution:

> RESOLVED, That the American Medical Association reaffirm its policy that only physicians licensed to practice medicine and surgery in all its branches are qualified to prescribe or apply eye medications; and be it further
>
> RESOLVED, That the American Medical Association continue to urge that state medical societies oppose any legislation or administrative attempt to give optometrists a license to prescribe or apply medications or to diagnose disease or injury or to diagnose the absence of disease or injury; and be it further
>
> RESOLVED, That the House of Delegates directs the attention of the constituent state societies to the position of the Association as stated in Resolution 169 (A-73).

SUBSTITUTE RESOLUTION 76 ADOPTED AS AMENDED

File — 7 AMA Resolutions 1976

272-1513

TELEGRAM

RCA ALASKA COMMUNICATIONS, INC.
PHONE: 586-6440
JUNEAU, ALASKA 99801

IPMAFUB AHG

4-043312E073 03/14/73

ICS IPMBNGZ CSP

2059344433 TDBN BIRMINGHAM AL 101 03-14 0223P EST

PMS DR AHARON STERNBERG

WESTERN UNION

JUNEAU AK 99801

IT IS MY UNDERSTANDING THAT MY POSITION ON THE USE OF DRUGS FOR DIAGNOSTIC PURPOSES BY OPTOMETRISTS IS BEING MISREPRESENTED TO YOUR LEGISLATORS. I WISH TO SET THE RECORD STRAIGHT. THIS SCHOOL OF OPTOMETRY AND I SUPPORT THE USE OF DRUGS FOR DIAGNOSTIC PURPOSES BY OPTOMETRISTS. SPECIFIC LECTURES, LABORATORY AND CLINICAL TRAINING IN PHARMACOLOGY ARE REQUIRED PARTS OF THE 4 YEAR CURRICULUM FOR OPTOMETRY STUDENTS AND HAVE BEEN SINCE THIS SCHOOL WAS STARTED. WE BELIEVE SUCH KNOWLEDGE AND SKILL ARE ESSENTIAL FOR OPTOMETRISTS TO DISCHARGE THEIR LEGAL AND MORAL RESPONSIBILITIES TO THE PUBLIC THEY SERVE.

HENRY B PETERS DEAN

SCHOOL OF OPTOMETRY, THE MEDICAL CENTER

UNIVERSITY OF ALABAMA IN BIRMINGHAM

1423 EST

IPMAFUB AHG

KETCHIKAN MEDICAL SOCIETY

3100 TONGASS AVENUE - KETCHIKAN, ALASKA 99901

March 14, 1978

TELETYPE TESTIMONY TO HEALTH EDUCATION & SOCIAL SERVICES COMMITTEE

Ketchikan Medical Society wishes to record its opposition to House Bill 664. Historically, and by Alaska statute, optometry has been a drugless profession. For the good of the people of the state of Alaska, we believe that optometry should remain drugless.

H.B. 664 requires only that optometrists pass a single examination before this significant expansion in their role is permitted. The examination will either be given by the optometry board itself with no legislated previous training requirements, or be given by a recognized school or college following an optometry board approved course of study. There is no mention of criteria for approval. There is no mention of by whom the institution is recognized. There is no mention of accreditation or university affiliation.

Further, the bill contains no definition of a diagnostic purpose, and no provision for any penalty for use of drugs in conditions other than those approved by the board. There is nothing in the bill to prohibit an optometrist virtually any use of this broad list of medications, if that use can be extended to be called diagnostic. Since optometrists by their licensing statute cannot legally have had any experience with these drugs, and since use of these drugs is part of the wider experience of medical doctors, it does not appear that the public is protected by the inexperienced licensing of the untrained to the exclusion of more experienced and qualified medical doctors.

Although optometrists are portraying the drugs they seek to use as harmless, it is precisely because of their effectiveness that they are being sought. Any drug brings with its desired effects certain other undesirable effects and occasional very serious complications. Optometrists are not trained or qualified to deal definitely with any of these complications; to whatever extent the complication involves more than the eye the optometrist is excluded by licensing statute from making anything other than a layman's assessment. We believe that the public deserves better protection than the optometrists offer in this bill.

In summary, although H.B. 664 is laudably brief and seductively simple, we do not believe that it serves the best interests of the people of Alaska.

DEPARTMENT OF THE ARMY
HEADQUARTERS. US ARMY MEDICAL DEPARTMENT ACTIVITY. ALASKA
FORT WAINWRIGHT, [redacted]
ALASKA 99703

AFZT-MD-CL

28 February 1978

STATEMENT

I am presently an Alaska licensed optometrist (#85) practicing in the U.S. Army at Fort Wainwright, Alaska. I have been here over three years, and in the military for over seven years. During all my years as a practicing optometrist in the U.S. Army, I have been authorized to use diagnostic pharmaceuticals in my practice. The use of diagnostic anesthetics, mydriatrics, miotics, and cycloplegics are required for flight physicals, tonometry, internal examinations, cycloplegic exams, etc., required by military regulations.

Upon arriving at Bassett Army Hospital here at Fort Wainwright in 1974, I submitted a request to the hospital Credentials Committee to use certain diagnostic drugs in my practice of optometry which was approved by the committee and endorsed by the Hospital Commander. In my experience in using diagnostic drugs on thousands of patients, I have never had an adverse drug reaction.

Robert P. Hammond

ROBERT P. HAMMOND, O.D.
CPT, MSC
Chief, Optometry

Section II

Items of interest to all members of the command:

DEPUTY CHIEF OF STAFF, PROFESSIONAL ACTIVITIES

a. Community Health Nurse (CHN) Referrals. All CHN referrals being sent to Europe must be addressed:

Commander
US Army Medical Command, Europe
ATTN: AEMPM (Community Health Nurse Consultant)
APO New York 09403

These referrals must be submitted on DA Form 3763 (Army Health Nursing - Case Referral), in duplicate, for each person or family referred. History should be outlined, problem should be identified, and priority of referral should be listed. All TB referrals should include DA Form 3897-R (Tuberculosis Registry (LRA)). A copy of orders assigning the individual or his/her sponsor to Europe must also be included with referrals.

1 Jul 77

(HSPA-H, AUTOVON: 471-6612)

b. Optometry Policy Statement. Army optometrists provide optometric patient services in accordance with accepted medical guidelines. They examine the eyes and adnexa, to include refraction and other procedures; and prescribe lenses to correct refractive error and improve vision. They refer patients to physicians for diagnosis and treatment of suspected disease. They use topical anesthetics and cycloplegic drugs to perform tonometry and cycloplegic refractions. When using these drugs, immediate medical care is available in the event of adverse reaction.

(HSPA, AUTOVON: 471-6527/6602)

DEPUTY CHIEF OF STAFF, LOGISTICS

a. Installation Property Book. All installation property books in HSC will be operated using Army Medical Department Property Accounting System (AMEDDPAS) procedures. MEDCEN/MEDDAC tenanted on installations assigned to other MACOM will be authorized only one installation property book. A single property book will provide for more efficient management of property assets. Biomedical equipment assets must be contained in one data base in order to accomplish effective maintenance management using AMEDDPAS procedures.

(HSLO-M, AUTOVON: 471-6448/6449)

b. Occupational Safety Health Act (OSHA)/Joint Commission Accreditation Hospitals (JCAH) Surveys. The United States Army Environmental Hygiene Agency is presently conducting surveys to identify OSHA/JCAH deficiencies at Health Care Facilities throughout CONUS, Alaska, Hawaii, and Canal Zone. Upon completion of the physical survey and preparation of a report itemizing deficiencies, the report is forwarded to the supporting district engineer for preparation of a cost estimate. This estimate is in three parts: administration; repair and maintenance; and alterations or additions. Copies of these cost estimates will be furnished MACOM engineers and installation facility engineers to assist in the preparation of a project or projects to correct deficiencies identified. MEDCEN/MEDDAC personnel are encouraged to involve themselves in the project development process at the earliest possible time. To date, surveys of MEDDAC have been completed at ten installations; of the ten, three have been forwarded to the Savannah District Engineer for costing. The remainder will be dispatched to the respective district engineer in the near future. It is anticipated that completion of the survey program will require approximately 2 years.

(HSLO-F, AUTOVON: 471-6441/2077)

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY HEALTH SERVICES COMMAND
Fort Sam Houston, Texas 78234

CG HSC BULLETIN NO. 7-77

1 July 1977

THE UNITED STATES ARMY HEALTH SERVICES COMMAND
COMMANDER'S NOTES

The COMMANDER'S NOTES are prepared and distributed monthly to Headquarters staff elements and units throughout the command. These notes are designed to provide management communication on subjects of current interest to all members of the command and the widest distribution is encouraged. Local reproduction is authorized.

Section I

Item of primary interest for commanders:

Relocation of Headquarters, US Army Health Services Command. I am pleased to report that the Headquarters, US Army Health Services Command, has completed relocation to refurbished Building 2792, immediately adjacent to and south of the Academy of Health Sciences, US Army main building on Stanley Road at Fort Sam Houston.

Spurgeon Neel MD
Commander HSC

7-320B "I" Street
Elmendorf AFB, AK 99506
1 March 1978

Dr. Box
611 W. Willoughby
Juneau, AK 99801

Dear Dr. Box,

I was asked to write to you and give you the latest information from the Air Force that I have concerning the use of diagnostic drugs that we can use.

Air Force Regulation 36-1 (dated 1 March 1977) states on Page A27-37: OPTOMETRIST 2. Duties And Responsibilities

a. Conducts Examinations of Eye: With or without the use of diagnostic drugs, examines eyes..... etc.

I know of no other regulation since then that states anything different. There is no place in the regulation that any of our professional activity is under the direct supervision of an ophthalmologist or other physician.

As you know, there are many places where the optometrist functions where there is no ophthalmologist assigned. At those locations the optometrist usually is called upon by the professional staff to do many of the more routine ophthalmological duties, because he knows more about these functions than do the other medical corps specialties. Even at locations such as Elmendorf where we have ophthalmological services, we can use diagnostic drugs and do minor ophthalmological services on our own, but we usually let the ophthalmologist or his technicians do these services.

I am licensed here in Alaska, and would appreciate being on the mailing list of any material associated with the changing of the optometric laws within the state. I am still a few years from retirement, but plan on coming back up here when I retire.

ROGER C. FITCH, Lt Col, USAF, BSC
Chief, Optometry Services
Elmendorf AFB, Alaska

DR. CURTIS M. JOHNSON
DR. D. R. SCHMIDT
OPTOMETRISTS
530 SEVENTH AVENUE
FAIRBANKS, ALASKA 99701

Telephone {456-4010
{452-3232

March 1, 1978

Representative Steve Cowper
Pouch V
Juneau, Alaska 99811

Dear Mr. Cowper:

I had a call today from Dr. Nancy Le Fevre and she was concerned with the mass of paper relating to HB 664 which you sent to her. She thought that as President of the Optometry Board I might be better able to comment on specific points raised in objection.

First of all, let me say that I have a penchent for telling the truth, and for calling a spade a spade, so if any of my comments seem blunt I will apologize ahead of time.

I have no way of knowing how aware you are of the ongoing conflict between optometry and ophthalmology, but there is one very important point to always bear in mind. After you filter through all the histrionics, hysterics, and scare tactics, the conflict boils out to be purely economic. We are competing for the same patients, it is as simple as that. The incidence of eye pathology in a normal population runs about 5%, and it is for this group that the ophthalmologist is trained. The optometrist is trained to treat the 95% with healthy eyes and to refer the rest to the proper discipline.

It does not take too much mathematics to deduce that 5% of the population in Fairbanks, for instance, is not nearly enough people to keep four ophthalmologists busy, so they must resort to prescribing spectacle or contact lenses, for which they have minimal training. In conversations with the local ophthalmologists I find that they practice their specialty about 15% of the time, and the balance of the time they are competing for the balance of the population which is better served by optometry. As I said, purely economic.

Another important point is that we are not attempting to expand the scope of our practice. All of the tests, procedures, etc. are already in our armamentarium, but there are instances where the use of the drugs we are asking for would make the testing easier on the patient and the results more meaningful. A case in point is an instrument mentioned by Dr. McConkey called a tonometer. This instrument is used to measure the internal pressure of the eyeball and is helpful in diagnosing glaucoma. The instrument most ophthalmologists use is called a Schioetz tonometer, costs about $70.00, is placed directly on the eyeball when used and cannot be used without a topical anesthetic.

DR. CURTIS M. JOHNSON
DR. D. R. SCHMIDT
OPTOMETRISTS
530 SEVENTH AVENUE
FAIRBANKS, ALASKA 99701

Telephone {456-4010
{452-3232

He mentions the air-puff tonometer which can be used without anesthetic, and is available to optometry. While it is true that the air-puff is a better and more accurate way of measuring eyeball pressure, it costs $3500.00, is suitable only for permanent installation because of its sophisticated electronic nature, and thus is not suitable for taking to the bush where most of us do travel on a part time basis.

In one of his letters, Dr. McConkey mentions the high incidence of glaucoma in our native population, and how the indiscriminate use of cycloplegics would induce a rash of glaucomatous attacks. I would like to state that I participated in a research project in Point Barrow several years ago with Dr. Francis Young, a noted researcher in the field of vision from Washington State University. Part of the testing required using a very potent cycloplegic. Over a period of two years this drug was used on virtually every eskimo in the village and no glaucomatous attacks were induced. I am not implying that it cannot happen, but it is very rare

Another implication throughout Dr. McConkey's correspondence is that we want the drugs to diagnose so that we may treat eye disease. Nothing could be further from the truth. I can vouch for the fact that none of my fellow practicioners in Alaska are frustrated M.D.'s. The bill speaks clearly of diagnostic drugs only and the only drug mentioned in the bill which could be used for treatment are myotics for the control of glaucoma. I can assure you that if any of my collegues were foolish enough to attempt this, they would be without a license immediately.

Dr. McConkey states that immediately upon passage of this bill, untrained people will begin using drugs. The bill clearly states that proper training must be had before drugs can be used. Twenty two other states have handled this problem very nicely to the satisfaction of their patients, their profession, and their legislators. The new graduates will have the proper training, but for those of us who have been in practice for awhile, it simply means going back to school. At my age that is something I do not relish, but I have been President of the State Board of Examiners for twelve years, and if I wish to continue serving I will have to be one of the first to get the training.

I resent Dr. McConkey's slur about the quality of our educational institutions. A couple of our schools are private, but the rest are university affiliated, many of them along with schools of medicine and and dentistry. I don't know where he got his information but I had my training in ocular anatomy, pathology, and pharmacology from a full time ophthalmologist on the staff of Pacific University over twenty years ago.

This letter is much too long, and I could go on for several more pages but I hope that at least some of your questions have been answered.

Sincerely,

Curtis M. Johnson, O.D.

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 <u>medical</u> 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.

DR. ED CRAIG
OPTOMETRIST
348 Main Street
KETCHIKAN, ALASKA 99901
Dial 225-

February 6, 1978

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.

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

Telephone 427-3111

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.

IlS:er
cc

ISOPTO® HOMATROPINE
(Homatropine Hydrobromide)
Ophthalmic Solution

DESCRIPTION: A sterile ophthalmic solution. Each ml contains: Active: Homatropine Hydrobromide 2.0% or 5.0%. Preservatives: Benzalkonium Chloride 0.01% (in 2% strength), Benzethonium Chloride 0.005% (in 5% strength). Vehicle: Hydroxyp opyl Methylcellulose 0.5%. Inactive: Sodium Chloride, Polysorbate 80 (in 2% strength), Hydrochloric Acid and/or Sodium Hydroxide (in 2%) (to adjust pH), Purified Water. DM-05

ACTIONS: A parasympatholytic agent.

INDICATIONS: A moderately long acting mydriatic and cycloplegic for cycloplegic refraction and in the treatment of inflammatory conditions of the uveal tract.

CONTRAINDICATIONS: Contraindicated in persons with glaucoma or a tendency toward glaucoma and in persons with hypersensitivity to belladonna alkaloids.

WARNINGS: Excessive use in children or certain individuals may produce 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

ALLERGAN

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 hyperallergic corneal reaction, with acute, intense and diffuse epithelial keratitis, a gray ground glass appearance, sloughing of large areas of necrotic epithelium, corneal filaments 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/

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 29901 Printed in USA

Homatropine

ocular pressure. Use of Cyclopentolate has been associated with psychotic reactions and behavioral 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 6 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 29983 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 anti-muscarinic 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.

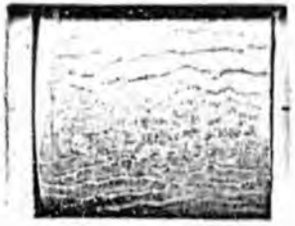
HOW SUPPLIED: 0.5% and 1.0% solutions in 15ml plastic Drop-Tainer® dispensers.

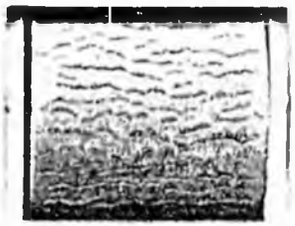
STORAGE: Store at 46° to 75° F. Do not refrigerate or store at high temperatures. Keep container tightly closed.

Alcon

ALCON LABORATORIES, INC.
Fort Worth, Texas 76134 USA
June 1975 29984 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.

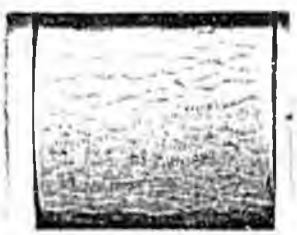
DESCRIPTION

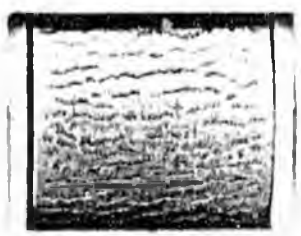
NEO-SYNEPHRINE hydrochloride is a syntactic sympathomimetic compound structurally similar to epinephrine and ephedrine.

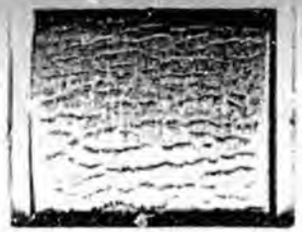
ACTION

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

STATE OF MINNESOTA

BOARD OF OPTOMETRY

February 18, 1976

Paul R. Nielsen, O. D., President
California Optometric Association
921 - 11th Street P. O. Box 2591
Sacramento, CA. 95812

Dear Dr. Nielsen:

Your letter has been referred to this office for reply.

In response to your specific questions the following can be reported:

1. No known deaths.
2. No known adverse reactions.
3. No complaints have been submitted to his board alleging misconduct, misapplication or malpractice from the use of the agents.
4. None
5. Virtually non-existent.
6. Yes
7. Impossible to estimate but our guess is that a high percentage do utilize these agents to a degree.

It is our hope that these brief answers meet your needs.

Sincerely,

L. A. Meyer

Leo A. Meyer, O. D.,
Secretary

copies: Board Members
Mr. Holley

MGMPHAT HSB
2-005914E126002 05/06/75
ICS IPMMTZZ CSP
1 2153776666 MGM TDMT PHILADELPHIA PA 05-06 0926A EST
ZIP 19151

western union Mailgram

BERNARD KUSHNER
6103 LANSDOWNE AVE
PHILADELPHIA PA 19151

THIS MAILGRAM IS A CONFIRMATION COPY OF THE FOLLOWING MESSAGE:

2153776666 MGM TDMT PHILADELPHIA PA 100 05-06 0926A EST
ZIP
DR FRANCIS BONIN BUREAU OF PROFESSIONAL
CENTER
NEW IBERIA LA 70560
FOLLOWING SENT TO AL KELLY JOINT COMMITTEE ON HEALTH AND WELFARE POBOX
44261 CAPITOL STATION BATON ROUGE LA 70804:

ACT NUMBER 29 COMMONWEALTH OF PENNSYLVANIA BECAME LAW MARCH 1 1974 AND GRANTS CERTAIN QUALIFIED OPTOMETRISTS THE USE OF DIAGNOSTIC AND PHARMACEUTICAL AGENTS.

SINCE THAT TIME NOT ONE CASE, NOR COMPLAINT, NOR INCIDENT OF ANY TYPE INVOLVING OPTOMETRIC DRUG USAGE HAS BEEN BROUGHT BEFORE THE STATE BOARD OF OPTOMETRICAL EXAMINERS OR THE HEALTH DEPARTMENT OF THE COMMONWEALTH OF PENNSYLVANIA.

DR BERNARD KUSHNER, O.D.
CHAIRMAN PENNSYLVANIA STATE BOARD OF OPTOMETRICAL EXAMINERS
MATTHEW JACKSON, ESQUIRE
DEPUTY ATTORNEY GENERAL
BUREAU OF LAW ENFORCEMENT
COMMONWEALTH OF PENNSYLVANIA

09:26 EST

MGMPHAT HSB

RUTHANN SAXON SELDEN

March 10,1978

Dear Dr. Grendahl,
The PEER Group of Alaska (Practitioners Entering Expanded Roles) voted to oppose HB664 at our March 7, 1978 meeting. We are making our decision known via the Legislative Coalition of Health Care Professionals and this letter.

This is a serious issue. To be specific, we feel that the educational background of an optometrist does not include the essential indepth knowledge of how to correctly treat the untowarded side effects that may result when medication is used on the human body. As you know, some patients may be in life threatening situations as the result of the use of a medication that their body is sensitive to.

We as Nurse Practitioners do use medications that have possible untowarded side effects; obviously, we do not have the indepth knowledge of pharmacology and emergency medicine that the physician does. However, our role is in collaboration with a physician.

Therefore, in the interest of the people of the State of Alaska, we are making our decision known.

Sincerely,

Ruthann Selden, R.N., N.P.
Chairperson
PEER Group of Alaska
6615 Abbott Loop Rd.
Anchorage, Alaska 99507

BARTLETT MEMORIAL HOSPITAL

P. O. BOX 3-3000 • JUNEAU, ALASKA 99801 • TELEPHONE (907) 586-2611
MILE 3 — GLACIER HIGHWAY

March 16, 1978

The Honorable Charles Parr, Chairman
Health, Education & Social Services Committee
House of Representatives
Pouch V
Juneau, AK 99811

Re: HB664 - Optometry

Dear Representative Parr:

The Juneau Medical Society is unanimously opposed to granting optometrists the right to practice medicine. We do not feel that it is in the best interest of our community health program.

We respectfully request that you take negative action on this piece of legislation.

Respectfully yours,

Estol Bellflower MD

Estol Bellflower, M. D., President
Juneau Medical Society

THE ALASKA HOSPITAL AND MEDICAL CENTER, Inc.

February 7, 1978

House Commerce Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

RE: House Bill No. 664
"An Act Relating to the Practice of Optometry"

Gentlemen:

The Medical Staff of The Alaska Hospital and Medical Center at their annual meeting, January 25, 1978, unanimously (75 members present) passed a motion to disapprove House Bill No. 664.

The Medical Staff feels that the use of medication requiring a prescription to purchase, to use and to dispense should be reserved for physicians. The drugs listed in the bill, namely: topical anesthetics, mydriatics, cycloplegics, and myotics, all have potentially serious side effects including anaphylactic shock, cardiac arrhythmias, significant elevation of blood pressure, stroke, psychosis, convulsions, precipitation of gluacoma, cataracts and retinal detachments. Any of these conditions, even if they would be recognized by an optometrist, could in no way be treated by an optometrist.

It is for this reason the Medical Staff feels very strongly that it is in the best interest of the citizens of Alaska to keep the use of potentially harmful and toxic drugs under physicians specifically trained in such areas and licensed in the state to use such preparations in the cure of the sick and in the diagnosis of disease states.

Sincerely,

C.J. Little, M.D.

C.J. Little, M.D.
President/Medical Staff

JP:CJL:lw

cc: House Judiciary Committee
Anchorage Ophthalmologic Society

2801 DeBarr Road • Pouch 8-AH • Anchorage, Alaska 99508 • Phone: (907) 276-1131

State Medical Board
Conference Call
February 2, 1978

A conference call was held by the Board of Medical Examiners on February 2, 1978, at 10:30 a.m., Juneau time.

Those present were:

Thomas Harrison, M.D.
Hilbert Henrickson, M.D.
Hugh Gellert

Also present was Loretta Prescott, License Examiner, from the Department of Commerce and Economic Development.

On February 6, 1978, Loretta Prescott, License Examiner, polled the remaining medical board members by phone:

Dr. William Compton - unavailable
Dr. Gary Walkup - unavailable
Louise Beighle - unavailable

Dr. Thomas Stengl voted yes to the following, constituting a quorum:

RESOLVED, that the Alaska State Board of Medical Examiners, requests that House Bill 664, "An Act relating to the practice of optometry." be defeated, as the State Medical Board feels that it allows the use of dangerous drugs by unsupervised, non-medical personnel.

LP/sa3/34

GLYER MEDICAL GROUP

Founded by R. T. Glyer, M. D.
260 Hope Street, Mountain View, California 94040 (415) 967-5701

Offices of

C. Hartley Glyer, M.D.
John L. Anderson, M.D.
Victor M. Zuriman, M.D.
Joachim H. Buchholz, M.D.
Howard L. Nudelman, M.D., F.A.C.S.

William L. McDonald, M.D.
Frank R. Williams, M.D.
James B. LeRoy, M.D.
Douglas E. Downey, M.D.
Gert E. Polony, M.D., F.A.C.O.G.

John R. Young, M.D.
George J. Kiricenkov, M.D.
Seymour A. Rapaport, M.D.
S. B. Fox
Administrator

June 3, 1974

Senator George N. Zenovich
State Capitol
Sacramento, CA 95814

Dear Senator Zenovich:

I have been asked by an optometrist acquaintance of mine to write you concerning SB 1989 (definition of optometry).

I support SB 1989, I am particularly interested in their ability to use pharmaceutical agents topically to assist in diagnosing disease. They should be permitted to do this. They do an excellent and professional job at the present time without the capability of using these pharmaceutical agents and permitting them the use of these agents would enable them to do their job even better. This is for the benefit of society and any argument that this bill could be construed to benefit optometrists and harm ophthalmologists or physicians is, to my mind, ridiculous.

Limiting optometrists from diagnosing disease by the use of topical pharmaceutical agents in the eyes would be like asking dentists to diagnose disease without x-ray. The optometrists are highly trained professionals and certainly have a great deal more knowledge about the eye plus much more sophisticated equipment than the average non-ophthalmologist physician who is permitted to use all sorts of agents in both diagnosis and treatment of eye disease, and I therefor cannot see why optometrists should not be permitted the use of pharmaceutical agents for diagnosis.

In summary, for the above reasons I support SB 1989.

Sincerely,

F. R. Williams

F. R. Williams, M.D.
FRW:st

cc. Senate Health & Welfare Committee; California Optometric Association

Oregon XII

JAMES F. BOURGEOIS, M. D.
P. O. BOX 1516
HOUMA, LA. 70360
TELEPHONE 876-0431

January 25, 1977

The Honorable Mickey Leland
The House of Representatives
Austin, Texas 78711

Dear Representative Leland:

As a Practicing physician of Ophthalmology in Louisiana, I would like to report that since the passage of legislation similar to your House Bill 21, I do not know of any adverse reaction or bad effects from the Optometrists using diagnostic drugs in their practice.

The use of these drugs will enable the Optometrists to perform better examinations and help to detect ocular diseases during their early stages. In our area the Lions Club recently sponsored a screening program for Glaucoma in which three Optometrists and I Participated.

I am familiar with the academic requirements for admission to optometry school and they are very similar to those for medical school. The professional training at the University of Houston Optometry School is one of the best in the country. On completion of their courses in pharmacology the Optometrists will be more than adequately prepared to use the diagnostic drugs for the good of the general public.

The passage of your House Bill 21 will be in the best interest of the people and Texas will continue to be one of the leading States of our Nation.

If I can be of any assistance to passage of the Bill, please feel free to contact me.

Sincerely yours,

James F. Bourgeois M.D.

JFB/ab

REFERENCE QUOTATIONS FROM AUTHORITATIVE AND QUALIFIED PERSONS REGARDING USAGE OF DIAGNOSTIC AGENTS BY OPTOMETRISTS

A. SUBSTANTIATING MINIMAL RISKS TO ADVERSE DRUG REACTIONS

1. "In a series of more than 1000 patients anesthetized with benoxinate, no toxic effects were encountered, either locally or systemically."

   Havener, William H., M.D., M.S. (Ophth.), Ocular Pharmacology, P. 51.

2. "There have been no reported systemic toxic reactions in amounts used for topical anesthesia for the eye."

   Leopold, Irving, M.D., Ocular Therapy Vol. 1, p. 16

3. "None of the drugs I shall be discussing were available fifty years ago...they are all less toxic, less irritating and shorter acting than their predecessors."

   Garston, Mathhew J., O.D., "A Closer look at Diagnostic Drugs for Optometric Use", Massachusetts College of Optometry Boston, Mass.

4. "After having seen the use of local anesthetics discussed here in over 20,000 patients I have yet to see any adverse reactions. I have seen the dilating agents discussed here in over 10,000 patients and likewise have seen no ill effects. (this includes not causing an angle-closure glaucoma)."

   Garston, Matthews, J., O.D., ibid.

5. Seventy to eighty percent of drug reactions are predictable and most are preventable."

   "New England Journal of Medicine" Vol. 285, pg. 1361, June 1971 cited by Lyle W.M., O.D., "Relationship of Pharmaceuticals to Optometry", American Academy of Optometry, 1971.

6. "Abraham in 1933 surveyed the literature for reports of acute glaucoma produced after the use of mydriatics in patients previously free from clinical signs of glaucoma. He calculated an incidence of one case of acute glaucoma for each 18,400 instances of application of anticholinergic eyedrops for refraction of other eye examination.

In Abraham's data it was strikingly evident that age was an important factor in determining susceptibility to acute glaucoma from topical application of anti-cholinergic drugs. In nearly all instances of acute glaucoma the patients were over 30 years of age. Among patients younger than 30 years, Abraham found only four instances of this type of adverse effect in the literature. Also, it must be emphasized that the above one case in 18,400 patients was from a population group who were dilated without the aid of angle evaluation techniques."

Leopold, Irving, M.D. (ed.) Ocular Therapy, Vol. III, Chapter 4 "Conservatism in Glaucoma Management" by Robert Shafferf, M.D. and John Hetherington, Jr., M.D. p. 63

7. "Beach noted that increased intraocular tension from the use of a mydriatic does not occur one in 10,000 examinations."

   Lyle, W.M., O.D. Op. Cit.

8. "Havener says that a physician who dilates many eyes may expect to precipitate not more than one case of acute glaucoma in his lifetime."

   Havener, W. H., Synopsis of Ophthalmology cited by Lyle, W.M., O.D. ibid.

9. "It was reported in Australia that .. ly one case out of 12,000 can glaucoma be precipitated and then only in people who have a predisposition to react in that way to the drug."

   Parliament, 2nd Session, Vols. 59, 60, 73, Act. No. 34, 1963 the Optometrists Act. 1963, Cited by Lyle W.M., O.D. ibid.

10. "After the child is first examined, the doctor usually tells the mother to instill atropine drops or ointment into the child's eye...Atropine is used because it is the most powerful cycloplegic drug...One in 500 children develops a sensitivity reaction to this cycloplegic drug... The mother should not become alarmed; she should simply discontinue the drug."

    Abrahamson, Ira A. Jr., M.D. Know your Eyes, Medcom Press, 1972, pp. 76-77.

B. ESTABLISHING THE LARGER RISK TO THE PUBLIC HEALTH IF THESE DRUGS ARE NOT ADMINISTERED BY OPTOMETRISTS:

1. "Newell reports that there is more danger of missing a significant ocular of systemic disease by failing to dilate than there is of precipitating glaucoma by dilation."

   Newell, F.W. Ophthalmology, Principles and Concepts, 2nd Edition, C.V. Mosby Co. 1969, p. 140, cited by Lyle W.M., O.D., "Relationship of Pharmaceuticals to Optometry", American Academy of Optometry, 1971.

2. "In their role as the first line of defense against glaucoma and other vision-threatening conditions (Optometrists) must be free to utilize all appropriate tests if they are to continue to bear these responsibilities."

   "Should the patient be deprived of a variety of tonometry test, or of gonioscopy or of tonography because his optometrist was not permitted to utilize a broad spectrum of diagnostic procedures?" Cited by Lyle, W.M., O.D. Ibid p.6

3. "A recent opinion of the attorney general of New York State affirms that it is the duty of the optometrist to use his training to uncover any need for the patient to seek further medical advice."

   Forgotson, E.H. et al Report of the National Advisory Commission on Health Manpower, Vol II, Nov. 1967, U.S. Gov't Printing Office, cited by Lyle W.M. O.D., Ibid p.7

4. "...In view of the unavailability of appropriate medical services, for example in remote areas and in other unusual circumstances, there appears to be a need for optometrists to employ topical anesthetics...optometrists...in many cases... are the first trained person consulted."

   Anon, Joint Declaration on Behalf of Ophthalmologists and Ophthalmic Opticians (optometrists). The Ophthalmic Optician, Feb., 21, 1970 p. 173, cited by Lyle W.M., O.D. Ibid p.7.

5. "In those parts of the world where high quality vision care is generally available, 60% to 80% of this health service is the responsibility of optometrists."

   Lindsey A. Socialized Medicine in England and Wales, National Health Service, 1948-1961, University of North Carolina Press 1962.

6. Woodruff, M.E. "Statement Relating to the Effective Utilization of Optometry and Optometric Services in Fulfillment of the Aims and Objectives of the United States Dept. of HEW", American Optometric Assoc, 1964 cited by Lyle W.M., O.D., Ibid p. 11

STATE of INDIANA

INDIANA STATE BOARD OF OPTOMETRY

INDIANAPOLIS 46202

State Board of Health Annex
1375 West 16th Street
(317) 633-4837

February 23, 1976

Paul R. Nielson, O.D., President
California Optometric Association
921 11th Street
Post Office Box 2591
Sacramento, CA 95812

Dear Dr. Nielson:

I am writing this letter to state briefly to you and members of your Association information concerning the use of diagnostic drugs by Indiana optometrists.

Indiana O.D.'s have used diagnostic drugs since 1935, when the present statute was amended to read:

"or the employment of any means, for the purpose of detecting any diseased or pathological condition of the eye, or the effects of any diseased or pathological condition of the eye, etc."

I am enclosing a statement which the Indiana Optometry Board mailed recently to all licensed O.D.'s in the state. This I feel explains our position quite clearly.

To our knowledge, there has never been a case of adverse reaction to the use of topical diagnostic agents in the clinical practice of optometry. The utilization of diagnostic drugs by optometrists in Indiana over the past 40 years has reduced significantly the incidence of blindness through early detection and referral.

If I can offer further assistance, please do not hesitate to contact me.

Sincerely,

R. Lewis Scott

R. Lewis Scott, O.D., President

RLS:bj

enclosure

over

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

EYE, EAR, NOSE & THROAT CLINIC

February 9, 1978

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

Dear Mr. Parr:

This third installment will be devoted to optometric education in the United States and also on the quality of care that the citizen of Alaska might expect from optometrists practicing in Alaska.

OPTOMETRIC EDUCATION

A study entitled, "New Englanders, Their Eyes, And Those Who Profess To Care For Them", by Samuel E. Wallace, PhD (sociology), University of Tennessee, was sponsored by New England Council of Optometrists and funded by the National Institutes of Health (NIH). This study was completed in 1974 and was intended to provide justification for a new optometric college in New England. The report deals with a single school, the "MCO" (Massachusetts College of Optometry), now called New England College of Optometry, which evolved from a private school begun in 1896. The degree O.D. was first conferred in 1951. Today (1970) there are 209 students in four classes. Entrance requirements are a minimum of two years undergraduate college work with at least a "C" average, then four years are required to earn the O.D. degree.

Dr. Wallace evaluated the quality of the students and noted the following (Quotes are direct quotations from the text): 1) All students had two years of undergraduate training with most earning a B.A. or B.S. degree. 2) Only nine of the 209 students had an entrance grade average of B or better; therefore, 200 students were C students (only 4% of the students at this college, then, had a B or better average. 3) Most of the students took premedical or predental undergraduate courses but "had to give up their original aspirations because of their poor grades." 4) The professors "complained that the students refused to do any assigned homework and are immature in their study habits, that they have to be spoon fed." The students "refused to take any initiative in the learning process" and "will learn only what is specifically presented to them in class."

Wallace, too, reviewed the faculty and noted the following: 1) Thirty full-time and 14 part-time faculty members hold degrees varying from O.D. to PhD and M.D. Most, 19, holding an optometric degree alone is their highest academic degree. 2) Several teachers proudly said that some of their courses

are "almost as good as the courses given in medical schools." 3) "Faculty members must share and unconsciously reinforce the anti-intellectualism and the inferiority feelings" of the students.

Regarding the quality of courses, Wallace noted: 1) Several of the required courses "repeat knowledge that the students should already have when he arrives. 2) "Many of the courses are conducted basically on the level of a high school or freshman college introductory biology course." 3) The classes are "almost all lectures where the professors simply repeat what's in the text." 4) In a typical pathology course, the practical advice given by the professor to the student, if he recognizes the disease, is to "refer it out." 5) "The classes are characterized by a lot of whispering, sleeping, and general inattention on the part of the students." 6) The optometry students "tend, as a group, to be unimaginative and show a remarkable lack of initiative."

Wallace concludes that the optometric student's education "seems almost as if it is make-work to take up the four years that the Optometric Society has decided should be devoted to the study of optometry for the sole purpose of achieving a social status comparable to that of medicine."

THE CLINICAL TRAINING OF AN OPTOMETRIST

Wallace investigated the optometry students exposure to patients and their problems. This is the nonlecture portion of their training and takes place in the optometric clinic. It is during this period of time that the student gains practical experience in both "visual examination" and, hopefully, some experience in the detection of pathology.

The following points of interest were made by Dr. Wallace: 1) One of the primary problems of the clinics is "a lack of patients." Students are "fortunate to fit a dozen pairs of contact lenses, shared between two students." Students "carry out maybe 25 or 30 complete visual examinations in the course of an entire academic year." 2) The limited time an ophthalmologist spends on call in these clinics indicates "the very few cases of pathology which the optometric clinic sees." 3) "In general, 90% of the patients are between the ages of 15 and 30 years." (It should be noted that this age group has a very low incidence of eye diseases.) 4) The optometry students provide "routine eye examinations rather than investigating pathology." 5) At another optometric clinic, "cases of pathology are so few and far between at the clinic that he (the ophthalmologist) has very little to do." 6)When pathology was suspected, the work-up was improper and the follow-up not documented. 7) Regarding the use of tonometry (measuring the eye pressure for purposes of detecting glaucoma) optometry students have "very little confidence in the tonometry readings." The findings, with respect to readings obtained by the optometry students, "seem to be quite unstable" and interpreted by Wallace as being "worthless."

Even if we ignore the supposed exposure and training the optometry students obtain in detecting pathology, Wallace notes that in the area of visual examinations, "The clinic staff did prescribe spectacles more often than was absolutely necessary." (It would seem that this certainly would increase the cost of health care to the consumer.)

THE PRACTICING OPTOMETRIST

Because of the lower educational requirements, optometrists begin practice generally at a lower age than most other professionals. The average optometrist has been in practice 18 years and, therefore, has the educational standards of 1951. Wallace notes that 80% of practicing optometrists do not have a bachelors degree and 33% do not even have an O.D. degree. Within that 33% group, some have had no formal training. (The average age of the practicing optometrist in Alaska today is 40. On the average, they have been in practice 15 years. The average graduate finished optometry school in 1962.)

Wallace observed the efficiency and competency of an ophthalmic assistant who had only two years of training and contrasted him with a recent graduate of MCO. He noted that only "a few minutes of observation was needed to conclude that the ophthalmic assistant was far superior in all respects."

Wallace continues, recognizing the "incompetent optometrists found among recent graduates, as well as among older ones" in observing the "low and inadequate academic standards at the MCO" coupled with the "poor quality of optometric performance and pathology detection," he suggests "the average level of patient care in the future will deteriorate."

Wallace notes that organized optometry is attempting to establish 10 to 20 new colleges of optometry and that "at a time when we need more ophthalmologists, we are getting more and more optometrists." The current oversupply of optometrists increases "commercial competition", gives "them so little to do that they do even less," contributes to lowering "the income of all practitioners and gives them no choice but to sell spectacles in order to survive."

"Quality is optometry's most pressing need, not quantity." Recognizing the quality of optometry students, Wallace reports that half of the current students "probably should be dismissed before they have a chance to go in to practice."

Wallace suggests that increased communication between ophthalmologists and optometrists would indicate to many optometrists "just how inadequate their examinations now are."

Alluding to the optometric-ophthalmologic conflict, Wallace notes that "optometrists have numbers on their side while ophthalmologists have everything else." "Ophthalmologists should begin now to assert the changes which they too know should be made in optometry."

In summary, Wallace states that with the present underutilization of optometrists, "at least 10,000 vacancies now exist every week in optometrists' appointment schedules" and that no new optometrists are needed in New England for at least three years. In contrast, there is a serious shortage of ophthalmologists and projected growth of ophthalmologic manpower falls far below that required just to maintain the present level of "overutilization."

ON OPTOMETRIC "FACT SHEETS"

You will be seeing so called "optometric fact sheets" and will be hearing optometric testimony as to their capabilities in pharmacology, diagnosis, and pathol-

ogy after approximately 3,500 hours of lectures in clinics and optometry school. 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 circumstances 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.

Optometrists will incorrectly imply that their courses in pharmacology compare favorably with those of medical and dental students, but they won't tell you that medical students go far beyond the textbook courses in pharmacology and spend many more 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 have never considered themselves adequately trained to evaluate drug dosage or administer drugs. They won't tell you that the average ophthalmologist, in addition to medical school and an internship, has, in a three year residency, spent more than twice the number of hours required in the entire optometric curriculum, devoted solely to ophthalmology lectures and constant clinical exposure to the diagnosis and treatment of disease and surgical problems of the eye.

The fact sheets won't tell you 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 is no hospital training whatsoever, nor are optometry students exposed to sick eyes or sick patients.

The Optometric Manpower Resources Projects, published by the United States Department of Health, Education and Welfare in 1976, shows that the median age for active optometrists in this country is 49.4 years; that only 25% of active optometrists in 1973 were under 40 years of age and that 48% were over 50 years of age. This means that about 75% of optometrists practicing today have had little or no exposure, even at the textbook level, to pharmacology and clinical disease diagnosis. Are these the people we wish to entrust with the use of potentially dangerous drugs. Bill 664 would allow this if it were enacted.

Today there are no M.D.'s teaching at two of the nations 13 optometry schools and no full time M.D. professors in any optometry school, according to a catalog study by the Physicians Education Network in December of 1977. In truth, a new accredited optometric school called Ferris State College of Optometry, has no M.D. on their staff in either a full or part-time capacity and only one O.D. If this is an accredited school with the lack of qualified instruction, even at the optometric level, this certainly qualifies as a "diploma mill" in all senses of the connotation. If then this is a diploma mill and is an accredited school of optometry, one must question the validity of the accreditation methods for all of the schools of optometry throughout the United States.

Optometrists also won't tell you that many of them in practice today have only the degree of bachelor of science in physical optics. The O.D. degree originated in independent optometric institutes and is a relatively recent degree in many optometry schools. They won't tell you that under the statutes, optometry is not considered to be one of the "healing arts." They almost certainly won't

tell you that a recent study conducted by the American Board of Ophthalmology and instigated by the federal General Accounting Office, shows not only that we have too few ophthalmologists in this country, but that the number of optometrists 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 thier capabilities by legislative acts; they need to make work for themselves.

ON OPTOMETRISTS PRACTICING IN THE STATE OF ALASKA

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 (1951 to 1976)
5 attended Illinois College of Optometry (ICO)
4 from 1948 to 1950 and 1 graduated in 1977
3 attended Southern College of Optometry
2 attended the University of Houston College of Optometry
1 attended Southern California College of Optometry
1 attended Los Angeles College of Optometry (No longer listed as an optometric school)
1 attended Northern Illinois College of Optometry (No longer listed as an optometric school)
In one case, it is 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 1977 may have been taught by 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 teaching 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 institution.

Southern California College of Optometry has NO M.D. teaching in pharmacology; 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 pharmacology training from any qualified instructor at all, is two; one from the Illinois College of Optometry who graduated in 1977 and the one graduate of Southern California College of Optometry. It appears that the maximum number of optometrists in the state that had any pharmacology training from any M.D. or M.D./PhD in pharmacology is zero.

The maximum number of optometrists in the state that had any instruction at all from any full-time M.D. on the staff of the school is zero.

The maximum number of M.D.'s in even a part-time capacity on the staff of any school attended by 37 of the 38 optometrists in Alaska, is two. From a survey of the Blue Book of Optometry which was last issued in 1976, it appears that the maximum number of members of the State Board of Optometry that even have a bachelors degree from any school is two of the six board members that are listed. It would seem reasonable that there would be an ophthalmologist either in the teaching or in the clinical aspect of optometric education, but it appears from the available evidence, that the maximum number of optometrists currently practicing in Alaska that had any full or part-time instruction, either by lecture or in the clinical setting by an ophthalmologist, is zero.

Please find enclosed a study compiled by the Educational Catalog Study Committee of the South Carolina Ophthalmologic Society in December of 1977, entitled, "Who Teaches Optometrists Medicine." The data that I've previously described can be substantiated from this chart, as well as other quite interesting points including faculty/student ratio as compares with three southern medical schools. The Comments section is particularly important when it shows what the position of the M.D.'s on the staff of any of these schools participated in. It should be noted that I completed by ophthalmology residency in 1975 at the Medical University of South Carolina College of Medicine.

Sincerely,

Sam A. McConkey, M.D.

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cc: Representatives: M.F. Beirne
Don Bennett
Fred E. Brown
Thelma Buchholdt
C.V. Chatterton
Samuel R. Cotten
Steve Cowper
Alfred C. Nakak
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PLASTIC AND RECONSTRUCTIVE SURGEON
WILLIAM W. WENNEN, M.D.

EYE, EAR, NOSE & THROAT CLINIC

February 10, 1978

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

Dear Mr. Parr:

It is appropriate that in this installment, the medical community's views on the use of medications and the potential hazards of same be discussed.

DRUGS AND DRUG CARE

Optometrists claim that the drops they propose to use are necessary and innocuous and the health care system will thereby be expanded. This is a spurious claim. The health care system will not be expanded and the rural areas will not be served by allowing nonmedical people to dilate pupils to look for disease which they are not trained to diagnose. Death or serious disability can be caused by an untrained person overlooking a tumor, early glaucoma, or a detached retina in a nonmedical attempt at "diagnosis." Diagnosis is (by definition) the determination of the presence or absence of disease and, if present, a determination of its nature. Optometrists are not able to make this medical determination 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.

The use of cycloplegics, mydriatics, topical anesthetics, and miotics by optometrists nonmedically trained, as called for in Bill 664, could be extremely dangerous. These drugs cover an extremely broad range of action. Some can produce serious systemic side effects or surgical emergencies which require immediate recognition and treatment. Also, since these drugs are often used for treatment, rather than as diagnostic aids, in the hands of the nonphysician, they could be subject to abuse. Cycloplegics paralyze the muscle within the eye which controls focusing of the lens; mydriatics dilate or enlarge the pupil of the eye; topical anesthetics are drops which numb the lining membrane of the lids and outer eyeball; miotics make the pupil smaller and are used in the treatment of glaucoma. In passing, it should be stated that at no place in the drug formulary does the Food and Drug Administration suggest that miotics are to be used for any diagnostic purposes. This is a quite obvious additional reason why Bill 664 is a sham for therapeutic use of drugs.

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

ON THE DANGER OF DILATING DROPS

In some instances, dilating drops can cause acute glaucoma which may then be a surgical emergency or at least require intensive medical treatment. An optometric "fact sheet" just being circulated, widely claims that this does not occur. This is just not true. Any ophthalmologist in active practice has seen drop induced acute glaucoma. In susceptible individuals, cycloplegics and mydriatics can produce a wide variety of complications, can aggravate existing heart problems, or may even produce toxic mental disorders or coma. Children are particularly susceptible to these eye-drops and often become cranky, sleepy, or even delirious while waiting in the office. Action to remedy this must be immediately available and can't wait on referral to medical help elsewhere. I always have on hand emergency medical equipment, such as oxygen, airways, and oral and injectable drugs to handle unforeseen emergencies. No optometrist is capable of this medical response. There is no justification for optometrists to want to use mydriatics or cycloplegics. Until very recently, they opposed ophthalmologists use of cycloplegics in refraction of the eyes and labeled it in one of their little bulletins "a cruel test" that produces "an abnormal state for examining the eye for glasses." If they want these drugs to better look into the interior of the eyes, it is truly a sham because most optometrists have not been trained in peripheral retinal examinations. Symptoms calling for this type of evaluation, such as floaters and flashes of light, are fairly specific and deserve prompt referral to an ophthalmologist. New, small pupil ophthalmoscopes will enable the optometrist to see more clearly into the inside of the eye, and they do not require the use of dilating drugs. The more common eye diseases, such as diabetes, evidence of high blood pressure, glaucoma, optic nerve injuries, edema, or swelling of the optic nerve due to brain tumors, and infections commonly presenting in the back part of the eye can all be diagnosed quite adequately without the use of any dilating drops.

ON THE SIDE EFFECTS OF MIOTICS

Miotics are a large group of drugs of varying properties and actions which are used chiefly in the treatment of glaucoma. They are not diagnostic aids and while certain miotics may be used in one kind of glaucoma, their use in another kind of glaucoma may be wrong. In glaucoma caused by inflammation, all miotics may be contraindicated. Side effects of many miotics are common, often serious, and require an absolute appreciation of high blood pressure, coronary heart disease, circulatory and respiratory collapse (shock), and the way one drug may react with other drugs that the patient may be taking. Only an ophthalmologist can appreciate the consequences of these side effects.

ON TOPICAL ANESTHETICS

Ophthalmologists use topical anesthetics in certain tests to measure the pressure within the eye. This is called tonometry; one test used in determining if a patient has glaucoma. We also use topical anesthetics for minor surgical procedures. New air puff tonometers and others which do not require

anesthesia are more than adequate to satisfy the optometrists' desire to screen a patient for glaucoma. These non-drug methods, coupled with examination of side vision and looking at the optic nerve through normal size pupils, provide adequate data to the optometrist with regard to the possible presence of glaucoma. The final diagnosis and treatment of the glaucoma must rest with the ophthalmologist.

In downgrading the risks of adverse reactions to anesthetic drops, optometric "fact sheets" often refer to medical reports out of context or use authorities with the title "doctor" who are not M.D.'s and who do not personally participate in the day to day eye care of real live people. This is especially significant when the so called authorities are PhD's teaching in optometry schools or are faculty members of schools of public health whose doctorates are often in vital statistics or health systems planning.

Dr. William Havener, Professor of Ophthalmology at Ohio State, is frequently quoted as an authority who denies existance of toxic effects to topical anesthetics. Yet the item to which optometric fact sheets refer, namely Dr. Havener's report of the relative lack of a toxicity to a single dose of benoxinate in 1,000 patients, fails to explain that this is only one of many available types of anesthetic drops.

Dr. Havener, a strong opponent of optometric drug legislation, in his recent book, "Synopsis Of Ophthalmology" on page 430, states that "the surface active anesthetics are often relatively toxic and severe systemic reaction may result from applications of excessive amounts of topical anesthetics. Healing the corneal epithelium (outer cell layer) is markedly slowed by topical anesthetics which inhibit cell metabolism and growth...also, local allergies may develop (which may be) recognized by red and swollen eyelids accompanied by itching."

Dr. Robert P. Burns at the University of Oregon Medical School, echoed Dr. Havener's concern in "A Synopsis On Occular Pharmacology And Therapeutics," published by C.V. Moseby Company. He warns that "severe hypersensitivity reactions with corneal clouding have been described after the use of topical proparacaine."

There have been documented examples of patients requiring corneal transplants because an optometrist had illegally provided them with a bottle of proparacaine for pain relief after the optometrist had illegally performed a minor surgical procedure on the cornea. He didn't have the foggiest notion that these drops were potentially dangerous, so when the patient complained of increased pain, he just told the patient to use the drops more often. This, of course, further damaged the cornea.

Even an article in the American Journal of Optometry and Physiologic Optics in November of 1977, stated that "adverse drug reactions are potentially serious and becoming increasingly common."

At a meeting of the New England Ophthalmologic Society in Boston, a symposium devoted to toxic reactions to eyedrops, such as those which optometrists seek legislative approval to use through Bill 664, revealed that mild to severe reactions to these drops in office practice are seen by all ophthalmologists and

often require immediate medical care.

I'm offering to the committee a copy of the 1977 Physicians' Desk Reference for Ophthalmology. This lists, among other drugs, all the approved topical anesthetics, cycloplegics, mydriatics, and miotics, along with the literature required by the FDA that must accompany each bottle of drops or tube of ointment. This includes the possible side effects of each medication. The book also lists systemic medications which can have adverse effects upon the eye, something only the physician can appreciate.

Bill 664 is the more illogical for assuming that a hurry up lecture course in pharmacology, whether in optometry college or in an optometric meeting, 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 on the qualifications of their own people in these medical areas.

Ophthalmologists in Alaska have long been well aware of the fact that Alaskan natives have a particular predisposition to a condition known as narrow angle glaucoma. This condition or predisposition in the native population is more than just occasional, and I can assure members of this committee that if optometrists are allowed the unrestricted use of drops that dilate the eye, that they will increase the morbidity among this group of patients to an alarming degree. The ultimate health costs are going to be astronomically increased because of the surgery fees that are going to be required to solve the problems created by the narrow angle glaucoma cases that we will have necessity to operate on. This is a most important consideration, and if anything, the problem in the preceding paragraph has been understated.

Optometrists have recently claimed that the use of drops would provide increased benefits to the patient and aid in earlier detection of eye disease. The fact is, that since the origin of their profession, optometrists have taken pride in and proclaimed their ability to measure the eye, fit glasses or contacts, and refer the patients whose vision deviates from normal for medical evaluation and care, all without the need to use eyedrops. All aspects of eye examinations and vision care, for which optometrists are trained, have been and can continue to be performed without the use of drugs. The noncontact air puff tonometers permits screening of intraocular pressure to detect the possibility of glaucoma without the need to use anesthetic drops. Topical anesthetics, mydriatic, or miotic drops are not required for the fitting of eyeglasses or contact lenses. External defects of the eye can certainly be recognized without the use of eyedrops. Defective vision not correctable by refraction and visual field defects indicative of internal eye or nervous system disorders, can easily be detected without the use of drops. Optometrists are adequately trained to recognize the many symptoms which indicate a need for medical referral. They are not trained in medical diagnosis and, therefore, have no real need to use so-called "diagnostic drops." It is misleading to the legislature and to the

public to imply that any drug is purely diagnostic. The classes of drops optometrists are seeking to use for "diagnostic purposes" are, in fact, used for therapeutic purposes in the evaluation and treatment of eye diseases.

Thank you again for your time in reading this material.

Sincerely,

Sam A. McConkey, M.D.

SAM:ls

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TELEPHONE 262-4462

February 20, 1978

Charlie Parr, Chairman,
"Hess Committee'
House of Representatives
Pouch V
Juneau, Alaska 99811

There is a bill in the "Hess Committee" (HB664) which I would like to offer some comments upon. The bill would authorize optometrists to use drugs on the eye in the course of a routine eye glass exam.

BACKGROUND

Currently eye care in this country is delivered by two types of providers. An optometrist possesses an O.D. degree which means he has completed a minimum of two years of college and an additional four years of optometry school. He is well trained to fit eye glasses and restore vision thru the use of glasses and in some instances eye exercises. At no time in his academic career does he become exposed to clinical medicine, sick people or the effects of medicine upon the eye and body in general. An ophthalmologist possesses a M.D. degree which means that he has completed four years of college, four years of medical school, one year of internship as well as three or four years of a residency program specializing in the eye, its diseases, surgery of, as well as its relationship to the body as a whole. Many ophthalmologists have practiced general medicine for some time before specializing.

Although ophthalmology dates back to the early 1800's in this country the optometrists (O.D.) are a relatively recent entry into the field of eye care, came in arount 1910. For the past 60 years the O.D."s have been content to practice within their capabilities and education by fitting eye glasses and occassionally prescribing exercises for the eye. In the past 4 years however some optometrists across the country have decided that they are no longer content to practice within their capabilities but they are asking various state legislatures to allow them the use of eye medications. The reasons for their expansionist attitudes are varied but suffice it to say that the optometry schools are graduating optometrists at an unprecedented rate. A study supported by the General Accounting office showed that they are being graduated at a rate which exceeds the work available to them. Thus the necessity for an expansionist attitude!

THE PROBLEM

The problem from the public health standpoint is this: Should you take a layman (be it an optometrist or chiropractor or psychologist) give him the responsibility of using potentially harmful medications on the human body! I (as well as the other ophthalmologists in the state) feel it would be an injustice to the people of Alaska to subject them to such scantily trained purveyors of medications. If such laymen decide they

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SOLDOTNA, ALASKA 99669

TELEPHONE 262-4462

would like to use drugs on humans, I feel that they should re-cycle themselves into that profession properly trained in the use of drugs, i.e. medicine. This should be done by attending a accredited medical school and not by legislative fiat!

I have more information available for your use but I'll hold it for a later date. I appreciate any consideration you may give this matter and if more information is desired please do not hesitate to notify me.

Sincerely,

Peter E. Cannava, M.D.

Peter E. Cannava, M.D.
President Alaska Association
of Ophthalmologists

PEC/bc

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

February 10, 1978

The Honorable Charles H. Parr
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Mr. Parr:

I wish to request your support for an item of great importance. The House Health, Education and Social Services Committee, of which you are Chairman, 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

PHARMACEUTICAL LEGISLATION

	1970	1971	1972	1973	1974	1975	1976	1977
ALABAMA						NP		
ALASKA								
ARIZONA							I	I
ARKANSAS								I
CALIFORNIA					I		E	
COLORADO								I
CONNECTICUT								I
DELAWARE						E		
FLORIDA NP						I		
GEORGIA								I
HAWAII								
IDAHO NP								
ILLINOIS								
INDIANA NP								
IOWA								I
KANSAS								E
KENTUCKY							I	
LOUISIANA						E		
MAINE				I		E		
MARYLAND								
MASSACHUSETTS			I			I	I	I
MICHIGAN								
MINNESOTA NP								
MISSISSIPPI					I	I	I	I
MISSOURI								I
MONTANA								E
NEBRASKA								
NEVADA NP								
NEW HAMPSHIRE								
NEW JERSEY NP								
NEW MEXICO							I	E
NEW YORK			I	I	I	I	I	I
NORTH CAROLINA				I				E
NORTH DAKOTA								
OHIO								I
OKLAHOMA								I
OREGON						E		
PENNSYLVANIA				I	E			
RHODE ISLAND	I	E						
SOUTH CAROLINA								I
SOUTH DAKOTA								
TENNESSEE						E		
TEXAS								I
UTAH							I	I
VERMONT								
VIRGINIA NP								
WASHINGTON						I		
WEST VIRGINIA							E	
WISCONSIN								I
WYOMING								E
DISTRICT OF COLUMBIA								

I: Introduced

E: Enacted

NP: No Statutory Prohibition

DR. ED CRAIG
OPTOMETRIST
348 Main Street
KETCHIKAN, ALASKA 99901
Dial 225-3975

February 6, 1978

Representative Charles H. Parr
Pouch V
Juneau, AK 99811

Dear Representative Parr:

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.

2/15/78

DR. JOHN J. LOUNSBURY
127 Alaska Nat'l Bank Bldg
Fairbanks, Alaska 99701
452-3694

Mr. Charles Parr
Chairman of House Health & Social Services
Pouch V
Juneau, Alaska 99811

Dear Charles;

I'm writing this letter urging your support of House Bill #664---diagnostic pharmacuetical agents .

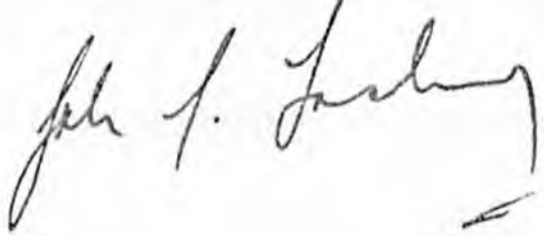
I'm the practicing Optometrist in the lobby of the Northward Bldg. and have been for 10 years. I'll also mention that I was born and raised in the Fairbanks area and do support you in your elective office.

In essence the above described bill allows optometrists to practice their profession with a greater scope or use of diagnostic tools. It enables the patient to receive more benefits as a consumer in that many simple tasks can be performed in office without laboring the patient with unnecessary referals, added expense and etc.

I would expect that all elected officals regarding this matter will be urged by the AMA to defeat the above bill. Don't be bullied into to thinking that these drugs are dangerous and only special magical men can handle them.. There concern is one of purely economics and many other states have seen through their smoke screen and have passed necessary legislation that will enable optometrists to use diagnostic pharmacuetical agents.

Please support this bill. Thanks!

John J. Lounsbury



WHO TEACHES OPTOMETRISTS MEDICINE?

CURRENT SCHOOL CATALOG STUDY COMPARES FACULTIES AT SEVERAL TYPICAL MEDICAL AND DENTAL SCHOOLS WITH FACULTIES AT ALL OPTOMETRY SCHOOLS IN THE U.S.

	Total # of Students	Total # of Faculty	Faculty/ Student Ratio	Total # of M.D. Professors (Full or Part Time)	Full Time Clinical* Teaching M.D. Specialists	OPHTHALMOLOGISTS (M.D. Eye Specialists)			PHARMACOLOGY DEPARTMENT		O.D.s	O.D./Ph.D.	Other Ph.D., M.S. or B.S.	COMMENTS
MEDICAL COLLEGES						Full Time	Part Time	M.D. Residents	M.Ds - M.D./Ph.D.	Ph.D., M.S. or B.S.				
Medical University of South Carolina College of Medicine	660	1,281	1.9	651	201	3	23	9**	6	25	0	0	630	* *CLINICAL* — Refers to working with patients in hospitals or out-patient clinics. ** Ophthalmology Residents spend 3 months during their 3-year residency in an intense basic science course taught by nationally prominent Ophthalmologists at Colby College, Waterville, Maine.
Duke University College of Medicine	489	1,102	2.3	632	483	8	10	16	2	7	0	0	470	
Medical College of Georgia	720	944	1.3	495	246	3	10	8**	2	10	0	0	449	
DENTAL COLLEGES														
Medical University of South Carolina College of Dentistry	160	312	2.0	74	0	0	0	0	6	25	0	0	123	84 D.D.S. teaching mostly Clinical 9 are D.D.S., Ph.D.
Medical College of Virginia College of Dentistry	439	353	.80	33	0	0	0	0	8	20	0	0	127	126 D.D.S. teaching mostly Clinical 20 are D.D.S., Ph.D.
COLLEGES OF OPTOMETRY														
Southern College of Optometry	604	49	.08	2 PART TIME	0	0	0	0	0	0	37	2	7	The 2 part time M.D.s are classroom lecturers in Pathology.
Illinois College of Optometry	600	56	.09	1 PART TIME	0	0	0	0	0	1	47	1	6	The only M.D. is a part time Lecturer in Pathology.
Pennsylvania College of Optometry	552	89	.16	5 PART TIME	0	0	2	0	0	1	55	4	17	
Southern California College of Optometry	384	83	.22	5 PART TIME	0	0	2	0	0	2	65	5	8	
Pacific University College of Optometry	340	23	.07	1 PART TIME	0	0	0	0	0	0	12	1	8	The only M.D. is a Professor of Physics and Optics, part time.
New England College of Optometry	332	66	.20	4 PART TIME	0	0	2	0	0	1	52	5	4	
University of Houston College of Optometry	284	64	.23	2 PART TIME	0	0	0	0	0	0	47	4	7	The 2 part time M.D.s are Classroom Lecturers in Pathology.
Indiana University College of Optometry	276	38	.14	0	0	0	0	0	0	0	21	4	11	No M.D.s on Staff.
Ohio State College of Optometry	228	63	.28	1 PART TIME	0	0	1	0	0	0	46	4	12	The only M.D. is part time. He lives 100 miles away in Cincinnati.
University of Alabama College of Optometry	160	48	.30	3 PART TIME	0	0	0	0	1	0	22	9	12	All M.D.s are part time classroom lecturers. One M.D./Ph.D. lectures in Pharmacology.
State University of New York College of Optometry	160	122	.76	9 PART TIME	0	0	6	0	0	0	87	3	22	
University of California Berkeley College of Optometry	256	77	.30	9 PART TIME	0	0	6	0	0	0	43	11	12	One part time M.D. teaches in Public Health, one in Engineering and one in Physiological Optics
Ferris State College of Optometry	100	31	.31	0 PART TIME	0	0	0	0	0	3	1	0	29	All but 2 of these 29 also teach in the Biology and Chemistry departments of the Undergraduate College.

STUDY THE CHART : CAN MEDICAL EYE CARE BE ENTRUSTED TO OPTOMETRISTS WHEN THIS STUDY PROVES THAT THERE ARE NO FULL-TIME M.D. INSTRUCTORS IN ANY OPTOMETRY SCHOOL ANYWHERE?

Study Compiled for PEN Inc. by the EDUCATIONAL CATALOG STUDY COMMITTEE OF THE SOUTH CAROLINA OPHTHALMOLOGICAL SOCIETY
DECEMBER 1977

HB 664

South Central District Dental Society

P.O. BOX 4-1800
ANCHORAGE, ALASKA 99503

March 20, 1978

Representative Charles Parr, Chairman
House HESS Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Representative Parr:

We, the South Central District Dental Society, wish to go on record as being opposed to HB 664, Practice of Optometry. Our position is based on information gleaned by the dental society that the current level of clinical and educational experience of the Alaskan optometrist is inadequate to take on responsibilities incurred with the administration of the drugs they requested in this bill.

Sincerely,

William P. Pell, D.D.S., President
South Central District Dental Society

cc: Jim Patterson, M.D.
Fred D. Bast, D.D.S.
Phillip L. Locker, D.D.S.
Mr. Henry Pratt

DR. M. C. FALCONER
DR. J. C. FALCONER
DR. G. L. HALL
DR. T. F. HARBOUR
DR. B. L. WALKER
DR. W. D. FAULKNER
OPTOMETRISTS

ANCHORAGE EYE AND CONTACT LENS CENTER
1345 W. NINTH AVE. PHONE: 272-2557
ANCHORAGE, ALASKA 99501

February 6, 1978

Mike Colletta
Pouch V
Juneau, Alaska 99811

Dear Senator Colletta:

As you may be aware, house bill #664 is now under consideration by your committee. I would like to briefly state the importance of this bill to the general public.

At the present time national statistics indicate that 70% of the patients use optometrists as a primary entry point for vision care. These patients are generally healthy patients not requiring medical eye care, but must be screened thoroughly for ocular pathology.

This screening included among other tests opthalmoscopy, or internal examination of the eye and tonometry or checking of intraocular pressure. A test used to detect glaucoma. I use these two as examples as they are representative of the use of diagnostic pharmaceutical agents. These tests are presently done by optometrists, but in some instances the difficulty is greatly increased, by not having diagnostic pharmaceutical agents at hand. drugs

Sincerely,

M. C. Falconer

M. C. Falconer OD

MCF/aeb

2-7
3-4

Mike:

I have been given, by law, The responsibility of detecting pathology in the eye but have been restricted in some instances because I can not use The agents. 20 states now permit our use. 5 more expected This year. Please contact me if you have any questions

MCF

The
ALASKA OPTOMETRIC ASSOCIATION

AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

Representative Parr

States that authorize optometrists to use diagnostic topical agents by statute charge are; California, Delaware, Louisiana, Maine, Montana, New Mexico, Oregon, Pennsylvania, Rhode Island, Tennessee, West Virginia, and Wyoming, and South Carolina.

States that I have either never prohibited by use or have attorney General opinions supporting their statute in by use. Florida, Idaho, Indiana, Minnesota, Nevada, New Jersey, Virginia.

I have prepared this list from memory as my research information

is at home. I believe there are five more states but can't remember which category they are in or the names of the states.

I have done no reports by any state boards of problems with the use of these agents where they are in use. I have full documentation showing these agents are beneficial to the treatment and done caused no significant adverse side effects.

Please let me know what information you require and I will be glad to provide it.

Sincerely

Dr Ray Box

ALASKA STATE MEDICAL ASSOCIATION
1135 W. Eighth Avenue • Suite 6 • Anchorage, Alaska 99501 • (907) 277-6891

February 14, 1978

Representative Charlie Parr
Chairman, House HESS Committee
Alaska State Legislature
Juneau, Alaska 99801

Dear Representative Parr:

The Alaska State Medical Association Council has reviewed HB 664, An Act Relating To The Practice Of Optometry. We see no purpose identified or expressed within the substance of the Bill. We further see no areas where the public interest will be served by its passage and several areas where compromised eye care, duplication and cost increases are possible if not likely.

At the outset, please understand that the ASMA properly has no interest or intent to interfere with the practice of optometry in Alaska. However, if an enlargement of the scope of optometry into the sphere of medical practice is comtemplated, it reasonably becomes our concern for the welfare of the public, not a simple jurisdictional dispute.

Optometry by derivation, definition, tradition, training and current practice means measurement of the eye for refractive error and a prescription of corrective lenses. Current practices also allows dispensing and sale of lenses and spectacles by the prescribing optometrist.

The current statute defining optometry is unfortunate in that it suggests diagnosis of visual impairment, apart from refractive error, lies within the responsibility of optometry.

Non-refractive visual impairment may be a most difficult and subtle medical diagnostic problem, at times challenging the combined expertise of ophthalmologist, neurologist, radiologist, and internists, and requiring sophisticated diagnostic equipment. Causes range from simple cataracts to subtle brain tumor, from transient vascular insufficiency to obscure metabolic disorders. The visual problem may be the first and only lead to a serious medical disease. Almost all non-refractive visual impairments will come to confirmatory diagnosis and treatment by a physician. It goes without saying that missed or delayed diagnosis can have serious potential consequences.

Before extending the scope of optometry, well beyond refraction and the sale of contact lenses and spectacles, into the intricate area of complex ophthalmological diagnosis, we ask that you assure yourself of the following:

(1) That there is a clearly demonstrated and defined unmet public health problem, that this legislation will solve it, and it is the most appropriate solution.