



a technician prepared 30 to 40 sections from the eye. A section is less than a tenth of a millimeter and unless the entire eye is sectioned it is possible to miss the larva. In Dr. Krupp's opinion insufficient sections of the eye were examined to exclude the possibility that the larva was in the eye. Other possibilities suggested by Dr. Zimmerman that bleeding into the vitreous was caused by persistent hyperplastic primary vitreous were ruled out during the medical examination in July at Letterman, nor is there anything to suggest the possibility of a foreign metallic object as the cause of the inflammation.

I find on the basis of the testimony of the treating physicians, including Dr. Wolf, Dr. Kinn and Dr. Black, that toxocara canis was the probable cause of the inflammation in Timothy's right eye. The opinions of the treating doctors are substantially similar to the opinion of Dr. Krupp whose qualifications in this field are outstanding. I find in all probability the larva entered the eye through the retina prior to the time Dr. Shank made his examination in December of 1973. Probably the vitreous hemorrhage observed by Dr. Shank was caused by underlying lesion in the retina of the eye.

While it cannot be known with absolute certainty what an ophthalmologist would have done or been able to do if Timothy had been seen in December, 1973, Dr. Kinn testified that the ophthalmologist would have been immediately concerned with making a diagnosis. At that time the physician might have had some indication of a retinal lesion which would cause him to suspect either a granulomatous reaction or a retinoblastoma. The ophthalmologist would have been able to examine the

inflammatory cells were observed, the doctor could have concluded that an inflammatory reaction was present.

In such circumstances a diagnosis of toxocara would be likely. Dr. Kinn explained that since the eye was functioning in December it would not have been prudent to remove the eye even if retinoblastoma was suspected. Rather, Dr. Kinn would recommend a therapeutic trial of steroids be undertaken and if the response would be favorable, then the eye not be removed. But if the mass continued to grow despite the treatment and if retinoblastoma could not be ruled out, it would be necessary to enucleate the eye.

Although in Dr. Zimmerman's opinion there is no recognized treatment for toxocara canis, in fact according to Dr. Krupp, the use of steroids in treating toxocara appeared in the medical literature as long ago as 1961.

And since that time, Dr. Krupp maintains there have been numerous reports in the literature on the use of steroids. In her own right, Dr. Krupp has participated in treating approximately 20 cases involving ophthalmic toxocara.

Her treatment for toxocara includes thiabendazole and steroids, generally used in combination. Thiabendazole is an anthelmintic medicine which kills the larva. The steroid is an anti-inflammatory agent which reduces the mass of inflammation generally associated with toxocara. In each of the cases in which Dr. Krupp participated treatment was able to arrest the loss of vision at the stage it was when the patient was first seen. Results of treatment can usually be observed within three to four weeks. In the event a patient does not respond to treatment, retinoblastoma may be indicated.

7/ By Schneider at the Oxnard Clinic.

Dr. Black was also aware of several cases where inflammation of the eye was treated with steroids, and in isolated cases steroid treatment has decreased the inflammation, resulting in minimal scarring. But in Dr. Black's opinion in most instances toxocara is not seen by the ophthalmologist until it has been quite destructive. However, assuming that visual acuity in Timothy's right eye was 20/30 in December of 1973 and treatment with steroids was instituted, some vision might have been salvaged.

In Dr. Wolf's opinion if Timothy had been seen by an ophthalmologist in 1973, very possibly the eye could have been saved. Since a granulomatous inflammation is a cellular reaction to a foreign object, treatment would be taken to block the reaction. Steroids are a recognized form of treatment for granulomatous inflammation.

I find it probable that an ophthalmologist examining Timothy's right eye in December, 1973, would have diagnosed possible granulomatous reaction, toxocara canis or retinoblastoma. Although there was a lesion in the eye that to some extent impaired Timothy's vision, his visual acuity in the eye was 20/30, the best that could be measured on Dr. Shank's eye chart. The ophthalmologist under such circumstances would almost certainly institute a course of treatment involving steroids in order to reduce the inflammation. The treatment would have prevented further loss of vision and toxocara inflammation would have caused minimal scarring. The eye would have been saved.

Since the jurisdiction of the court is found under the Torts Claims Act, Alaska tort law controls. Richardson v. U.S., 369 U.S. 1; U.S. v. English, 521 F.2d 63 (9th Cir. 1975).

The concept of liability arising out of negligence has been recently stated by the Alaska Supreme Court to be:^{8/}

It is elemental that in order for liability to be imposed in a negligence action, the plaintiff must establish a duty of due care owed him by the would-be defendant, a breach of that duty, and finally, that the injury was proximately caused by the breach of duty. Generally speaking, the duty of due care or ordinary care is the duty to act with that amount of care which a reasonably prudent person would use under the same or similar circumstances.

Leigh v. Lindquist, 540 P.2d 492, 494 (1975).

Dr. Shank's failure to promptly inform Mr. and Mrs. Steele of the vitreous hemorrhage in their child's eye and his accompanying failure to refer Timothy to an ophthalmologist was a breach of the standard of care owed to Timothy Steele and his parents. I find Dr. Kinn's testimony as the duty owed to be especially persuasive. Not only is he a board certified ophthalmologist who continually deals with optometric referrals, but Dr. Kinn was previously chief of the eye clinic at Bassett Army Hospital for three years. During those years, he was in charge of the optometrists at the eye clinic and had overall responsibility for all medical and optometric care at the clinic. Additional evidence of the breach of the standard of care is found in the established text "The Optometric Profession." That authoritative work explicitly

8/ The standard of care required of medical doctors, osteopaths, and dentists is found at AS 09.55.540. Optometrists were not included. In 1976 the statute was broadened to include all health care providers. 34 Ch. 102 SLA 1976. The amendment was limited, however, to actions filed after the effective date, May 29, 1976. Since Steele v. U. S. was filed August 20, 1976, the amendment is not applicable.

states that an optometrist is bound not to try to differentiate between pathologies such as hemorrhages. Instead, an optometrist must refer the patient to a medical practitioner for prompt examination.

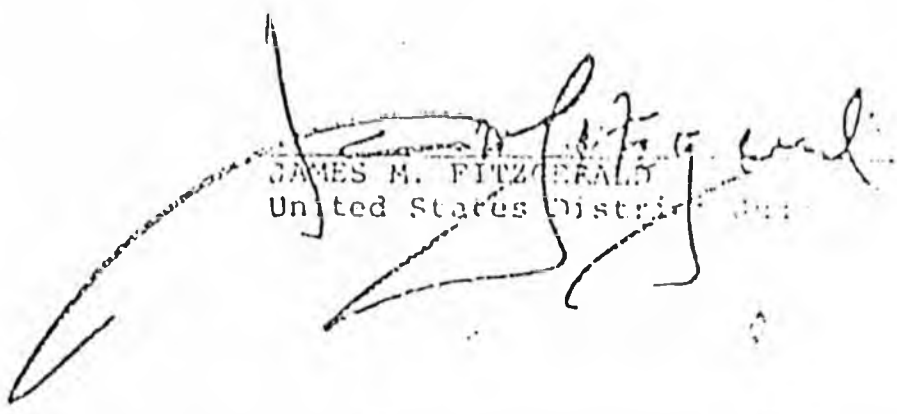
I conclude that competent optometric practice required that Timothy's parents be notified and that the child be referred. The failure to inform and refer was not a "judgment call" but a violation of the governing principles of professional standards.

Optometrists are trained to recognize symptoms of many diseases which may be discovered by eye examination. They are not permitted under recognized optometric standards to undertake a definite diagnosis but recognize this as the responsibility of a medical doctor. ^{9/} Obviously, it is foreseeable that failure to refer to a qualified medical practitioner, when required to do so, will result in delay of diagnosis and the institution of treatment; so it proved to be in Timothy's case. At the time the referral was finally made to an ophthalmologist, it was too late. Time had run out, and the only thing that could be done was to remove the eye.

may not diagnosis

I conclude that the plaintiff is entitled to recover in this action from the United States for the loss of Timothy's right eye.

DATED at Anchorage, Alaska, this 20th day of October, 1978.


JAMES M. FITZGERALD
United States District Court

^{9/} The Optometric Profession, pp 6, 17.

THE PRECEDING DOCUMENT(S) MAY NOT FILM
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ORIGINAL.



LASKA STATE MEDICAL ASSOCIATION

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



February 26, 1979

Representative Thelma Buchholdt, Chairman
House of Representatives
Health, Education, and Social Services Committee
Pouch V, Mail Stop #3100
Juneau, Alaska 99811

Dear Ms. Bushholdt:

The Alaska State Medical Association Legislative Committee has reviewed House Bill 79, an act relating to the practice of optometry.

Enclosed is a copy of correspondence relating to the issue during the 1978 Legislative Session. The position of the Association remains essentially the same, namely:

- (1) We are unable to determine how this legislation will improve eye care or specifically benefit the public.
- (2) Specifically, we know of no diagnostic use for the drug class, miotics, requested; in converse, their use would be appropriate for treatment of narrow angle glaucoma, precipitated by a mydriatic/cycloplegic use. This condition, we understand, is more prevalent amongst the Alaska natives than the general population, such that bush use of these drugs could carry increased risk.
- (3) We approve the educational requirements added in the 1979 legislation. It follows that should the Legislature believe the proposed legislation is in the broad public rather than for special interest, no grandfather type clause should be allowed.

Sincerely,

Winthrop Fish, M.D.
Chairman, Legislative Committee
Alaska State Medical Association

WF:mlm

Enclosure

February 14, 1978

Representative Charlie Parr
Chairman, House HFSS 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 contemplated, 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.

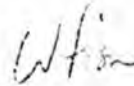
Before extending the scope of optometry, well beyond refraction and the sale of contact lenses and spectacles, into the intricate area of complex ophthalmological diagnosis, we ask that you assure yourself of the following:

- (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.

- (2) That the general level of training of the practicing optometrist in Alaska at present is at a standard which will preclude frequent mis-diagnosis, delay, duplication of expense and inappropriate trials of corrective lenses for non-refractive disorders of the eye.
- (3) That the use of ophthalmologic drugs in the practice of optometry is free of risk.
- (4) That the expanded drug use is necessary and essential to increased accuracy in refractive error diagnosis.

We feel the answers to the above are not obvious, we see no urgency to enact the legislation without the most careful study of the implications and therefore urge that you allow ample time for its consideration.

Sincerely,



Winthrop Fish, M.D.
Chairman, Legislative Committee

WF:mlm

cc. ASMA Council
ASMA Legislative Committee



why drops?



"WHY DROPS?"

Patients sometimes ask their eye physician, "Why do you use 'drops' when you examine my eyes?"

A clear answer to this question will help one understand the fundamentals of medical eye care and the relationship of his eyes to the health of his body.

"Drops" are of several kinds and they serve several important medical purposes.

One of the commonest uses of drops is to **enlarge the pupils**, so that the physician may examine more thoroughly the interior of the eye—to "look through the open door instead of through the key-hole." There, for the trained medical man to see, may be the first sign of disease elsewhere in the body. Drops make it possible for him to study not only the lens through which the light must pass, but also the retina where the image is formed, and the optic nerve which transmits the picture to the brain.

Such drops are particularly important in examining older people, who are prone to eye diseases, and often have a small pupil that becomes even smaller under the light of the examining instrument. Dilation of the pupil is necessary in examining the eye for suspected cataract, diabetes, hardening of the arteries, high blood pressure—to name a few examples. The effect of drops used merely to dilate the pupils lasts only a matter of hours, and frequently causes little or no blurring of vision.

A second common use of drops is to **relax the focusing muscles** in the eye. This is often necessary to determine the true degree of refractive error that has to be corrected by glasses. Because the focusing muscles in the eye are relaxed by these drops, the eye cannot focus and the vision is blurred until the effect of the drops wears off. These drops also cause the pupil to dilate; however, it is not the dilated pupil but the relaxed focusing muscle that causes blurring of vision. The use of these drops is especially important when examining children. When a physician examines a young child with strabismus (crossed eyes), it is essential to use drops that relax the focusing muscles in order to determine what corrective glasses are required.

A third use of drops is to **anesthetize the eye**, to permit the physician to perform certain diagnostic tests without discomfort to the patient. These drops cause little or no blurring of vision. They are required for the all-important testing for glaucoma. Anesthetic drops are also necessary for the relief of pain resulting from injury.

Finally, there are several ways in which drops are used in the **treatment of the eye**. Some drops are used to destroy bacteria, some to relieve inflammation within the eye, others to relieve a bloodshot condition, and still others to make the pupil small in order to lower the pressure within the eye. Drops to dilate the pupil are used in certain diseases to keep the muscles resting while the eye recovers, or to prevent complications which might develop if the muscles controlling the focus and the pupil were not kept at rest.

Of course, all drops are medicine and they can be prescribed only by a physician, who is licensed to practice medicine and surgery, and administered only by him or someone acting on his order. You should never let anyone else put anything in your eye. Sometimes drops are prescribed by your family doctor, to whom you can always turn for advice about your eyes. He or any other Doctor of Medicine can also tell you of a Doctor of Medicine who specializes in the eye—an ophthalmologist.

Whether or not drops of any kind are to be used is a decision for the attending physician. Only the Doctor of Medicine who examines your eyes can say whether drops are needed.

* * *

Why drops? Because they are useful medicines in the modern scientific care of the eyes—as useful in their place as any other drug or instrument that physicians have at hand for the relief of pain and the restoration of health. They are often the key to the prevention of blindness and even the saving of the eye itself.

American Association of Ophthalmology
1100 17TH STREET, N.W. • WASHINGTON, D. C. 20036

Joyce -

Dave Walker
has added a sec. to
this (sec. 4) on the last
pg. You might want
to take a look @ it.

Sham

Original sponsors: Martin, McKinnon,
Meekins, et al

1 IN THE HOUSE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2 CS FOR HOUSE BILL NO. 79

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 ELEVENTH LEGISLATURE - FIRST SESSION

5 A BILL

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

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

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

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

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

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

20 Sec. 08.72.305. USE OF DRUGS FOR DIAGNOSIS. (a) No person prac-
21 ticing optometry may use drugs for diagnostic purposes unless he has

22 (1) passed the board's examination on the subject of pharma-
23 cology as it relates to optometry and the use of topically applied
24 drugs; and

25 (2) completed courses and clinical experience approved by the
26 board and offered by a recognized and accredited school or college of
27 optometry and passed an examination, given by that school or college,
28 which relates to topical application of drugs to the eye, including
29 proper responses to reactions which may result from topical applications

1 of drugs to the eye.

2 (b) No person practicing optometry may administer drugs except for
3 recognition of pathology and diagnosis of a vision anomaly.

4 (c) Topical anesthetics, mydriatics, miotics and cycloplegics may
5 be used by a person practicing optometry under conditions approved by
6 the board.

7 * Sec. 3. AS 17.15 is amended by adding a new section to Article 1 to
8 read:

9 Sec. 17.15.055. SALES TO OPTOMETRISTS. A person licensed to
10 practice optometry under AS 08.72 who has been authorized by the Board
11 of Examiners in Optometry to use topically applied drugs under AS 08.-
12 72.305 may purchase topical anesthetics, mydriatics, miotics and cyclo-
13 plegics.

14 * Sec. 4. AS 08.80.260(7) is amended to read:

15 (7) conviction of selling federal legend drugs without pre-
16 scription of a licensed physician, surgeon, dentist, optometrist, or
17 veterinarian;

HB 79

REPORT TO
THE CONGRESS:
REIMBURSEMENT
UNDER PART B OF
MEDICARE FOR
CERTAIN SERVICES
PROVIDED BY
OPTOMETRISTS

The Bureau of Health Manpower projects the overall number of active ophthalmologists in the United States to rise to 13,300 in 1980 and to 18,400 by 1990; this compares with projected levels of 22,000 and 28,200 for optometrists in the same time intervals. The proportion of ophthalmologists as a percent of total professional vision care manpower is projected to grow from 35 percent in 1973 to 38 percent in 1980 and 39 percent in 1990. These estimates should be interpreted cautiously, and should be undertaken in the context of written documentation available from the Bureau of Health Manpower. Available data preclude such projections on a detailed geographic basis.

More specific data indicates that in recent years many areas of the country, particularly non-metropolitan areas, are served only by optometrists. Approximately 40 percent of counties have an optometrist but no ophthalmologist. Another 27 percent have neither.

Optometric Practice

The Institute of Medicine of the National Academy of Sciences, in describing primary health professions who are direct providers of patient care, defined optometry as follows: "The Doctor of Optometry (O.D.) is a health professional who performs eye examinations to determine the presence of visual, muscular, or neurological abnormalities, and prescribes lenses, other optical aids, or therapy, such as eye exercises to enable maximum vision. Optometrists are trained to recognize disease conditions of the eye and ocular manifestations of other diseases, and to refer patients with these conditions to the appropriate health professional."

This definition, as well as available documentation on the utilization of optometric services, points to the optometrist's role as a provider of primary health care services. In this role, the optometrist functions as a principal point of contact within the health care system for persons having visual complaints, including certain numbers who have symptoms or conditions that require referral to other health practitioners.

The scope of practice for optometry, similar to that for other health care providers, is difficult to define precisely. However, information is available from a number of sources to develop valid concepts of a profession's role and function. Such sources include State laws, judgments of courts concerning the responsibilities of practitioners, the usual and customary practices of the profession, and the objectives, content, and standards of education and training for the profession.

An examination of a variety of such sources suggests that optometry is a profession qualified to provide a broad range of services which are effective in patient management, including the management of aphakic and cataract patients. (See discussion in Part II of this report for detail on sources cited and information examined.) It is reasonable to infer that such services correspond to many specific

BASIC ELEMENTS OF THE CURRICULUM OF SCHOOLS OF OPTOMETRY

1. Biological science knowledge base.

- a. Gross human anatomy and microscopic anatomy, with emphasis on head, neck, and thorax.
- b. Embryology, gross and microscopic anatomy of the human nervous system - concentrating on the central nervous system.
- c. General human physiology, including the study of the fundamental organ systems and the mechanisms which regulate body function. Emphasis is on the sensory, motor and cardiovascular systems.
- d. Basic concepts of general and cellular biochemistry, with study of nomenclature, structure and reactions of organic molecules. Emphasis is on the visual system - tears, intra-ocular fluids, lens, retinal photochemistry, and actions of drugs upon these.
- e. Concepts of human genetics and genetic disorders, including the frequency and distribution of genetic disease, inheritance patterns, polygenic inheritance, chromosomal aberration syndromes, multifactorial genetics, and principles of genetic counseling.
- f. Gross and microscopic anatomy of the lids, orbit, orbital content, globe, muscles, nerves, and vessels, and embryology of the eye.
- g. Vegetative physiology of the eye, extraocular and intra-ocular fluids, corneal and lens metabolism, ocular circulation, retina and optic nerve metabolism.
- h. General pharmacological principles, methods of administration, various systemic drugs and their pharmacological action and side effects with emphasis on those that affect the visual system, such as cataractogenic and glaucoma-producing drugs.
- i. Pharmacology; uses, doses, contraindications, and adverse effect of drugs producing miosis, mydriasis, cycloplegia, accommodation, and ocular anesthesia. The pharmacology, use contraindications, and adverse effect of drugs commonly used in treating visual and ocular problems.

As is evident from the discussion above, the Department endorses the first recommendation. For reasons cited, however, Department endorsement of the second recommendation is viewed as inappropriate and premature at this time.

During the course of the study effort, a number of additional issues and concerns were identified by the expert consultants which, although important considerations, represent matters not directly responsive to the specific legislative charge as interpreted by the Department. These recommendations and comments, made unanimously by the consultants, are presented here to provide an opportunity to bring these matters to the attention of Department Agencies and the Congress. Because the following items go beyond the requirement of this report, the Department has not fully examined them and makes no recommendation at this time.

1. Refractive services for aphakic patients

Aphakic patients, specifically, should be considered as having special needs given their disabled condition. Refractive services for such patients represent non-routine and necessary services in the provision of prosthetic devices, i.e., lenses.

Study advisors recommend that consideration be given to extending coverage under Part B of Medicare to include refractive services for aphakic patients when provided by either ophthalmologists or optometrists.

2. Low vision services and aids

For those patients who have inoperable cataracts or have less than optimal results from cataract surgery, that is, those who have reduced visual acuity, low vision services and aids represent essential components of reasonable and necessary health care services for these patients.

Study advisors recommend that coverage under Part B of Medicare be extended to include the provision of appropriate low vision services and optical aids for the above-referenced patients, when provided by either ophthalmologists or optometrists.

3. Prevention, health maintenance, and health education

In the interests of health care cost advantages, effects on productivity, and the overall improvement of benefits that can be afforded our population, the expert consultants recommend that a more effective effort be made to improve preventive, health maintenance, and health education measures. While this is needed in all areas of health services, the vision/eye care field offers a particularly promising area for such approaches.

4. Other service provided by optometrists

Vision/eye care services currently covered by Part B of Medicare, when provided by ophthalmologists or other physicians, include eye conditions other than cataract and aphakia. Optometrists can provide appropriate services for some of these conditions. It is recommended that extension of reimbursement to include the services of optometrists for such appropriate conditions is a desirable subject for further consideration.

5. Administrative considerations

Also during the course of the study effort, expert advisors raised several concerns pertinent to the administration of the Medicare program. These issues, also applicable to other Medicare services, include the following: (a) inconsistent application of coverage and reimbursement policies by individual carriers, (b) the problem of payment duplication for services and reimbursement for similar diagnostic procedures when performed for specific individuals by more than one provider, and (c) need of improvement in coding and billing procedures for vision/eye care services.

6. Cooperative working relationships between vision/eye care professionals

It became clear during the course of this study that more effective working relationships between optometry and ophthalmology and other providers in the vision/eye care field would enhance patient care and result in improved services to individual patients. While improved interdisciplinary coordination applies to all the health disciplines and specialties, it is a problem of particular concern in the vision/eye care field. Such working relationships could be significantly strengthened by

- a. Development of joint educational programs at the undergraduate and graduate levels, including rounds, clinics, conference, and meetings and publications.
 - b. Establishment of interdisciplinary clinics with optometrists and ophthalmologists working together.
 - c. Facilitation of referral of patients between the optometrist and the ophthalmologist when in the best interest of the patient.
 - d. Joint development of quality standards for service and materials by peer review mechanisms. By materials, particular reference should be assigned to varying quality of lenses and frames and the need for furnishing laboratory invoices of material costs for reimbursement.
-
- e. Joint development of appropriate revision to state licensure laws to permit use of diagnostic drugs (anesthetics and local anesthetics) by optometrists

While such services are available in various areas of the country, they need to be localized and routinized.



Official Business

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

March 13, 1979

Ms. Maureen Roche
3311 Eureka Street #3
Anchorage, Alaska 99503

Dear Ms. Roche:

Thank you for your recent letter regarding HB-79, "An Act relating to the practice of optometry."

This bill did pass the House last year as HB-664 but was held up in Senate Rules. This year, the House Health, Education and Social Services Committee has held three hearings on the bill so far. We've heard testimony from both Optometrists and Optomologists and have had work sessions on the bill. We do plan to hold at least one more hearing on HB-79, which will probably be another work session to mark up the bill.

So, at this time, we are still giving consideration to HB-79, hence, your letter of suggestions will help.

I do appreciate your taking the time to write to me to express your feelings on this bill. I will keep your suggestions in mind when I make my vote.

Sincerely yours,

THELMA BUCHHOLDT
Chairman
house HESS Committee

TB/ch

3311 EUREKA St.#3
Anchorage, Ak.99503
March 3,1979

Dear Ms. Bucholdt,

It is my understanding that House Bill 79 is under view by your committee in the eleventh legislature-first session. If at all possible I would appreciate being informed as to the status of this "act relating to the practice of optometry".

My interest in this matter takes on a fervent stance due to the fact that I have been directly involved in the delivery of eye care services to those recipients in the Bering Straits Region. In light of this I feel obligated as well as deeply concerned with this notion of introducing Sec.08.72.305 to the enactment of the legislature.

I need not inform you that we both share a vested interest in this matter since we are potential candidates of optometric services; let alone the populus that this bill will effect if passed.

This missive serves you in a genuine tone of concern since Alaska now is beseiged by the "drug bill", SEC. 08.72.305. Pursuant to this is the idea that health care, specifically, the medical health eye care aspect should be viewed under a microscope for what is to be understood as a redefinition of the scope of the optometrist. Or, if you would, a broadening of the defined scope of the optometrist. To wit... allowing the utilization of pharmaceutical agents (drugs). I beseechingly ask that you read the following paragraphs for the sole purpose of another outlook from a concern citizen, not to mention for the sake of the public whom you represent in this permissive matter of eye care.

The decision that confronts the legislative body is a precarious one. Due to the fact that a question must be brought forth & posed, what constitutes the optometrists in this state to utilize drugs in their non-medical profession.

An apparent exigency is prevalent to bring to attention the delination between the non-medical profession (optometrists-O.D.) & the medical profession, (ophthalmologists-M.D.). Both are distinguished in their own right & certainly are awarded the recognition & respect from our society. However the ophthalmologist has gone through an intense array of medical education & training for his endavour of the total encompassing diagnosis, treatment, & care of the eye. The optometrist need only attend a few years of schooling for gainful knowledge of a cognizance of an optical deficiency correctable as he sees it by administering & prescribing lenses &/or prisms. Hencefore, the medical profession is more adequately & better prepared for the entire entity of tending to the eye than the optometrist, merely by training & education. Be it stated here that the above mentionned was not meant in a derogatory fashion nor a demeaning one towards the optometric profession.

In conjunction with this is the question posed, why would a non-medical profession such as optometry effaciously invade the medical profession in medicine. Both are sciences, but, both are concerned with different concentrations intrinsically related to their science. Optometry was established with the initial purpose as a profession to aid in "vision improvement" acting as a liason for the ophthalmologists.

At this propitious time of concern with rising health care at an annual rate of 12% & an approaching make-up of 10% of the GNP the non-medical profession of optometry has sought an entrance into & engagement in being a medical provider of health care delivery by the pursuit of practicing ophthalmology. I can only surmise this from reflecting observations of the events & recent developments between these two professions & what is taking place in the state house / senate in Alaska.

This issue becomes sensitive not only for the reason that the eye as an organ is one of man's most cherished & most relied upon senses but primarily how Alaska will handle, cope, & decide upon what constitutes the profession of optometry to utilize drugs in their profession. Advertently, how health care will be delivered to its constituents. All legislative powers are in throes of controlling this predicament. However, I fail to see how amending this bill will alleviate & eliminate the cost of medical care, let alone upgrade & enhance the quality of medical health eye care.

As with any service rendered in our society one seeks the quality of service for the least amount of cost to them. The same holds true in medicine. I believe as you might concur that a patient seeks a physician eye doctor for his knowledge, skill, ability, talent in his area of medicine with a degree of trust for all intents & purposes of efficaciously being relieved of whatever objective &/or subjective sign &/or symptom that the individual had to seek the M.D. in the first place. For you to fully understand the topic in deliberation, this missive necessitates that you be privy to the condition of glaucoma. The example to be cited is stated in order to stress the full impact & seriousness of Sec. 08.72.305

Pertinent to this is the prevailing factor that Alaska is different than the other states that have considered the "drug bill" in regards to its recipients of eye care health services. For the Alaskan Natives are predisposed to the condition of glaucoma, particularly of the four types, narrow angle glaucoma. This is due to their anatomical trait of a shallow anterior chamber.

I ask that you bear with me in a basic description of the eye & vocabulary related to it.

Affecting 1 out of every 100 people over 40 & being the second leading cause of blindness in the U.S.: glaucoma is an afflicting disorder. There exists within the eye an intricate drainage system, so established that the aqueous humor (fluid which aids in maintaining the shape of the eye & its nourishment for it) continuously leaves the eye through the drainage network. In the case of an individual afflicted with glaucoma the exit route is complicated. Basically, a squelching effect of that which is a composite of the angle of drainage in the anterior chamber of the eye becomes narrow, or more fluid is produced than what is considered the normal. Hence, the subsequent build-up of pressure within the eye. IT IS THIS intraocular pressure that jeopardizes the sight of an individual. For glaucoma is that injurious increase of pressure within the eye pressing on the optic nerve. The optic nerve being the running umbilical cord to the brain for the interpretation of vision. If you will, it is the M.D.'s insight & his ability to detect this disorder that is quite significant, whether or not the individual will maintain good vision. For this is an eye condition that is not curable, solely controllable with medication &/or surgery.

Narrow angle glaucoma may be precipitated when the pupil (black portion of the eye) dilates (enlarges) as it encounters darkness or after the administration of mydriatics (dilating drugs).

The latter precipitory factor arises when a doctor utilizes one of many mydriatic drugs during the course of an eye exam , fundus exam (viewing the posterior portion within the eye) & for evaluating refractive errors.
(Sec. 08.72.305 2,c) Mydriatics facilitate examinations of that already mentionned.

A patient with an underlying condition of narrow angle glaucoma may be subjected to medication by the attending physician whether it be for any one of the mentionned eye examinations. In view of this, induced is the incidence of an attack of acute narrow angle glaucoma. WHY? The iris, (colored portion of the eye) had been induced to dilate by the administered drug. Consequently, this inhibits the muscle to constrict therefore closing off the escape route for the aqueous fluid. What now occurs is excruciating & intense pain due to the escalating intraocular pressure upon the optic nerve. If not quickly tended to with the attention of rectifying the precarious situation by a counter effect of medication whether this be administered orally, or intravenously irreversible damage will ensue.

Obviously, at this point & time the reflexive resposes of the attending eye examiner is weighted with responsibilities of anothers vision AS you & your committee are weighted with the responsibility of answering what constitutes the optometrists in this state to utilize drugs in their non-medical profession. My faith lies herein with your time & consideration of Sec. 08.72.305.

Sincerely,

Maureen Roche

Peter E. Cannava, M.D.

OPHTHALMOLOGY

BOX 1629

SOLDOTNA, ALASKA 99669

TELEPHONE 262-4462

March 15, 1979

Representative Thelma Bucholdt
Pouch V.
Juneau, Alaska 99811

RE: HB79

Dear Mrs. Bucholdt;

Many legislators have asked about the harm which can come to Alaskans as a result of HB 79 (optometric drug bill). In addition to the Fairbanks case which you are well aware, please see the enclosed list of patients across the country whom have suffered as a result of optometrists attempting to practice medicine. A study of the individual cases is educational and provocative.

Sincerely,

Peter E. Cannava, M.D.

Peter E. Cannava, M.D.

ENC;PEN

PEC/bc

PUBLIC DANGER DOCUMENTED

SPECIAL SUPPLEMENT

ANNUAL REVIEW OF SELECTED CASE HISTORIES

As published in *THE PEN...—* during 1977-78

TUMOR OVERLOOKED

Mrs. Lois McWalters
Massachusetts Widow



Vol. 1, No. 1, July 15, 1977

The first issue of THE PEN featured a tragic testimonial headlined "Massachusetts Widow: 'It Seems Bizarre.'" Excerpts follow:

Five years ago my husband began complaining about his eyesight. He decided to see an optometrist and he continued to do so for 2 1/2 months. As his vision deteriorated at this time, he experienced headaches so violent they would awaken him from a sound sleep. I pleaded with him to see an ophthalmologist or some person with a medical background. He became increasingly irritated at my suggestions and I was forced to bow to his decision or submit to an unhappy home life.

As each day passed, before my eyes his personality changed; this sweet gentle man became verbally abusive and the general tenor of our home was unbearable. At that time our four children were 6, 7, 8, and 9 years old. They watched their father hold a cup of coffee, his hand tremors so pronounced he would spill it and leave the table in a terrible rage.

I pleaded again, to no avail. How does a wife forcibly take a grown man to a doctor? He trusted

SPECIAL ANNUAL PERSONAL EXPERIENCE REVIEW ISSUE

During its first year, THE PEN has published numerous carefully documented cases of eye damage resulting from attempts by non-medical practitioners to practice medicine. These four pages are a collection of selected excerpts of those cases which have prompted expressions of maximum interest from readers.

While there has been no official response or challenge from organized optometry, individual optometric lobbyists have advised legislators that these cases are "isolated instances." The steady flow of similar testimony pouring into PEN headquarters prompts us to suggest that the cases are not "isolated," but rather "the tip of an iceberg."

The Editors

OPTOM-PSYCHIATRY

Barbara Cosgrove

"Lack of Love"

Vol. 2, No. 3, Feb. 1, 1978



A Connecticut woman, interviewed by Jeffrey Gold, M.D. of New Haven, told how an optometrist

DANGER AND WASTE IN THE VA

Robert B. Nolan
Disabled Veteran



Vol. 2, No. 8, April 15, 1978
Vol. 2, No. 11, June 1, 1978

In these issues, a totally and permanently disabled veteran told how he got less than the deserved in-depth investigation into the problem of allowing VA optometrists medical functions. Mr. Nolan again found more evidence of danger and waste in the VA. Excerpts from the first story follows:

"... The VA would not permit me to receive outpatient treatment from a private physician unless I lived 30 to 50 miles from a VA treatment center. I didn't, so I decided to pay for my own doctor and then go to the VA and see their M.D. for medication only.

"My wife called the VA in the federal building in downtown St. Petersburg for an appointment early in August of 1977. She told the girl on the phone that I needed an eye doctor because I had glaucoma.

"My first visit to the VA eye 'doctor' was August 22, 1977. I presumed that the doctor I saw was an M.D. ophthalmologist. His name was on the door and it said 'doctor.' . . .

"The 'doctor' finally tested my tension with a hand tonometer after three months of

The optometrist. The optometrist changed his glasses three times - each prescription being for stronger lenses - during those 2½ months. Each time his eyesight and the pain was not even slightly improved by the change of glasses. He was told it would take time to get used to them. The optometrist never suggested he see a medical person.

His suffering increased to such a point he could not work or concentrate. I suggested a vacation and he agreed. . . . He now had a black patch over one eye "to rest it" prescribed by the optometrist.

I was frightened; I felt he was dying and I was helpless. After a few days of rest I gently broached the subject again and very unlike me, burst into tears. . . .

Our vacation was cut short because he was so ill. He insisted upon going to work when we got home, but surprised me by phoning from the hospital. He had seen an ophthalmologist who immediately spotted the problem and within minutes called in a neurosurgeon. The neurosurgeon admitted him to the hospital at once. I discovered later that when the ophthalmologist's secretary heard the symptoms over the telephone, she had insisted Dick come to the office immediately.

The neurosurgeon told me frankly he felt that Dick had a brain tumor. At our community hospital, tests were done in the next few days; the consensus was a brain tumor.

Surgery was at nine. . . .

Bad news it was, a malignant brain tumor called an astrocytoma. "I would give him about eighteen months," the doctor said, "but be prepared for some horrible times ahead." Twelve days later God mercifully took his beautiful soul and left his tired, worn body. . . .

In retrospect, it seems bizarre to me that when one (in this case the optometrist) realizes a situation is out of his control, that he wouldn't immediately make a referral, especially when seeing a patient suffer so much. ●

claimed her child's blurred vision could be cured with "more love and understanding at home" in a story headlined "O.D. Calls Diabetes A 'Lack of L. c.'" Passages of that interview follow:

Dr. Gold: "Mrs. Cosgrove, why did you bring Barbara to me?"

Mrs. Cosgrove: "We were referred here by our family doctor who just found diabetes in Barbara. She is 11 years old. I told him I had just had her eyes checked by an optometrist."

Dr. Gold: "Do you mean Barbara was examined by an optometrist lately?"

Mrs. Cosgrove: "Yes, she failed the school vision test in November and they said to have an examination. He (the optometrist) has a great big sign out in front, that says 'Doctor,' and I thought he was one."

Dr. Gold: "What did he find?"

Mrs. Cosgrove: "He said there was nothing wrong with her eyes and when I asked him why she kept getting blurred vision, he told me that she was a nervous child and when she gets up-tight, her eyes get blurry. My reaction was to take her to a social worker, but he (the optometrist) told me she just needs more love and understanding at home and that there was no reason to do any more than see him again next year."

Dr. Gold: "Then what happened?"

Mrs. Cosgrove: "I thought I was some kind of a rotten mother with such a nervous child, and I cried that night."

Dr. Gold: "Did you pursue the blurred vision at that time?"

Mrs. Cosgrove: "During December, Barbara seemed to have the flu, but it didn't go away and by Christmas Eve, I real-

ized I had a problem. After the eye test for glasses and said the pressure was 19 in each eye. I showed him the prescription I had received from Kenneth Saffko, M.D., my own ophthalmologist, and he said, 'Wait until I xerox this as it is no good here. I will have to write my own prescription.'

"After copying Dr. Saffko's prescription and putting it in my file, he wrote his own prescription and took it next door to get it co-signed. . . .

"On my way to the pharmacy with my wife, she looked at the prescription and said it didn't look right. We took it back and the 'doctor' changed it from pilocarpine to 3/4% carbachol with six refills. Another doctor (probably an M.D.) co-signed the new prescription. . . .

"Or our next trip to the VA center, my wife asked the woman at the front desk if the doctor we saw was an M.D. and an ophthalmologist. The woman at the desk replied, 'Yes, he is a full-fledged doctor and an ophthalmologist fully qualified to treat eyes.' . . .

"When I finally got the glasses, sometime in late November or early December of 1977, I discovered I could see much better without them.

"On my next trip to the VA on December 19, 1977, I returned the glasses. The 'doctor' told me the reason the glasses had been so long coming was because he rejected them two or three times, since they were not to his prescription. When he took the glasses to the next office to check them, my wife and I looked at his diploma on the wall. It said 'Doctor of Optometry.' When I told him we thought he was an ophthalmologist, he became very angry and said, 'Do you question my qualifications?' I told him I certainly did question his qualifications to treat glaucoma or any other eye disease. He told me that the people at the front desk didn't know the difference between an ophthalmologist and an optometrist. I said, 'If this is true, what if my eyes need surgery?' He said if that were the case, I would have to go to the Tampa VA Hospital or the Bay Pines VA Hospital and some other doctor would operate. . . .

"Talking to people in the waiting room, we

Continued on page 6

Continued on page 6

Tragic Case Histories Dramatize The Need To

NETWORK TV WARNING

Totie Fields

Comedienne



Vol. 1, No. 8, Nov. 1, 1977

The following is a portion of an interview between TV-talk show host Merv Griffin and comedienne Totie Fields, during which she warned all diabetics to seek eye care only from ophthalmologists:

MERV: It was kept very quiet; but all of a sudden, about two months ago we all heard rumors that, now you were losing your eyesight from the diabetes.

TOTIE: It's true, it's true! — and you know why I want to talk about it?

MERV: Blue Cross must hate you!

TOTIE: They have lost so much money on me.

MERV: Have they?

TOTIE: Yeah, but you want to know? I didn't know it, Merv, I swear to you I saw 20/20! . . . this is what I want to make a point of, I went to an optometrist all the time and he said, "Totie you're doing wonderfully, everything is fine," . . . I've been a diabetic since I was nineteen years old, and you know how I watch myself; I weighed 200 pounds; all I ever thought about was eating. I swear to God they told me I couldn't eat and that was the end of it!!! I mean, I just ate myself into

oblivion! I used to do a show and in the

I did "Fight for Sight" — the benefit "Fight for Sight" for about five, six years in a row and that's the money that helped this whole thing! (applause) To get this discovery! Isn't that incredible? (applause) And you won't believe how I can see every wrinkle in your face, Merv, every wrinkle in your face, I never could see them before . . . ●

GLAUCOMA UNDETECTED

Mrs. Agnes Karrman

Connecticut Housewife

Vol. 1, No. 5, Sept. 15, 1977



Appearing in this issue of THE PEN under the headline "Conn. O.D. Tells Housewife: 'You Don't Have Glaucoma'," a Conn. woman told of an optometrist who failed to recognize her glaucoma. Excerpts follow:

"I was a nervous wreck before I visited the ophthalmologist that day in October, 1975, and then the bottom had just dropped out of everything. My fears had been justified because the ophthalmologist had just told me that I was suffering from far-advanced glaucoma. For some time I had experienced increasing difficulty with my vision. I couldn't read the paper without a magnifying glass. My eyes were constantly watering and sometimes I awakened at night with a headache. I could no longer see well enough to play the piano or organ.

"...Yet, despite these complaints, my optometrist had assured me for over a year there was nothing seriously wrong with my eyes.

meantime, my vision had continued to get worse and I could no longer enjoy any activities that required good eyesight.

"As I said earlier, my first visit to the ophthalmologist was a shocker. It was such a different examination! Not only did the ophthalmologist find that my pressure was higher than normal, he also found that my optic nerves had been severely damaged by this long-standing pressure and that my side vision had been destroyed. I could only see as though I were looking down a gun barrel . . . He discovered that I did have cataracts, but they were only a small part of my eye health care difficulties.

"The ophthalmologist's diagnoses and explanation of the extent of my problems not only added to my nervousness but made me very angry. I was angry with myself for not having listened to my sister's advice months ago to see an ophthalmologist and not an optometrist, and I was plenty angry with the optometrist! The doctor told me that an optometrist is not trained in medicine nor to diagnose or treat eye diseases. How can an optometrist act like an 'eye specialist' and flatly assure people that he is capable of this type of decision making? How can he keep peddling new glasses and sell eyewash types of eyedrops with implied assurance that they can cure? How can he stand by and literally watch one of his longtime customers go blind?" ●

EXTENSIVE EYE DAMAGE

Denton Livensparger

Double Jeopardy

middle I used to think where could I get a pizza around here; you know. I thought of nothing but food, Mallomars if I could only eat a Mallomar! Oreos, you know I was an Oreo freak . . . Oh, I talk about them and my mouth gets filled with saliva!!! I saw a little thing floating in my eye like a little hair, you know, that you couldn't get rid of and so I went to an ophthalmologist. Diabetics should never go to an optometrist, they must go to ophthalmologists because they see behind the eye. He said, "Totie, you've got to go . . . the best man in the country is in San Francisco and you must get to him right away." The next morning I was there and this man was telling me I was going blind, and I said, "You're crazy! Why didn't anybody else . . ." Well, they were so busy worrying about everything else, no one thought of my eyes, and I've never (incidentally, no one's ever heard this story before) — Well, to make a long story longer . . . yeah! I want, because I really want diabetics to be so aware because this operation is only two years old, Merv, and ironically enough, my dad died blind, my brother died blind, and I would have . . .

One day you get to that age where all the print is gone and the paper comes and you say why did they send me a white paper (laughter) — you know, and you'd go to the toilet and drop it on the floor and read it there (laughter) . . . you know what I mean. But, I can read proof! I mean, to open a menu and be able to see it without looking for my glasses is the most exciting thing, but I want you to know, everybody out there that is a diabetic, please, please go to an ophthalmologist . . . because you can be saved! You know the ironic part of this entire story,

"I had been going to an optometrist regularly for about seventeen years — ever since he had opened his office. He was always pleasant and the glasses he fitted for me were generally satisfactory. In 1974 I went to him complaining of blurred vision. He gave me new glasses but they didn't help. I went back to him and he told me that they were the right glasses and that I just hadn't allowed enough time to get used to them. I told him that I was worried about glaucoma because my brother had had surgery for glaucoma and is almost blind, and my sister was being treated for glaucoma by an ophthalmologist. She is doing well because her problem was discovered early. The optometrist assured me that he had checked for glaucoma and that I didn't have it.

"Several months later, because of increasing trouble with my vision, I returned to the optometrist . . . He again changed my glasses. At that visit I again voiced my fear of glaucoma and once again he assured me that my eye pressure was normal and that I didn't have glaucoma. He said my eyes were just tired. Well, the new glasses didn't help at all. They seemed to be no different than the previous pair he sold me . . .

". . . After another month and a half had passed I returned to the optometrist because my eyes pained at times and I often awoke at night with headaches. My vision was getting worse and my eyes watered constantly. This time I really pressed about my fear of glaucoma. He re-examined me and again sold me a pair of glasses — the third pair in less than a year! He told me that his \$3,000 special instrument measured accurately for glaucoma and that a referral to an ophthalmologist was not necessary. In fact, he told me that I had nothing to worry about, that my eyes were perfectly clear. He said, 'You don't have glaucoma and you don't have cataracts.' He gave me some eye drops to use three or four times a day. I used them regularly for the next four months until my sister finally persuaded me to see her ophthalmologist. In the

In a story headlined "Misuse of Drugs Plus Misdiagnosis Puts Floridian In Double Jeopardy," a Florida ophthalmologist told of how an optometrist missed signs of glaucoma and serious corneal abrasions requiring surgery in both eyes of a male patient. Excerpts follow:

"Misdiagnosis combined with the misuse of powerful drugs by untrained practitioners poses a frightening threat to public health and places our citizens in double jeopardy," says John D. Mallonee, M.D., a practicing ophthalmologist in Ft. Pierce, Florida. "The advanced years of many of our patients makes this menace even more serious and the public must be made aware of this grave danger," Dr. Mallonee said.

In support of his forthright statement, Dr. Mallonee detailed the following case history.

"On February 4, 1978, I first saw Denton Livensparger. This 65-year-old man came to my office of his own volition, and without referral. He told me he lived at 1196 Proctor Lane in Port St. Lucie, Florida, a nearby retirement community, and had been suffering severe pain in both eyes for some time. Mr. Livensparger voluntarily gave the following account of his experience to date."

"In early November 1977, I think it was the 8th," the patient said, "I went to see an optometrist about the pain I had in both eyes . . . I told them that for a long time, maybe nine or ten months, I felt as though I had something in both of my eyes, and that the pain was just getting worse all the time. After they examined me, they told me all I had was an eyelid infection and they gave me some antibiotic drops called Neodecadron. I went back again the next day and they told me I didn't have glaucoma, and all that was the matter with me was a minor eyelid infection that would clear up if I used the drops."

Continued on page 6

Protect The Public From Sub-Standard Eye Care

GLAUCOMA UNNOTICED

Mrs. Florence Hubbard

Blinded High School Student

Vol. 1, No. 2, Aug. 1, 1977



The following excerpts are from a byline story by a Massachusetts student headlined "They Call Themselves Doctors" - . . . Blinded High School Student," in which she told how an optometrist could not recognize advanced glaucoma.

"In August 1967 I was walking home from a friend's house when I knocked over a trash can because I didn't see it. A couple of days later I noticed that things looked blurry. I couldn't read signs or make out faces and when I looked at lights, there was a rainbow around them.

"I went to an optometrist in September and told him about all of this and that I had a throbbing pain in my eyes. My left eye was worse than my right eye. The optometrist asked me to read his eye chart but I couldn't see where it was. He examined my eyes and told me not to worry, he could help me. He said I had a lazy left eye and astigmatism, and he had just the cure for me — he was going to prescribe some glasses.

"Before the glasses were ready, the pain got much worse and my eyesight got more and more blurry. However, I trusted the doctor. I figured you go to a doctor and he knows how to treat you. I had always thought optometrists were doctors. They call themselves doctor.

"When I went in to get my glasses in October, I told him that my vision was much worse and he

Similar heartbreaking circumstances have accompanied many of the cases in PEN's growing file. Here's a random sampling.

• From the Wills Eye Hospital, a division of the Thomas Jefferson Medical School in Pennsylvania, - when a female patient complained of pain in the eye, an optometrist gave her an anesthetic drop to use. Later, he refused to see her. She developed a pseudomonas ulcer (infection) and the eye had to be removed.

• Also from Wills, a female patient told an optometrist that for seven years she had episodes of blurred vision brought on by reading. They usually lasted about an hour and when severe were associated with headaches. She was followed by an internationally famous optometrist throughout the seven years and was reassured nothing was wrong. Later, an M.D. found textbook symptomatology of chronic angle-closure glaucoma and advised immediate surgery on both eyes.

GOING BLIND

Mrs. Anita Oliver

Baltimore Cook

Vol. 1, No. 10, Dec. 1, 1977



The following passages are from an interview between a blinded Baltimore cook and ophthalmologist

LED TO BLINDNESS

Charles B. Wilson

Arizona Steelworker

Vol. 1, No. 10, Dec. 1, 1977



The following are excerpts from the story of an Arizona man headlined "Arizona Steelworker Led To Blindness," in which he told how an optometrist informed him he would eventually go blind, but gave no reason, and his misadventures with more optometrists:

"When I first thought I needed glasses 25 years ago, there was only one place to go in my home town in Ohio — and that was to an optometrist. He had the whole works — he gave examinations and sold glasses.

"He checked me one time, gave me glasses and then he said, 'In about 20 years, you're going to think you're going blind.'

"I asked him why, but he wouldn't give me a definite answer. He just said, 'Well, your eyes are going to change that much and you're going to think you're going blind.' To this day, I still don't know what he was talking about.

"I just figured it was my nearsightedness or the opposite, whatever that was. I wasn't bothered with anything until I came out here 17 years ago.

"I worked in a steel mill and once my glasses got all burned up in there, so I went to an optometrist in Mesa.

"He just checked my eyes like everyone else does. I got a new pair of glasses there.

"In the meantime, the Union got into the plan

got out the glasses and said, 'These should take care of you.'

"I went home with the glasses but they weren't helping. I was banging into desks at school, I kept banging into people, I couldn't see the blackboard. I must have called the optometrist about 10 times and he kept telling me I would be all right, that I was getting too worked up and making myself not see.

"When my mother and I went to see him the next day, my mother said he looked a little worried. He told us that I lacked something in my body, that I had a deficiency, and he would make an appointment for me with an ophthalmologist but not until after Christmas. He said I should go home and have a nice Christmas.

"When my mother and I went to the ophthalmologist on December 27, it was the first time I heard the word 'glaucoma.' He said I had all the classic signs.

"The ophthalmologist found that I had a pressure of 95 in both eyes — normal is 20, and total blindness is 100, he said.

"In April the pressure in my eyes went up again and this time the ophthalmologist thought it would be necessary to operate. By now my parents were so upset they had decided that they should be extra careful and get another opinion and I should go to Massachusetts Eye and Ear Infirmary. I did and it was decided I should have surgery on both eyes, to save what little sight I had left. I've lost 99 percent in my left eye and I have only the very center of the vision in my right eye — I can only see things that are straight ahead.

"After I got out of the hospital and began to feel better, my little eight-year-old cousin began to take me all around Gloucester by the hand so I could learn my way around. I still don't like going to new places and there are some things I can't do for myself. Once I set myself on fire trying to reach something over the gas stove and I didn't even know it. I was lucky my husband was home and saw it." ●

resident Larry Thompson, M.D. In a story headlined "Mrs. Oliver: 'I Told Him These Are My Eyes,'" she told how a vision-center optometrist became annoyed when she told him the glasses he prescribed did not work:

Mrs. Oliver: "I came to University Hospital because I was getting this blindness, and I couldn't see. I was at church on the fourth Sunday in July, and I fell down those steps."

•••

Dr. T: "You were seen for your eyes before coming here — when, back in February of 1977?"

Mrs. O: "Yes, it was February."

Dr. T: "And you were seen at - - - Vision Center?" (an enterprise which employs optometrists, but has no medical personnel.)

•••

Mrs. O: "Yes, I was there for glasses. They examined me but they didn't tell me anything. I asked the doctor why I couldn't see. The doctor got angry with me when I said I could not see out of my left eye like I should. I was trying to read the board, the letters and the numbers. And when he put the glass to my eye, I couldn't see and I told him that I couldn't see. He got very, very angry. He told me that he was doing the examination, not me. *I told him that these were my eyes and I should know whether I could see or whether I couldn't.*"

•••

Dr. T: "OK, he prescribed new glasses for you at that time. After you got those glasses, you could not see with those glasses, is that correct?"

Mrs. O: "Yes. I went back to them again and had that left lens changed. It was supposed to have been changed."

Dr. T: "Did they ever measure the pressure in your eye, touch your eye with anything to measure the pressure?"

•••

Dr. T: "Did they ever measure the pressure in your eye, touch your eye with anything to measure the pressure?"

Continued on page 6

and the company had to furnish eyeglasses. So, another optometrist in Terape gave me a cut-rate price for an eye examination, since I was an employee. It was a ridiculously low price. After that exam, I went to that optometrist all the time, about every two years. I went through this same routine for about 10 years.

"I started noticing that I was stumbling a lot out at the steel mill. I was falling and tripping over things, which I don't ordinarily do, I tried to get an appointment with the optometrist, but most of them in town were at a convention. I finally found one to examine my eyes.

"He examined me and said he saw something in one eye, but he admitted that he didn't know what it was. He recommended that I see an ophthalmologist.

(At this point, Mr. Wilson was asked whether or not the optometrist who checked him every two years for a decade ever checked anything besides his vision, such as his eye pressure.)

"No, sir, he never did anything like that. I figured I was getting a complete eye exam, like I'd had all of my life. He was called a doctor, and to me an eye doctor was an eye doctor.

"An ophthalmologist was just a long word as far as I was concerned! I'd never been around one, and where we came from there wasn't any. This last optometrist I asked point blank what was in my eye and he said he did not know and that he recommended my coming to see one of you fellas. He said you would have to 'lift the pupil up and look behind it and see what was in that eye.'...

"Well, here I am. I was legally blind. Now I've had surgery to save what vision I had left, but I'm still in bad shape. I believe this other guy that I went to should have seen something and checked it. But I didn't know he should have looked into my eyes with all those lights and stuff that he didn't do it. He never gave me a pressure check or anything like that.

"So now I'm disabled. I was led to blindness for 25 years." ●

OPTOM-PSYCHIATRY

Continued from page 3

- ized that she had lost her appetite and was losing weight; also she was always thirsty and urinating excessively, so I took her to our family doctor."
- Dr. Gold: "What did he find?"
- Mrs. Cosgrove: "He found diabetes. Her sugar was 790!" (*Normal is around 100*)
- Dr. Gold: "Did the optometrist ever mention to you the possibility that variably blurred vision could be a sign of diabetes?"
- Mrs. Cosgrove: "No, never. I don't think he should be allowed to be out there, on the street, calling himself a doctor! He doesn't know anything about disease. Why is he there? What's wrong?"
- Dr. Gold: "Mrs. Cosgrove, do you give us your permission to publicize the danger to people inherent in Barbara's story?"
- Mrs. Cosgrove: "Yes, I do."
- Dr. Gold: "Thank you very much." ☉

NEW YORK SPECIAL REPORT

The following case histories of optometric failure to recognize and refer medical eye patients were collected by Karl J. Marchese, M.D. of Rochester. All patients except one were personally interviewed by Dr. Marchese. Except where indicated, the source of information was the patient. All cases came to the attention of Dr. Marchese within the past 12 months through his practice as an ophthalmology resident. The patients reported in this paper as incidents of failure to recognize or refer medical eye problems, outnumber appropriate referrals to the clinic by four to one.

☉ A young college student called a local HMO (prepaid health insurance in which the patients have little choice of physician) with complaints of an irritated red eye. He was seen the same

GOING BLIND

Continued from page 5

- Mrs. O: "No."
- Dr. T: "Did they ever suggest that you see a medical doctor?"
- Mrs. O: "No, never."
- Dr. T: "Do you feel that poor people — people that haven't had a lot of education — are at a particular disadvantage since they probably do not understand the difference between an optometrist and a medical eye doctor?"
- Mrs. O: "I sure do think so. I was getting blind."
- Dr. T: "Do you realize that you would have been totally blind in another couple of months if you had not come down here?"
- Mrs. O: "I sure do." ☉

EXTENSIVE EYE DAMAGE *Continued from page 4*

Mr. Livensparger continued, "I took the drops just like they told me, but my eyes got even worse and I went back to see them on November 14. They told me just what they said before, that I had an eyelid infection that would go away if I kept taking the drops, even though I told them my eyes felt worse, not better. I continued using the medicine they gave me but it didn't help at all and I went back again to see them (the optometrists) on January 10th of this year.

"Again, they examined my eyes. They didn't mention glaucoma or pressure — just looked into my eyes with a light. They told me the medicine I was using wasn't doing the job and gave me something called Vasocidin. I used the new drops for about eight days and my eyes only got worse, so I went back again on the 18th of January. They said just keep using the new stuff and your infection will go away.

"Since I was getting worse all the time and the medicine wasn't helping, I thought I should see somebody else," Mr. Livensparger concluded. "When I talked to Mr. Livensparger on Feb. 4," Dr. Mallonee said, "he told me, 'I have continuous pain in both of my eyes. I can't stand the light, and keep my eyes closed most of the time

DANGER AND WASTE *Continued from page 3*

found many had gotten the wrong glasses. One man didn't get bifocals and he had used them all of his life. This whole farce left me with little faith in the VA health care system. . . .

"On February 27, 1978, I returned to the VA and asked to see the M.D. I had seen on my last visit. I was told that he had retired, so they sent me to another M.D. This doctor assured me that he was an M.D. and an ophthalmologist, and when I told him of my previous experience, he agreed that optometrists should not treat eye disease, but explained that since he was new with the VA, he couldn't change the rules, and he didn't want to 'make waves.' He told me that he also co-signed prescriptions for the optometrists even though he never sees the patients. This doesn't seem right to me . . ." ☉

TREATMENT DELAYED

Mrs. Clara Jones

Writes Iowa Legislature

Vol. 2, No. 2, Jan. 15, 1978



The following excerpts are from a story headlined "Damaged Patient Writes Lawmakers," which carried a letter that an Iowa woman wrote to the entire Iowa Legislature, reminding them that optometrists have no medical training:

"For the last 25 years my family has been going to an optometrist for our eye care needs.

"Some time after the most recent change of lenses, I began experiencing difficulty with my vision. Consequently, I returned to my

day by an "eye doctor" whom he believed was a physician but was in fact an optometrist. The optometrist diagnosed "iritis" and gave the patient a prescription for two therapeutic eye medications (homatropine and a steroid preparation) which was filled in the HMO pharmacy. The patient reports that the prescription had another physician's signature preprinted on it. The patient was examined only by the optometrist. He was subsequently examined by the optometrist four additional times over a six-month period. The optometric records were obtained and revealed that several therapeutic agents had been prescribed and no mention was made of consultation with or referral to a physician. Ocular examinations and evaluations for systemic disease were inadequate. The optometrist was unsure of the diagnosis, at times referring to "recurrent conjunctivitis" and "eposcleritis" as well as iritis. Finally on the last visit the patient was referred to an ophthalmologist.

Comment: The optometrist clearly exceeded the limits of his licensure by attempting to make a medical diagnosis and prescribing therapy. It is illegal for an optometrist to fill in (and for an organization to provide) presigned prescription forms. It is inappropriate for an HMO to use an optometrist to care for patients with acute eye problems.

⊕ A 73-year-old woman with diabetes was followed for 15 years by an optometrist who knew about her disease but referred her for a medical eye evaluation only when cataracts caused a significant deterioration in her vision. The patient had evidence of diabetic retinopathy (blood vessel disease of the back of the eye) which was more difficult to evaluate because of the presence of cataracts.

Comment: All patients with diabetes are at a significant risk of major ocular complications (including total blindness) and should have a medical eye examination at regular intervals. The examination requires special expertise which only the ophthalmologist can provide. Treatment is available for retinopathy at some stages.

because they water when I try to open them. The pain is bad, and I have it all the time."

Dr. Mallonee reported that his external examination revealed a very obvious problem. A condition existed whereby the patient's lower lids had turned in, causing the lashes of the lower lids in both eyes to rub against the corneas causing recurrent and chronic corneal abrasions. It was lashes rubbing on the cornea that gave the patient the feeling he had a foreign body in his eyes. He was in so much pain that he kept his eyes closed almost constantly since the abrasions were causing him severe pain.

"I found on further examination that much of the corneal tissue was gone due to the constant irritation." Mallonee said, "I also found early vertical cupping of the optic nerve head — an early sign of glaucoma.

"I recommended immediate surgery on both lower lids to eliminate the severe irritation. This has been done since and the patient is much better at this point in time. I also discontinued the medication prescribed by the optometrists, both of which cause glaucoma in susceptible patients. The eye pressure is now down, verifying that the long use of drugs had contributed to increased pressure. In addition, we performed a complete glaucoma work-up, which was clearly indicated." ⊕

⊕ A 30-year-old woman was seen six weeks previously at work by an industrial nurse for complaints of a red, irritated eye. She was referred that day to a local HMO where she was seen by an "eye doctor" whom the patient thought was a physician, but was in fact an optometrist. He diagnosed an allergic problem, recommended "Sinutabs," and referred her to an internist in one to two weeks.

Comment: The patient was inappropriately evaluated by an optometrist for an acute eye problem. HMO's should not use optometrists to evaluate patients with acute eye problems without direct physician supervision.

and told him my sight in my right eye was blurred and that something was wrong. After his examination he told me my glasses were correct, the blood vessels were healthy, and further there were no signs of glaucoma or cataracts.

"I still believed that something was wrong in my right eye but believed the doctor must know, so accepted his diagnosis. However, as the difficulty continued and gradually increased, after five months I decided to consult a medical eye specialist. In his preliminary examination he immediately suspected glaucoma which was subsequently verified in both eyes and that the disease had been there for a long time. Also the cataracts are starting. I am informed that a considerable portion of my vision has been lost due to the delay of treatment and cannot be restored, all due to a false sense of security given me by my optometrist.

"My medical doctor tells me that an optometrist is not trained in medicine nor to diagnose eye diseases.

"Because of this lack of training, the optometrist, in my opinion, should be severely penalized when he tries to perform such services which could well end in blindness for his patient.

"I strongly urge you to give this matter your most rigid study and action."

Mrs. Jones later told her ophthalmologist that vision loss was not the only way she suffered due to the optometrist's bold attempts to practice medicine.

"I fell twice," she said, "broke my right arm near the shoulder and the second time my left wrist. I still can't see a step."

Her physician, Leo J. Plummer, M.D., reports that her glaucoma is currently under control, on a program of medications. The Des Moines ophthalmologist notes that dense and extensive visual defects in both eyes are permanent, and that it is necessary for her to learn to walk with her head down to avoid tripping. Dr. Plummer has noted that the drugs Iowa optometrists seek to use are not necessary for the trained physician to suspect, or in most cases, diagnose glaucoma. ⊕



the University of Alabama in Birmingham / UNIVERSITY STATION / BIRMINGHAM, ALABAMA 35294

the Medical Center / SCHOOL OF OPTOMETRY / February 27, 1979

Representative Thelma Buchholdt
Pouch V
Mail Stop Number 3100
Juneau, Alaska 99811

Dear Representative Buchholdt:

It is my understanding that the Legislature of the State of Alaska is considering legislation (HB 79, SB 75), sponsored by the Alaska Optometric Association, to authorize optometrists to use drugs for diagnostic purposes when qualified by the State Board of Optometry. A graduate of this School of Optometry, Dr. Aharon Sternberg of Anchorage, has written me about this matter and requested that I write you regarding the inaccurate statements contained in the letter from Dr. Sam A. McConkey to you on February 14, 1979.

First, I completely and wholeheartedly support the use of drugs for diagnostic purposes by optometrists. I believe this is in the public interest and an essential tool for the optometrist in the discharge of his moral, ethical and legal responsibilities for the early detection of ocular disease and ocular manifestations of systemic disease. This school has regularly provided, as part of its required curriculum, courses in general and ocular pharmacology for all optometry students from its beginning in 1969, as well as courses in general, systemic and ocular pathology. These courses (pharmacology and pathology) are presented by faculty of the Joint Basic Science Departments of the Medical Center, the School of Medicine and the School of Optometry include lecture, laboratory and clinical instruction.


I am enclosing a copy of our Bulletin for the year in which Dr. Sternberg graduated which is essentially the same as the previous four years. A casual look at the curriculum (pages 41-47, summarized on pages 48-49) and a look at the faculty, (pages 63-66) clearly indicates that Dr. McConkey is in error regarding the education of optometrists. Graduates of this institution have an extensive background in pharmacology and pathology taught by qualified faculty (O.D., M.D., Ph.D.).

This is not an Alaskan problem since optometrists in twenty-two states may now use drugs for diagnostic purposes and other states are seeking the privilege based on their qualifications and the needs of the public. I am sorry that the emotional response of some ophthalmologists leads them to circulating inaccurate information which tends to obscure the public interest.

Representative Thelma Buchholdt
February 27, 1979
Page 2

I hope this information will be of assistance to you in your deliberations on this matter.

Most sincerely,

A handwritten signature in cursive script, appearing to read "Henry B. Peters".

Henry B. Peters
Dean

Enclosure

cc: Dr. Sternberg

ROBERT N. PAGE, JR., M.D.
JUNEAU MEDICAL CENTER
R.R. 3, BOX 3031
JUNEAU, ALASKA 99801

PRACTICE LIMITED TO THE EYE

February 27, 1979

Honorable Thelma Buchholdt
House of Representative
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

Pending legislation in the form of House Bill No. 79 and Senate Bill No. 75 represents an attempt on the part of optometrists to gain, through legislation, the right to use drugs. This is a right heretofore granted only on the basis of educational qualifications for very sound reasons. Optometry is a measuring science and has no medical background. An optometrist is not clinically trained. They are not qualified by education to diagnose or treat disease.

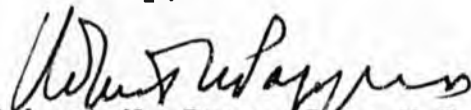
However, should this legislation pass, the public will be deceived into believing that they are receiving medical evaluation by optometrists, a definite hazard to public safety. Numerous cases substantiate this. The latest case occurred in Alaska (Steele v. United States of America) and is explained by an enclosure.

I hope that you will oppose this legislation which would downgrade the quality of medical care for the people of Alaska by allowing intrusion into the field of medicine by those without medical training or expertise. It is a dangerous precedent. Absolutely no shortage of medical profession talent exists anywhere in Alaska to justify such a compromise of professional standards of care and treatment. The cost of eye examination by optometrists in many cases is higher than that of a physician (ophthalmologist).

I would be happy to discuss with you the particular risks inherent in the use of the various drugs which are indicated in this legislation, since I will be responsible for treating the various drug complications, should they occur in this area.

Also find enclosed the reports of vetoes of similar bills by the governors of Virginia and Ohio. These are well thought out conclusions by men who are only partial to public well-being. Your serious consideration and concern is appreciated.

Sincerely,


Robert N. Page, Jr., M.D.

Enclosures

"M.D. IS THE MAJOR DIFFERENCE"

THE PEN...



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Published in the Public Interest by Ophthalmology

VOL. 3, NO. 2 JANUARY 15, 1979

RHODES OF OHIO: "WE CAN TAKE NO RISKS"

Ohio Governor Vetoes Optometric Drug Law

COLUMBUS, OHIO — On December 15, 1978, Governor James A. Rhodes of Ohio vetoed amended substitute S.B. 163, which would have permitted optometrists in Ohio to use diagnostic drugs. This marks the second time this year that a state governor has rejected optometric drug legislation in order to protect the citizens of his state.

The first veto came in Virginia when Governor John N. Dalton vetoed similar legislation, noting that, "There is reason for grave concern for patients' welfare where optometrists practice in isolation from medical backup."

Governor Rhodes echoed Governor Dalton's concern when he said in his veto message, "Health care is an area in which we can take no risks because any mistakes could bring tragic and irreversible results. We must be committed to our citizens to provide practitioners that are highly skilled individuals and who will at the same time provide the best health care at the lowest cost."

"Optometrists have been doing an excellent job in working with the medical profession to bring quality eye care to Ohio citizens. The tools that the optometrists are presently using are not dangerous and are effective in screening for eye disease."

He went on to point out that S.B. 163 "would

allow optometrists to use drugs in order to make a full diagnosis of the medical condition of the eye. If the individuals involved were properly trained," the Governor said, "this procedure would be in the best interest of Ohio's citizens. However, without proper training, the bill would allow unwarranted risks without corresponding benefits. The drugs involved are dangerous and have the potential of causing a great deal of pain including blindness. The adverse reactions associated with these drugs are not common, but they do occur and emergency treatment must be administered in those instances."

Noting that he vetoed the bill despite the fact that it included a provision that would require optometrists to take 180 hours of mandatory training, Gov. Rhodes said, "This amounts to little more than a month of isolated training in a clinical use of the drugs involved."

Concluding his commentary, the Governor pointed out that the issue of using drugs was one that should not be decided by the legislature.

The veto in Ohio brings to 15 the number of states that have rejected optometric drug laws this year. In only two states, Kentucky and Wisconsin, were such laws passed in 1978.

Continued on page 2



HONORABLE JAMES A. RHODES

... acts to protect Ohioans

Governor James A. Rhodes of Ohio has served in that capacity on two different occasions. He was first elected in 1962, serving until 1970, and was re-elected in 1974. The recently re-elected Governor, who attended Ohio State University, holds numerous honorary degrees from several institutions.

Prior to being elected governor, James A. Rhodes served as Auditor and Mayor of Columbus, Ohio and as State Auditor.

Author of three books on the Civil War, Gov. Rhodes was a delegate to the Republican National Convention in 1972, and is a member of the Professional Golfers Association Advisory Committee, and the United States Olympic Committee. ●

Ohio Veto Is Second Of 1978; Fourth Optometric Drug Law Veto



WHY "THE PEN?"

The files of state and national medical associations, all learned societies concerned with the public health, overflow with a preponderance of evidence that the quality of health care is threatened by the precedent of Government encouraging the lowering of professional standards by allowing medical functions to practitioners with no medical education. Medicine accepts the responsibility to respond to epidemics. Death and trauma are resulting, and Doctors of Medicine can do no less than warn potential victims through the continuous presentation of this evidence. The public press of America, given the facts, is supporting this cause, and concerned physicians throughout the nation are pooling their knowledge and resources to package and present the truth through the PHYSICIANS EDUCATION NETWORK.

VIRGINIA

Hon. John N. Dalton
vetoed H.B. 205
April 11, 1978



ARKANSAS

Hon. David Pryor
vetoed S.B. 48
1977



WEST VIRGINIA

Hon. Arch Moore
vetoed H.B. 1005
1976



THE PEN is a public newspaper, international in scope. Its readers include people from every walk of life. THE PEN is freestanding and independent of any national or state association, with the exception of its sponsor, Physicians Education Network, Inc. PEN, Inc. is a Florida non-profit corporation. Submissions to this newspaper are welcome and are published at the discretion of the editors. THE PEN does not accept paid advertising or paid subscriptions.

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OCHSNER *Continued from page 3*

administered to his grandchildren, as well as to many Ochsner pediatric patients. His daughter's eldest son contracted polio — possibly from the vaccine — and died. The intern who cared for the boy also got polio and both his legs remain paralyzed.

In those days, medicine had a few sharp peaks and lots of deep valleys. There were a few well-trained people, while the rest had almost no training at all. Today, medicine has progressed so that almost everyone is well-trained. By the late 1930s, New Orleans had lost its reputation as a major medical center.

"I saw that the city must do better medicine. And the only way to do this was through group practice. I had two ambitions: to build a medical referral center in the deep South that would give quality care reasonably, and to develop an institution that showed care and consideration — not only to the patient, but to the family." The Ochsner hospital maintains a Family Room, adjacent to the operating rooms and intensive care units, where families receive progress reports every half hour while a patient is in surgery and where coffee and doughnuts are dispensed.

"I went to five Tulane professors," Ochsner remembers. "Professors of otolaryngology, gynecology, orthopedics, and medicine. The surgeons were interested, but the medical man was not. This was in 1939, the end of the Depression. We had no money, only an idea. The banks wanted equity, not an idea. It looked as though we were going to have to give up." Alton Ochsner, however, doesn't give up easily; he persuaded Rudolph Hecht and the Hibernia Bank to finance that first Ochsner Clinic in an old building on Prytanis Street.

Not every doctor was convinced that Ochsner's idea was a good one. On Good Friday in 1941, small leather pouches filled with thirty dimes were delivered to the five Ochsner Clinic founders' homes. Inside each pouch was an anonymous typewritten note: "To the Judases of the Orleans Medical Society." The local doctors felt threatened and resentful. Ochsner argues: "We have helped the local physicians, raised the level of New Orleans medicine so that it is much higher than when we founded this place." ●

1978 American Medical Assoc. 3000

Mail to: James H. Allen, M.D., 9104 Quince St.
New Orleans, LA 70118

PEN MEMBER APPLICATION

"PEN MUST SURVIVE AND GROW... IT IS ALREADY THE MOST VIABLE, POTENT, AND ACTIVE COMMUNICATIONS FORCE IN MEDICINE — IT'S A MUST DO - CAN DO - AND WILL DO ORGANIZATION."

Alton Ochsner, M.D.

STATEMENT OF INTENT

I intend to be an active member of PEN and I endorse and support the STATEMENT OF PURPOSE.

In providing my resources I am assuring that PEN will continue to block efforts to invade medicine at the expense of the public health. I am subsidizing the ever-expanding promulgation of truth, the circulation of THE PEN and other publications to an ever-expanding audience. I am assuring the availability of resource materials, mass communications, legislative, and other expertise relating to this issue to all who support medicine in this cause.

I DESIRE TO INFORM AND BE INFORMED AND HEREBY PLEDGE DUES IN THE AMOUNT OF \$250 ANNUALLY. (Subject to reduction as PEN grows)

Date _____ 19__

Name _____

Address _____

City _____ State _____ Zip _____

Telephone: (Area) _____ Number _____

Ophthalmologist? _____ Other specialty _____

Profession, other than M.D.? _____

Check enclosed (\$250) _____ Please bill me _____

 Resident Dues \$25.00 Affiliate (spouses, office staff) \$25.00 Military M.D.s \$150.00

THE PEN FORUM



Editors' Note: Optometry's burning desire to invade the field of medicine was blatantly displayed when the Board of Regents of New York State, a non-medical, politically-appointed body responsible for directing the policy of higher education in New York, was persuaded to endorse optometric drug legislation.

It is unthinkable that political appointees, whose duties and responsibilities are not directly related to the issue, and who have never been informed by medicine as to the ramifications of the issue, should take such a position.

It would appear that the 15-member Board of Regents has been manipulated by optometry into taking a public political stance which will not only endanger the eye health of every New Yorker, but one which could cause that august body considerable, unnecessary embarrassment. Alden Haffner, O.D., an optometrist, is the State University of New York Vice Chancellor for Health Sciences.

Recognizing that legislators across the nation might well view this interference as an optometric credential, unless challenged, PEN has asked ophthalmologists nation-wide to express their views to all involved. Following are but a few excerpts from the flood of letters sent to the New York State Regents, the Chancellor and the State Commissioner of Education:

"The recent decision by the Board of Regents to support the use of drugs by optometrists ill-serves the public welfare as it reflects a lack of objectivity concerning this very important issue. The Board of Regents should be in the forefront of the battle to prevent non-medical measuring practitioners such as optometrists from becoming quasi-physicians by legislative fiat. Our educational system has numerous checks and balances to insure first that only the most highly qualified applicants are admitted to medical school; thereafter a medical school curriculum and periodic examinations standardized on a national level further insures scholastic fitness. The proper application of textbook knowledge to actual clinical pathology continues for the ophthalmologist throughout one year of internship and three years of specialized residency training in the diseases and surgery of the eye. The back door approach to medical school — via legislative fiat — should be a concept flatly rejected by the Board of Regents. The medical education as I outlined above should remain as the prerequisite to the use of pharmacological agents in the eye — the taking of pharmacology courses in or out of optometry school is in no way a substitute. Any optometrist who desires to assume medical functions should apply to medical school and obtain the proper training."

*Seymour R. Rosen, M.D.
Sunrise, Florida*

"The most important objection to optometric use of drugs is that authorization to use drugs implies the ability to judge the information obtained from such use and use it to make a medical diagnosis. Just as the possession of a stethoscope does not make one a cardiologist, the use of drugs to dilate the pupil or numb the eye will not make the optometrist equivalent to a physician. Patients will, however, be misled into believing that the optometrist is in fact qualified to make medical judgments and serious errors in diagnosis with accompanying missed opportunities to save eyes and even lives will occur.

"One has only to observe the level of optometric care throughout the State to realize the crass commercialism of many of their establishments. A little over a year ago the New York Daily News published a series of articles highly critical of the quality of eye examinations and glasses provided by many optometrists. How can the Board of Regents approve a group, which is not as yet meeting the standards for which they are licensed, to take on responsibilities for which they are not qualified?"

*J. S. Nauheim, M.D.
Merrick, New York*

"The recent decision by the Board of Regents of the State of New York to support optometric drug use legislation is ill-advised and myopic. In taking this decision, the Regents are permitting a group (the optometrists) to legislate medical privileges rather than obtain the medical privileges by education as the physician has."

*John B. Franklin, M.D.
Hartford, Connecticut*

"It seems obvious that we cannot, at this time, compromise these standards. Your decision to support optometric drug laws is just such a compromise. It is the same as suggesting that chiropractors are as well qualified to practice medicine as are physicians. Even a school such as the University of Alabama in Birmingham, has recently defined the practice of optometry as a non-medical discipline. A resolution by the Physicians Advisory Board at the University of Alabama, states, 'This education in no way prepares these graduates with the knowledge to prescribe or use drugs to treat eye diseases'. I urge you, therefore, to reverse this decision and to serve the citizens of New York State by so doing."

*William C. Frajer, M.D.
Philadelphia, Pennsylvania*

"I am writing to protest the action of the Board of Regents of New York State endorsing optometric drug use. It is unthinkable that highly educated people could advocate the use of medications by untrained practitioners. Furthermore, the training of optometrists in diagnosing medical eye diseases is terribly inadequate so that misdiagnosis and delayed recognition of disease is a greater danger than the complications of the pharmaceutical agents. . . . Please reconsider this issue."

*Thomas S. Harbin, Jr., M.D.
Atlanta, Georgia*

"The support given to the optometric drug bill must have been made without due consideration for the possible effects the legislation would have.

"Last year this legislation was voted down in fourteen other states whose legislators were given factual information concerning this issue. Most of the states which had passed the bill previously are now considering recall of the bill after documenting the serious harm done by optometrists using medication during their eye exams. It is unfortunate that in the states that passed the law the public had to suffer because of the inappropriate action of the legislators."

*Daniel W. Picroni, M.D.
Sheffield, Alabama*

UNITED STATES PHYSICIANS EDUCATION NETWORK

Statement of Purpose

PEN exists solely to utilize its resources and combined influence to present, promote, and promulgate, through communication outward, and communication inward, these simple truths:

- The American people must be protected by placing and keeping health care in the hands of experts, whose abilities are established by having reached a standard level of medical education.
- The logical minimum level of education necessary for leadership to protect the public in shaping the optimum health care delivery quality standards in the United States is the degree of Doctor of Medicine or Osteopathy, earned at a school of medicine or osteopathy — at an accredited institution of higher learning.
- Government at every level should cooperate with medicine in establishing these health safety standards.

Membership in PEN is available to any law-abiding citizen who subscribes to these truths, and desires to be informed, as well as to participate in informing the public at large.

"M.D. IS THE MAJOR DIFFERENCE"

THE PEN...



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Published in the Public Interest by Ophthalmology

VOL. 2, NO. 9 MAY 1, 1978

VIRGINIA VETO MESSAGE

Governor John N. Dalton: "There Is Concern"

Virginia Gov. John N. Dalton's courageous action in failing to sign House Bill 205 into law deserves high praise from both medicine and the citizens of the Commonwealth. Gov. Dalton has reaffirmed to his constituents and to the people of this nation that only through "education, not legislation," can a person become competent enough to use drugs on the human body.

The following is Gov. Dalton's comment after vetoing the bill:

"The bill defines what constitutes the practice of optometry; and defines requirements of persons who desire to be certified in the use of diagnostic pharmaceutical agents that they be examined in general and ocular pharmacology and in the use of approved topically applied diagnostic pharmaceutical agents. Although paramedics, physician assistants, and nurse practitioners may administer drugs in specific instances, this is done (a) under the supervision of a physician, and/or (b) under specifically developed protocols regulating such procedures. Given the rare, but devastating effects of adverse reaction following administration of diagnostic agents, there is reason for grave concern for patients' welfare where optometrists practice in isolation from medical backup. There is concern over public misunderstanding that complete medical care has been effected after having an optometric examination. Finally, there is concern of legislative appointment of 'medical' responsibility and authority to non-medical personnel prior to this matter being carefully studied as to its impact in the Commonwealth."

Honorable John N. Dalton ... 63rd Governor of Virginia

Gov. John N. Dalton, the 63rd governor of Virginia, took office on Jan. 14, 1978. A graduate of the College of William and Mary, he received his J. D. degree from the Law School of the University of Virginia in 1957.

Following graduation from law school, Gov. Dalton practiced law in Radford, Va. and began his political career in 1965 when he was elected to the Va. House of Delegates. After being re-elected to this post three times, he ran successfully for the State Senate in 1972. In 1973, he was elected lieutenant governor.

A 33rd degree Mason and an Eagle Scout, Gov. Dalton is a past-president of the Moneton District of Boy Scouts and a member of the Blue Ridge Council of Boy Scouts.



Eight States Reject Optometric Drug Law Petitions In 1978

Gov. Dalton's veto marks the seventh 1978 rejection of optometry's attempts to utilize legislative "clout" to invade medicine at the expense of the public health. Other states refusing optometrists the right to use drugs this year are Georgia, Mississippi, Missouri, South Dakota, Maryland and Oklahoma. At presstime, an optometric drug bill in Nebraska was reported to have "died on the calendar," bringing the total to eight.

So far this year, only Wisconsin and Kentucky patients face eye damage as a consequence of new optometric drug laws. In Kentucky, the law was passed and signed despite charges of impropriety, plus a call for a veto by the *Louisville Times*.

Unfortunately, the public health remains imperiled in several states: Massachusetts, New York, Ohio, South Carolina, Alaska, Hawaii, Iowa, and Arizona, where "the jury is still out."

WHY "THE PEN?"

The files of state and national medical associations, all learned societies concerned with the public health, overflow with a preponderance of evidence that the quality of health care is threatened by the precedent of Government encouraging the lowering of professional standards by allowing medical functions to practitioners with no medical education. Medicine accepts the responsibility to respond to epidemics. Death and trauma are resulting, and Doctors of Medicine can do no less than warn potential victims through the continuous presentation of this evidence. The public press of America, given the facts, is supporting this cause, and concerned physicians throughout the nation are pooling their knowledge and resources to package and present the truth through the PHYSICIANS EDUCATION NETWORK.

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DR. ALLEN'S DIAGNOSES



James H. Allen, M.D.; founding president, New Orleans Academy of Ophthalmology; professor of ophthalmology, Univ. of Iowa and Tulane Univ. for 30 years; Senior Surgeon, Tulane Univ.; awarded the prized Gold Medal of the Ophthalmology Section of AMA, 1976.

Governor Dalton — We Know That Any Veto Takes Both Courage And Conviction!

Being the captain of a ship is a lonely job — and in Virginia, like all states, the ultimate decision rests with the Governor.

During the past few weeks, Gov. John N. Dalton has faced the challenge of difficult decision-making as to whether all bills passed by the 1978 Virginia Legislature should be signed into law.

The intensity of the public outcry in Virginia against non-medical optometrists being allowed to use dangerous drugs and eye drops in the practice of their profession must have made the decision as to whether to sign House Bill 205 most difficult.

In protecting the public of Virginia, Gov. Dalton did far more than simply refuse to sign the bill. He presented his own conclusions (see page one) utilizing new phraseology which convinces us that the Governor is dedicated to the welfare of all Virginians. Speaking out in support of his veto, Gov. Dalton revealed that he reached the same conclusion as 46 major metropolitan newspaper editors who studied what is actually a simple issue. He came to the conclusion that, "There is concern of legislative appointment of 'medical' responsibility and authority to non-medical personnel prior to this matter being carefully studied as to its impact on the Commonwealth."

The Governor's conclusion is simple logic. Medicine in Virginia, in the early days of the 1978 legislature, did fail to meet the challenge and provide adequate information for careful study. When it was apparent, however, that many legislators actually believed that the petition of optometry to use drugs and eye drops would in some way be of benefit, medicine rallied to the challenge.

Prior to medicine's challenge, optometry found conscientious, but uninformed (on this issue) legislators easy prey for half truths, exaggerations, and even prevarications.

When medicine rallied its forces, however, an interested delegate commented that "ophthalmologists suddenly came out of the woodwork." Indeed they did, and medicine is so proud of them.

Ordinarily, ophthalmologists stay behind the woodwork in order to concentrate on providing medical care to a steady stream of people with serious eye problems who need and deserve full attention, treatment and cure.

The political scene is unfamiliar to medical people, and it took M.D.s some time to realize that the woodwork must give way when the public health is threatened by the body politic and that they must respond as they would to an epidemic.

By the time the issue reached the Senate floor, it was obvious that medical truths had changed the minds of many of the legislators.

The Governor is right — the measure deserves more study. Make no mistake. Medicine in Virginia welcomes further study, and so does PEN. The Virginia assembly was generous in allotting time to advocates of "both sides" and so was the Governor.

While it is difficult for us in medicine to acknowledge that there are "two sides" to this issue, we know that a preponderance of evidence is on our side and we intend and welcome the opportunity to present it on behalf of the people anywhere in the United States.

Finally, if Gov. Dalton had rendered an opposite verdict, we would have concluded that he, too, ignored the facts so obvious to the press of America, and REPEAL bumper strips would have been on the way to Virginia. The people of the Old Dominion deserve no less than insistence on high quality health care, and both medicine and the Governor have demonstrated high resolve to preserve just that!

JHA

Massachusetts Wins Committee Victory

On Tuesday, March 28, 1978, the Massachusetts Senate by voice vote, accepted the recommendation of the Joint Health Committee that the optometric drug bill (Senate S 402) "ought not to pass."

Medicine throughout Massachusetts is saluting the Senators for their caution and awareness of the necessity of protecting the public health.

A Health Care Committee report is on the House calendar for debate. The bill, having been filed in both houses, requires that each act independently on the Health Care Committee report.

No action in the House has been reported.

BULLETIN AT PRESSTIME

An optometric drug bill in Nebraska "died on the calendar," according to PEN Advisory Board member John Ramsell, M.D. of Omaha. Nebraska becomes the eighth state to protect patients from this threat this year.

UNITED STATES PHYSICIANS EDUCATION NETWORK

Statement of Purpose

PEN exists solely to utilize its resources and combined influence to present, promote, and promulgate, through communication outward, and communication inward, these simple truths:

- The American people must be protected by placing and keeping health care in the hands of experts, whose abilities are established by having reached a standard level of medical education.
- The logical minimum level of education necessary for leadership to protect the public in shaping the optimum health care delivery quality standards in the United States is the degree of Doctor of Medicine or Osteopathy, earned at a school of medicine or osteopathy — at an accredited institution of higher learning.
- Government at every level should cooperate with medicine in establishing these health safety standards.

Membership in PEN is available to any law-abiding citizen who subscribes to these truths, and desires to be informed, as well as to participate in informing the public at large.

THE PEN is a public newspaper, international in scope. Its readers include people from every walk of life. THE PEN is freestanding and independent of any national or state association, with the exception of its sponsor, Physicians Education Network, Inc. PEN, Inc. is a Florida non-profit corporation. Submissions to this newspaper are welcome and are published at the discretion of the editors. THE PEN does not accept paid advertising or paid subscriptions.

WOULD YOU LIKE TO RECEIVE THE PEN?

THE PEN, to be published 24 times annually, is an international publication — unique in that subscriptions cannot be purchased. Non-medical persons may petition THE PEN for a complimentary subscription. Just tell us who you are and what you are interested. Medical doctors can become subscribers by joining PEN as a dues-paying member (see application elsewhere in this issue). Elected officials — state or national — and executives of health care agencies can become subscribers upon request.

Industry Co-sponsors Portland Eye Exhibit

While medicine and ophthalmology concentrate on resisting the invasion of medicine at the expense of the public health, there are many painstaking efforts to provide education to encourage patients to protect themselves.

One such effort is a major new exhibit, the Sealy Ophthalmology exhibit, which opened Saturday, March 18, at the Oregon Museum of Science and Industry (OMSI), and promises to be a major tourist attraction this summer.

Funded by the Sealy Mattress Co., and enthusiastically supported by its president, Lloyd Rosenthal, the \$30,000 display was co-sponsored by the Oregon Academy of Ophthalmology, which will be responsible for its annual maintenance costs. Under the leadership of OMSI's Exhibits Director Shabtay Levy more than a year of planning and construction has gone into the exciting display.

The focal point of the exhibit is a 3 ft. in diameter, stylized anatomical model of the human eye. The model demonstrates the anatomy and functions of the human eye, and also demonstrates some pathological disorders, such as cataract, glaucoma, retinal detachment and diabetes. The viewer can actually see how these diseases affect human vision.

By pushing buttons, the viewer is able to activate functional parts of the exhibit to show how the iris changes its size related to changing levels of light. Supporting exhibits include visual acuity, peripheral vision, color vision, depth perception and even one which shows the viewer the pupil of his own eye dilating and contracting as light values change.

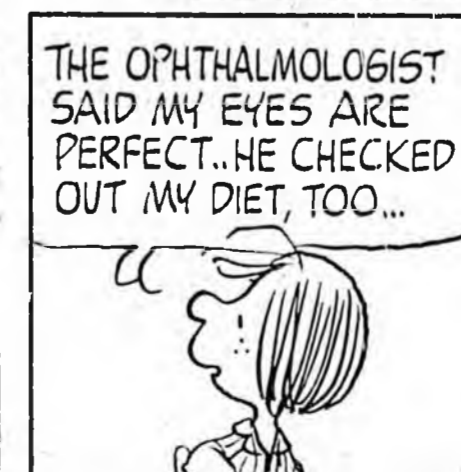
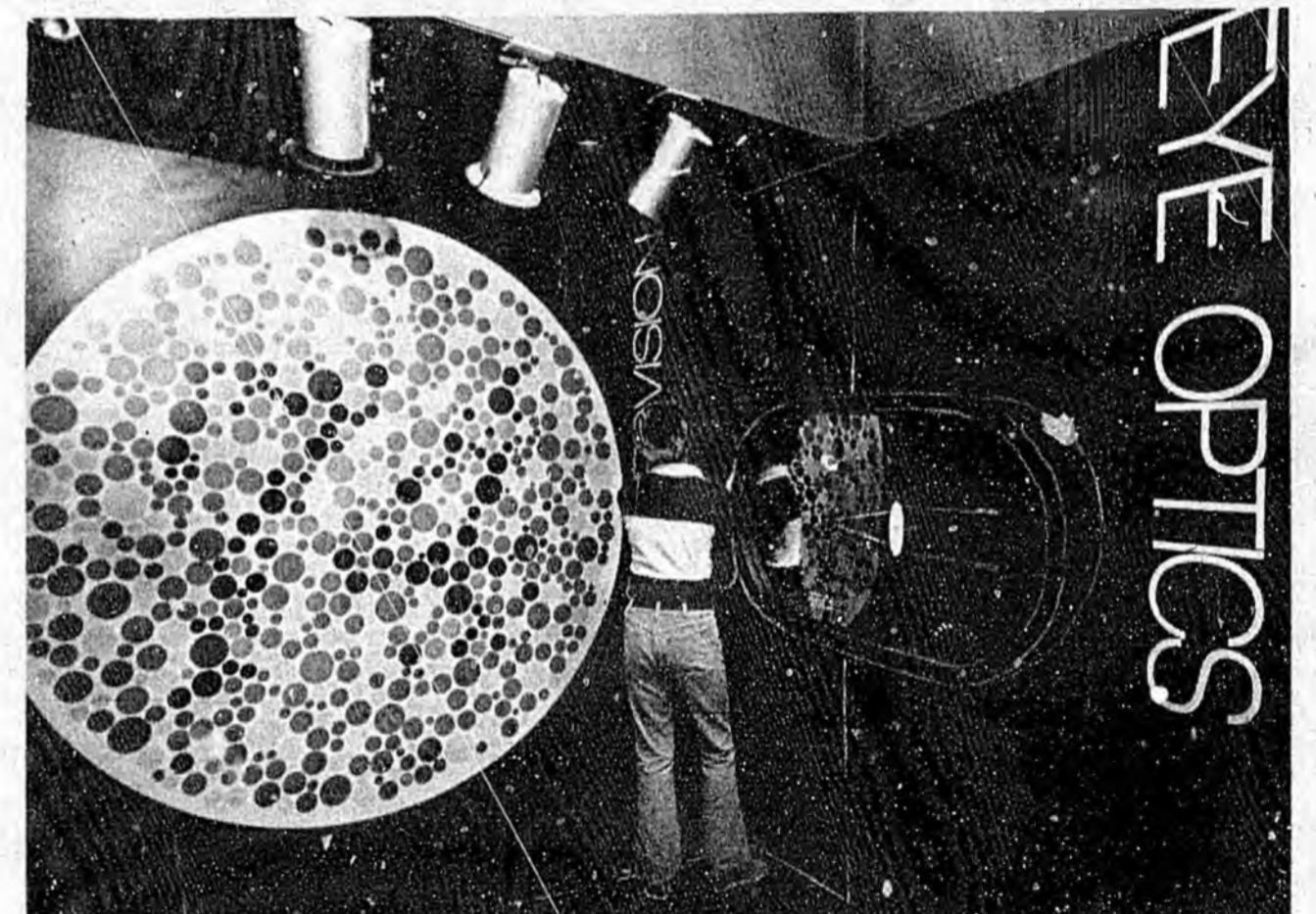
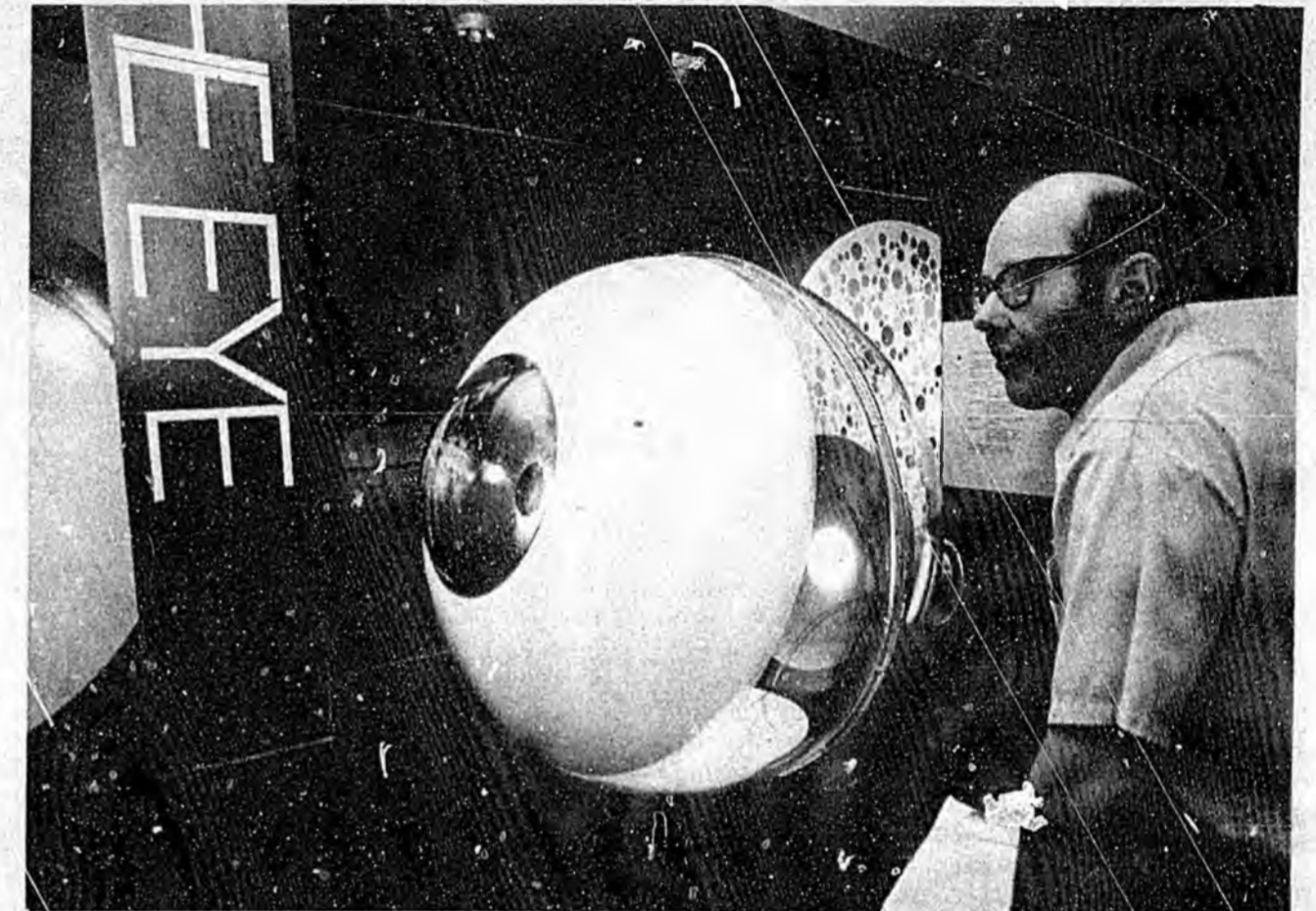
Under Mr. Levy's direction, and in cooperation with expert ophthalmologists, the entire concept, design and construction of the exhibit was completed by the OMSI Exhibits staff.

The Oregon Academy has prepared educational pamphlets complementary to the exhibit which cover various phases of eye care, including the "major difference" between ophthalmologists and optometrists, and advice on seeking out an ophthalmologist.

Members of the Oregon Academy of Ophthalmology working closely with the Exhibits staff include Merritt Linn, M.D., Donald Plumb, M.D., Robert Burns, M.D. and John Wobig, M.D., all of Portland.

The Sealy Ophthalmology exhibit opening is expected to be of great interest to the casual visitor to OMSI, and will be of special value for school tours and other interested groups for whom more detailed lectures and demonstrations will be offered.

The current "Book of Lists," a best seller, identifies PEANUTS, created by Charles Schulz, as the most popular cartoon strip in the world. At least creator Schulz, Lucy, Charlie Brown, Snoopy et al obviously know "The Major Difference," and hopefully, so do many of their readers. PEN is grateful to United Feature Syndicate, Inc. for permission to reprint this significant, educational, and as always, humorous, cartoon which has appeared in newspapers throughout the world.



THE PEN...

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ST. PETERSBURG, FLORIDA

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"A little learning is a dangerous thing... drink deep, or taste not, the Pierian Spring/Shallow draughts intoxicate the brain, and drinking deep largely sobers it again."... Alexander Pope

MARYLAND DAILY NEWSPAPER ADVISES READERS


THE SUN

A 14

BALTIMORE, THURSDAY, MARCH 23, 1978

WILLIAM F. SCHMICK, JR., President and Chief Executive Officer, The A.S. Abell Company

DONALD H. PATTERSON, Publisher • PAUL A. BANKER, Managing Editor • J.R.L. STERNE, Editorial Page Editor

Optometrists and Drugs

Optometrists are trained in four-year schools to fit glasses, using various optical methods to determine the kinds of lenses patients need for correction of vision problems. Ophthalmologists have had more sophisticated training. Like optometrists, they fit glasses. But because they are physicians who have specialized in ophthalmology after completing medical school, they are prepared to do a great deal more. For instance, they can use and prescribe drugs, treat eye diseases and do eye surgery.

Under current Maryland law, optometrists are not allowed to use drugs in their practice. But a bill now in the Maryland Senate would give them that right in certain cases. Optometrists make superficially plausible arguments in favor of the bill, pointing out that, with amendments they support, it would allow them to use only four types of drugs, all administered topically in the eyes, and only for diagnostic purposes; and that they would be required to

take a minimum of 70 hours of training in pharmacology before they could use the drugs. They add that adverse side effects of the drugs are so rare as to be almost non-existent.

Unfortunately, say ophthalmologists, the side effects are not all that rare. Allergies to the drugs might, in severe cases, result in death. Certain of the drugs can cause hallucinations, and others can result in detached retinas or acute glaucoma. Coping with these side effects requires the skills and equipment of a physician. A severe allergic shock reaction, for instance, might require adrenaline and cortisone injections which only a physician is qualified to administer. As the ophthalmologists point out, 70 hours of training in pharmacology—as opposed to the 2,400 hours or more physicians receive—might not even qualify optometrists to recognize the side effects for what they are, let alone be able to treat them. The bill should be defeated.


THE PEN FORUM

PEN has received more than 200 pieces of mail to Veterans Administration officials and congressmen from medical doctors concerning passage of Public Law 94-581, which gives measuring scientists with no medical training a primary health care role at VA hospitals throughout the country.

About 50 United States Senators and Representatives have responded to M.D.s' claims that raising optometrists to a primary health care level will jeopardize the public health.

The following letter to James H. Parker, Jr., M.D. of Wyomissing, Pa. from Rep. Gus Yatron is typical of letters from concerned congressmen received since the circular was signed Nov. 4, 1977:

Dear Dr. Parker:

Thank you for your recent letter expressing your continued interest and concern over the possibility of optometrists being allowed to take over part of the medical care of eye patients in the Veterans Administration.

Please be assured that I feel you have raised some valuable and serious points regarding such an action. Before such a proposal is approved, I feel that all possible questions pertaining to the adequacy of optometric education must be resolved. You can be certain that I will continue to scrutinize all of the implications and possible ramifications of this change, and that I will not endorse any action that could endanger the health of our nation's veterans. Additionally, I will not support any move to downgrade the quality of care offered in veterans' hospitals.

Sincerely,
Gus Yatron

Mail to: James H. Allen, M.D., 9104 Quince St.
New Orleans, LA 70118

Founded as O.P.E.N.

PEN CHARTER MEMBER APPLICATION

This is my statement of intent to be an active member of the United States Physicians Education Network — I endorse and support the statement of purpose.

In providing my resources to guarantee the continuation of a strong and viable international entity I acknowledge and understand the following:

— That my membership in PEN will bring me a minimum of 48 mailings annually including 24 issues of a national publication as described, in keeping with the statement of purpose.

— That, as a Charter Member, I accept the responsibility of attempting to recruit members. I further understand that my state society will automatically be qualified for WAFS line telephone consulting services and direct public relations advice and counseling, tailored to my state, as soon as either ten percent (10%) of the membership of my state society, or 20 members, (whichever is the least) are recruited.

I desire to inform and to be informed and to join this movement, and hereby pledge my support through dues, not to exceed \$300 annually.*

— I understand that as a Charter Member, I will be issued a silver lapel emblem signifying my Charter status as soon as available after formation.

Date _____ 1978

Name _____

Address _____

City _____ State _____ Zip _____

Telephone: (Area) _____ Number _____

Ophthalmologist? _____ Other specialty _____

Profession, other than M.D.? _____

Check enclosed (\$300) _____ Please bill me _____

* Charter Members (enrolled before July 1, 1978) will be awarded a dues decrease as of the second full year.

Visual and Medical



The Visual Part can be performed by an optometrist or an ophthalmologist.



The Medical Part can only be performed by a qualified medical doctor (an ophthalmologist).

When having your eyes examined you should know whether you are receiving a *complete* eye examination or only a part. When an optometrist (O.D.) examines a person's eyes he is qualified and licensed only to perform the visual part. He is not educated nor trained to perform the medical part.

When an ophthalmologist (M.D.) examines a patient's eyes, he performs both parts on an inter-related basis. He not only evaluates visual functions and performance, but also analyzes and diagnoses diseases and physiological disorders.

Ask the individual examining your eyes whether he is an O.D. (optometrist) or an M.D. (ophthalmologist). Only an ophthalmologist M.D. can perform a *complete* eye examination — both visual and medical.

While the Massachusetts Society of Eye Physicians and Surgeons (MSEPS) energetically resists attempts to endanger the eye health of Bay State citizens, the MSEPS also endeavors to educate the public to protect themselves. The centerfold of a small but potent folder being circulated by medicine in Massachusetts is reproduced above with permission of the Society.

Name	Organization	Address	Bill No.
DR. BOYD L. WALKER	ALASKA OPTOMETRIC ASSN.	1345 W 9 th ANCH.	79
DR. A. RON STERNBERG	" "	1016 W. 6 th Ave, Suite A, Anchorage	79
JEFF LANDRY	AK. STATE MEDICAL ASSOC.	320 W. 3RD. ST. JUNEAU, AK.	79
Dr. John T. Shank	State Board of Examiners in Opt.	Box 827 Kodiak	
Dr. Maynard Falconer	AK Optometric Board of Examiners	1345 - W - 9 th Anch	79
Doris P. Falconer	A.O.A. (Chairman)	" " " "	
Dr. T.B. McLaughlin	Alaska Optometric Association Board member	Box 498 Sitka	79
Royce, Box 010	alaska optometric	Jensen	79
Rep. Patrick M. O'Connell	- State Leg. - Dist 13	Anchorage	79

POSITION PAPER
ON
HOUSE BILL NO. 79

"An Act relating to the practice of optometry."

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

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

Recommended by:

Robert I. Fraser
Robert I. Fraser, M.D., Director 2/14/79
Division of Public Health

Approved by:

Helen D. Beirne 2/16/79
Helen D. Beirne, Commissioner
Dept. of Health and Social Services

Rep. Buchholdt

Alaska State Legislature

POUCH V
JUNEAU, ALASKA 99811



P. O. BOX 9
KENAI, ALASKA 99611

REPRESENTATIVE HUGH MALONE



24 January 1979

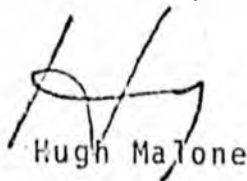
Peter E. Cannava, M.D.
Box 1629
Soldotna, AK 99669

Dear Peter:

I received your letter and court brief regarding the optometric drug bill and have forwarded a copy to Rep. Thelma Buchholdt. She is the new chairperson of the Health, Education and Social Services Committee. As yet, no legislation has been introduced regarding this issue, however, I expect it will be soon.

Thank you for the information.

Sincerely,


Hugh Malone

jk

Peninsula Eye Clinic

PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99889
TELEPHONE 262-4462

Hugh Malone
State Capitol Building
Pouch V
Juneau, Alaska 99811

Dear Hugh:

I gave the enclosed talk to the legislators present at our political meeting and I thought it would be helpful to you to receive a copy of it considering your vote of last session.

The case illustrates the fact that the optometric drug bill represents more than a political "power play" but in fact has and will mean loss of eyes of our fellow Alaskans. We have at least two other cases documented where vision was lost because of inadequate medical knowledge on the part of optometrists.

The judges decision clearly states that there is no reason why optometrists can be permitted to make medical diagnosis on a legal basis. In addition the testimony by the "professor of optometry" clearly illustrates the lack of medical knowledge on the part of optometrist educators.

Sincerely,

Peter

Peter E. Cannava, M.D.

PEC/bc

*Hugh,
Please have one of your staff save this
court brief as it will have to be used
for the "HESS" committee hearings & also
for future discussions I will have to you.
Good Luck this yr & I wish you a short
and day vacation.*

Given to Legislative Meeting
13 Dec 78. Copy to Dr. [unclear]

American medicine has established a tradition which dates back well over 200 years! Despite the ups and downs of certain aspects of American medicine the very basic integrity of the system has never and will never be challenged. This is fact because the system rests upon a foundation of sound scientific principle. American people may not like what type of treatment is offered them but they at least can rest assured that any prescription promulgated by our traditional medical system is based upon a scientific method, and those practitioner licensed with-in the system have completed a satisfactory curriculum approved by both private and governmental bodies who attest to the fact that medical practitioners are qualified to practice with the use of drugs and other modalities. In addition to the traditional modality of medical care there are two other broad categories of health care which our people choose to utilize. One is not based upon scientific methodology, cannot be supported by established objective data. Examples of these would be naturopathic healing and chiropractic.

The second category of non-medical health care sought by Americans is based upon scientific principles but is not traditionally associated with medical education. Examples of those are psychology and optometry. In past years no major conflict has arisen between traditional medicine and other forms of health care. However, of late there is a movement on by non medical people to seek enactment of legislation which would grant them privileges which traditionally have been the provence of medical practitioners. Examples would include attempts by chiropractors to utilize medical facilities for laboratory testing and more germane to our state the attempt by optometry to seek legislation approved for their use of drugs within their practice.

Legislators must be aware of the short and long term implications of such legislation! Granting non-medical practitioners medical priveleges obscures the traditionally clear cut lines between the dicipline of medicine and the non-medical practices. Such obscuration of lines of deliniation serves to thoroughly confuse the public as to what type of health care is to be expected from each type of practitioner! In such confusion the public will have no clear concept of what type of "product" to expect of each health care practitioner. I wish now to focus upon a problem which confronted last years legislators and may surface again! Optometrists as you may be aware are non-medical practitioners by viture of their ancestry, training, current definition and as of several months ago defined by U.S. District judge for Alaska. They are requesting the legislature to grant them privilege of using drugs in their practice! Such a privilege would have two fold effect and firstly it would set a precedent with-in our state and open the door to all non-medical health personell to seek similar privilege. Secondly it would further endanger the people of Alaska to the risk of loss of sight because of the injudicious use of drugs and false sense of security the use of drugs imparts upon the recipients of such treatment. Indeed as time goes on I will supply you with case histories of Alaska residents who have lost eyes because they were lured into feeling they had been examined by eye physicians or ophthalmologists. I will also supply you with a legal suit prompted by such a loss of eye and additional pertinent information. I urge you not to grant non-medical health practitioners by legislation what they should rightfully earn by education that is the right to join the ranks of traditional medicine thru time honored institutions, established testing proceddures and time tested licensing procedures.

A. C. Amawa, M.D.

Rep. Buchholdt

5 February 1979

Peter E. Cannava, M.D.
Peninsula Eye Clinic
Box 1629
Soldotna, AK 99669

Dear Pete:

Yes, I did receive your packet of information and I apologize for the length of time it took me to respond.

I will forward the new information to Rep. Buchholdt as I did earlier for her files.

Again, thank you.

Sincerely,

Hugh Malone

jk

Peninsula Eye Clinic

PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669
—
TELEPHONE 262-4462

February 1, 1979

Representative Hugh Malone
Pouch V
Juneau, Alaska 99811

Dear Hugh:

I hope you received my last packet of information on HB79 (optometric drug bill) As you will recall it included a copy of Judge Fitzgerald's decision regarding the loss of a child's eye because of optometric mis-management! Since I have not heard from you I presume you are quite busy and I wish you luck in your difficult task.

Enclosed please find two items: 1. the copy of "P E N" describing optometric education, 2. Veto message of Gov. Rhodes, Ohio.

Sincerely,

Peter E. Cannava, M.D.
Peter E. Cannava, M.D.

PEC/bc

Governor's Veto Message
(Unofficial Copy)

December 15, 1978

Pursuant to Article 2 Section 16 of the Constitution of Ohio, I return herewith to the Clerk of the Senate for presentation to the Senate Amended Substitute Senate Bill 163 which I disapprove and have not signed. Amended Substitute Senate Bill No. 163 would expand the definition of the practice of optometry to allow the use by optometrists of specific diagnostic drugs to the eye in the form of eyedrops. If the specified drugs are used solely for the purpose of detecting disease and are of a specific level of potency the matter of health care is of vital concern they must insure to all Ohio citizens that they receive the highest quality health care possible. Health care is an area in which we can take no risks because any mistakes can bring tragic and irreversible results. We must be committed to our citizens to provide practitioners that are highly skilled individuals and who will at the same time provide the best health care at the lowest cost.

Optometrists have been doing an excellent job in working with the medical profession to bring quality eye care to Ohio citizens. The tools that the optometrists are presently using are not dangerous and are effective in screening for eye disease. However, Amended Substitute Senate Bill No. 163 would allow optometrists to use drugs in order to make a full diagnosis of the medical condition of the eye. If the individuals involved were properly trained this procedure would be in the best interest of Ohio citizens, however without proper training the bill would allow unwarranted risks without corresponding benefits. The drugs involved are dangerous and have a potential of causing a great deal of pain including blindness. The adverse reactions associated with these drugs are not common but they do occur and medical and emergency treatment must be administered in those instances. While this bill does provide for mandatory training of 180 clock hours this amounts to little more than a month of isolated training in a clinical use of the drugs involved. The goal of this legislation should be to build a working relation between optometrists and the medical community. The issue of using drugs should be an issue decided by the professions rather than by the legislature. Both professions have taken an oath to provide quality health care, they should work together toward that end. I pledge the aid of my office for that purpose. For the foregoing reasons I have vetoed Amended Substitute Senate Bill No. 163 and urge the General Assembly to sustain my veto.

James A. Rhodes
Governor



Official Business

House
Committee on
Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

February 7, 1979

Peter E. Cannava, M.D.
Peninsula Eye Clinic
Ophthalmology
Box 1629
Soldotna, Alaska 99503

Dear Dr. Cannava:

Thank you very much for your letter and back up material regarding HB-79. I do appreciate your taking the time to send this information to the committee.

We have, to date, received this same information from Rep. Hugh Malone, and I am sure it will be of help to members of this committee.

At this time, I have not yet scheduled the bill for hearing, but I will keep you informed as to when the bill will be up for a hearing.

Again, thank you for your interest.

Sincerely yours,

THELMA BUCHHOLDT
Chairman
House HESS Committee

TB/ch

Peninsula Eye Clinic

PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669
—
TELEPHONE 262-4462

February 1, 1979

Thelma Bucholt, Representative
Pouch V
Juneau, Alaska 99811

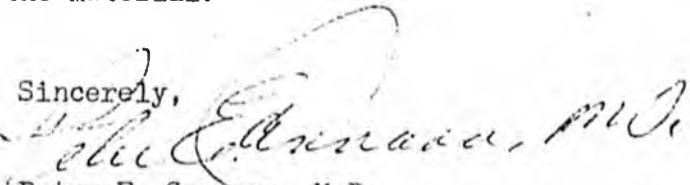
Dear Mrs. Buckhodt:

HB 79 (optometric drug bill) has been sent to your committee for review. It is essential that you review the enclosed court decision concerning the loss of a young Alaskan's eye due to optometric irresponsibility. As you will recall the issue last year was whether or not optometrists were qualified to use dangerous drugs on the eyes of Alaskans. Judge Fitzgerald's decision should settle that question in the minds of Alaskans.

In addition you will find enclosed the Ohio Governor's veto message of such a dangerous bill.

I would appreciate your response to the material.

Sincerely,


Peter E. Cannava, M.D.

PEC/bc

Governor's Veto Message
(Unofficial Copy)

December 15, 1978

Pursuant to Article 2 Section 16 of the Constitution of Ohio, I return herewith to the Clerk of the Senate for presentation to the Senate Amended Substitute Senate Bill 163 which I disapprove and have not signed. Amended Substitute Senate Bill No. 163 would expand the definition of the practice of optometry to allow the use by optometrists of specific diagnostic drugs to the eye in the form of eyedrops. If the specified drugs are used solely for the purpose of detecting disease and are of a specific level of potency the matter of health care is of vital concern they must insure to all Ohio citizens that they receive the highest quality health care possible. Health care is an area in which we can take no risks because any mistakes can bring tragic and irreversible results. We must be committed to our citizens to provide practitioners that are highly skilled individuals and who will at the same time provide the best health care at the lowest cost.

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James A. Rhodes
Governor

February 14, 1979

Representative Thelma Buchholdt
Pouch V
Mail Stop Number 3100
Juneau, Alaska 99811

Dear Representative Buchholdt:

House Bill 79 (Senate Bill 75) relating to optometrists (nonphysicians) using medications has recently been introduced this session. I hope you can take a few moments from your busy schedule to read a brief summary of what I feel are important points as regards this legislation.

1. Optometrists are not physicians. No optometrist in Alaska has had any instruction in pharmacology or drug side effects from anyone with a Ph.D. or masters degree in pharmacology, no optometrist in Alaska has ever had any instruction in anything from a full-time M.D. on any optometric school staff, and no optometrist in Alaska has ever had any formal classroom or clinical training by an ophthalmologist (a physician with specialty training in eye disease and management).
2. Legislation, as presented, would let the Optometric Board evaluate the qualifications for drug use by optometrists. The Legislative Audit Performance Review of 11-1-78, noted:
 - a. The state licensing examiner was asked not to attend the last examination given by the Optometric Board.
 - b. The Audit Committee also found evidence of examination results being changed, regrading of examinations, and deletion of examination questions.
 - c. The Audit Review was unable to find recent oral, written, or practical exam questions and answers.

How can this Board, who has apparently compromised its integrity and responsibility given them by state statute but has also never had any experience in pharmacology, be expected to fairly pass on the qualifications of one of its own practitioners to use medicines in the eye.

3. The trend across the country is to defeat this sort of legislation. In 1977, this type of legislation was defeated in 17 states and passed in four; in 1978, it was defeated in 15 states and passed in two; and already in 1979, it has been defeated in one state and passed in none. This legislation is not beneficial to the public welfare, further confuses the consumer as to who he is entrusting the care of his eyes, and endangers the public at the hands of nonphysicians.
4. "Diagnostic drops" is a misnomer. The drugs don't diagnose - people diagnose. Dilating the eye is not a prerequisite to making a diagnosis of eye disease, dilating the eye is not a prerequisite to supplying children with the proper correction for glasses, and anesthetic drops are not a prerequisite for the diagnosis of glaucoma.


5. Optometrists (non-M.D.s) have no training in the management of side effects of these medications; e.g., myocardial infarction (there were seven cases of documented heart attacks due to these drugs in the United States in the past 12 months) or narrow angle glaucoma caused from dilating the eyes (there's an extremely high incidence of this condition in Alaskan natives).
6. Optometrists are not trained in the detection of pathology. An optometrist, currently a member of the Alaska Optometric Board, caused an eye to be lost in a four year old child because of his inability to recognize disease and refer the child in a timely fashion. Please find enclosed an issue of PEN newsletter which, in detail, describes Judge James Fitzgerald's findings in the Fourth Judicial District, U.S. District Court in the State of Alaska in October of 1978.
7. Let me suggest some appropriate amendments to this legislation if you feel it is in the public's best interest:
 - a. There should be mandatory referral if the vision cannot be corrected to 20/20 in each eye in an adult or 20/30 in a child under eight years of age (this is a current law in England).
 - b. There should be no "miotic drop" inclusions. No one considers miotic drops as a diagnostic drug.
 - c. It would be appropriate to ensure the availability of malpractice insurance to optometrists to protect the public.
 - d. There should be no grandfather clause.
 - e. Any pharmacology or pathology testing should be done by the American Board of Ophthalmology. They are the most experienced group and the logical group to design such an examination.
 - f. There should be mandatory referral, as per Dr. Alfred Lemoine who is often cited by optometry as an ophthalmologist in favor of diagnostic drug use by non-M.D. optometrists (see enclosure - 10 points in the history, 33 points in the clinical evaluation).

The regulation of the practice of the various professional and paraprofessional groups is not for the benefit of the licensee but for the benefit of the state and its people. No where does case law suggest that public protection will be qualified; i.e., that the risk may be increased a little bit but not a lot. The intent is protection and the language is explicit.

A disregard for excellence, as would result with passage of House Bill 79 (SB 75), as it is presented to you, will adversely affect the superior level of eye care currently offered to the citizens of Alaska. A little bit of this Bill is like a little bit of syphilis.

Thank you for the time you have taken.

Sincerely,



Sam A. McConkey, M.D.

Submitted by
Dr. Sam McConkey

SUMMARY

Albert N. Lemoine, M. D., F.A.C.S.

There are ocular complaints obtained in the history and findings during an ocular examination that almost without exception are an indication for referral to an ophthalmologist for definitive diagnosis and therapy.

HISTORY

1. Rapid visual loss - over a period of minutes or hours.
2. Episodes of intermittent periods of reduced vision.
3. Sudden onset of "floating spots" in the field of vision.
4. Flashes of light in the visual field.
5. Defects in the field of vision, scotomas.
6. Distortion of objects or lines.
7. Rapid onset of visual haze with no specific complaint of decreased visual acuity.
8. Severe pain around the orbit or in the eye.
9. Prolonged severe pain in the occipital area.
10. Diplopia or visual confusion.


CLINICAL FINDINGS

1. Best corrected visual acuity 20/40 or less, unless they have had a prior diagnosis by an ophthalmologist.
2. Any patient whose refractive error changes one half a diopter or more, especially on the hyperopic side, within ninety days except for children with myopia.
3. Masses of the lids or adnexa either with or without inflammatory signs.
4. Defects in the lid margin.
5. Redness that is most marked in the 2 mm. zone adjacent to the cornea.
6. Any type of corneal clouding or infiltration either with or without congestion of the conjunctiva.
7. Cloudy anterior chamber.
8. Blood in the anterior chamber.
9. Small, poorly or nonreactive pupil.
10. Dilated, poorly or nonreactive pupil.
11. White pupil reflex.
12. Cataracts or lens opacities before the visual acuity is reduced to 20/40 or less.
13. Vitreous "floaters".
14. Blood in the vitreous.
15. Papilledema.

16. Optic atrophy, primary or secondary.
17. Larger or smaller than normal disc.
18. Abnormal disc cupping.
19. Dilated veins with or without retinal hemorrhage.
20. Narrowed arteries with or without retinal hemorrhage.
21. Any masses seen in the fundus, pigmented or nonpigmented.
22. Retinal hemorrhages, one or both eyes.
23. Pigment disturbance, either increase in pigment or decrease other than the dark fundus of the black race or lack of pigment in blond or albino patients.
24. Any areas of retinal elevation.
25. Retinal tears.
26. Presence of diplopia.
27. Nystagmus.
28. Scotoma.
29. Distortion of lines Amsler Grid or objects.
30. Any visual field defect other than blind spot.
31. Ptosis.
32. Intraocular tension of 22 or more on two or more occasions.
33. Exophthalmos, unilateral or bilateral.

Don Hostak, Director
Div. of Occupational Licensing

XXXXXXXXXX
02 13 79

Byron Perkins 
Licensing Examiner

I spoke with Eldon Ulmer, President of the Board of Pharmacy, and he asked me to convey the following to you in response to your teletype to him last week.

RE House Bill 79 ~~XXXXXXXXXXXXXXXXXXXX~~ regarding optometrists and particularly their ability to prescribe legend drugs and pharmaceuticals, the Alaska Board of Pharmacy has not changed its position on this issue. The board is not primarily concerned with whether or not an optometrist should be given this privilege, but rather, that the proposed bill in no way addresses the legal question of how they are to obtain legend drugs. Current Federal and State statutes do not permit pharmacists to fill prescriptions for legend drugs by any one but Medical Doctors, Veterinarians, and Dentists.


Re House Bill 101 and Senate Bill 65, the Uniform Controlled Substances Act, this is the number one legislative priority for the Board of Pharmacy, and the board supports it conceptually. However, the current bill is primarily a police bill, and needs to be amended substantially to make it palatable to the industry. There is not enough language addressing the rights and responsibilities of professionals authorized to handle controlled substances. The Board of Pharmacy is pushing for a Uniform Controlled Substances Act that parallels the federal guidelines.

cc: Eldon Ulmer, R.Ph.
Chairman, Board of Pharmacy

Don Hostak, Director
Div. of Occupational Licensing

XXXXXXXXXX

02 13 79

Byron Perkins 
Licensing Examiner

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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

March 7, 1979

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

Dear Representative Buchholdt:

It has been brought to my attention that information in opposition to HB 79 has been distributed to all legislators. Some of this information contained in an ophthalmological tabloid newspaper entitled The Pen, although a sensational distortion of fact, demonstrates the responsibility of optometrists to detect and refer pathological eye conditions. The use of drugs (DPA's) requested by optometrists in HB 79 is simply a tool to help better serve the public, so that unfortunate incidents such as those described in The Pen will be more easily detected.

I urge you to consider the following facts prior to making a commitment for or against this bill. These facts are excerpted directly from a report to the United States Congress by the U.S. Department of Health, Education and Welfare which I am enclosing.

1. It is the responsibility of optometrists to detect and refer pathological eye conditions.
2. Optometrists currently receive training in detection of ocular disease as well as in the use of pharmaceutical agents including management of side effects.
3. H.E.W. consultants on this report unanimously recommended that state licensure laws be revised to allow the use of diagnostic pharmaceutical agents by optometrists. (24 states now allow this practice)

If you have any questions regarding this bill or statements made in opposition to it, I would like to have the opportunity to respond with documented facts from objective sources. I appreciate the time you have taken to consider this very important legislation.

Thank you.

Sincerely,



Boyd L. Walker, O.D.

BLW:ah

REPORT TO
THE CONGRESS:
REIMBURSEMENT
UNDER PART-B OF
MEDICARE FOR
CERTAIN SERVICES
PROVIDED BY
OPTOMETRISTS

The Bureau of Health Manpower projects the overall number of active ophthalmologists in the United States to rise to 13,300 in 1980 and to 18,400 by 1990; this compares with projected levels of 22,000 and 28,200 for optometrists in the same time intervals. The proportion of ophthalmologists as a percent of total professional vision care manpower is projected to grow from 35 percent in 1973 to 38 percent in 1980 and 39 percent in 1990. These estimates should be interpreted cautiously, and should be undertaken in the context of written documentation available from the Bureau of Health Manpower. Available data preclude such projections on a detailed geographic basis.

More specific data indicates that in recent years many areas of the country, particularly non-metropolitan areas, are served only by optometrists. Approximately 40 percent of counties have an optometrist but no ophthalmologist. Another 27 percent have neither.

Optometric Practice

The Institute of Medicine of the National Academy of Sciences, in describing primary health professions who are direct providers of patient care, defined optometry as follows: "The Doctor of Optometry (O.D.) is a health professional who performs eye examinations to determine the presence of visual, muscular, or neurological abnormalities, and prescribes lenses, other optical aids, or therapy, such as eye exercises to enable maximum vision. Optometrists are trained to recognize disease conditions of the eye and ocular manifestations of other diseases, and to refer patients with these conditions to the appropriate health professional."

This definition, as well as available documentation on the utilization of optometric services, points to the optometrist's role as a provider of primary health care services. In this role, the optometrist functions as a principal point of contact within the health care system for persons having visual complaints, including certain numbers who have symptoms or conditions that require referral to other health practitioners.

The scope of practice for optometry, similar to that for other health care providers, is difficult to define precisely. However, information is available from a number of sources to develop valid concepts of a profession's role and function. Such sources include State laws, judgments of courts concerning the responsibilities of practitioners, the usual and customary practices of the profession, and the objectives, content, and standards of education and training for the profession.

An examination of a variety of such sources suggests that optometry is a profession qualified to provide a broad range of services which are effective in patient management, including the management of aphakic and cataract patients. (See discussion in Part II of this report for detail on sources cited and information examined.) It is reasonable to infer that such services correspond to many specific

ATTACHMENT B

BASIC ELEMENTS OF THE CURRICULUM OF SCHOOLS OF OPTOMETRY

1. Biological science knowledge base.
 - a. Gross human anatomy and microscopic anatomy, with emphasis on head, neck, and thorax.
 - b. Embryology, gross and microscopic anatomy of the human nervous system - concentrating on the central nervous system.
 - c. General human physiology, including the study of the fundamental organ systems and the mechanisms which regulate body function. Emphasis is on the sensory, motor and cardiovascular systems.
 - d. Basic concepts of general and cellular biochemistry, with study of nomenclature, structure, and reactions of organic molecules. Emphasis is on the visual system - tears, intra-ocular fluids, lens, retinal photochemistry, and actions of drugs upon these.
 - e. Concepts of human genetics and genetic disorders, including the frequency and distribution of genetic disease, inheritance patterns, polygenic inheritance, chromosomal aberration syndromes, multifactorial genetics, and principles of genetic counseling.
 - f. Gross and microscopic anatomy of the lids, orbit, orbital content, globe, muscles, nerves, and vessels, and embryology of the eye.
 - g. Vegetative physiology of the eye, extraocular and intra-ocular fluids, corneal and lens metabolism, ocular circulation, retina and optic nerve metabolism.
 - h. General pharmacological principles, methods of administration, various systemic drugs and their pharmacological action and side effects with emphasis on those that affect the visual system, such as cataractogenic and glaucoma-producing drugs.
 - i. Pharmacology; uses, doses, contraindications, and adverse effect of drugs producing miosis, mydriasis, cycloplegia, accommodation, and ocular anesthesia. The pharmacology, use contraindications, and adverse effect of drugs commonly used in treating visual and ocular problems.

As is evident from the discussion above, the Department endorses the first recommendation. For reasons cited, however, Department endorsement of the second recommendation is viewed as inappropriate and premature at this time.

During the course of the study effort, a number of additional issues and concerns were identified by the expert consultants which, although important considerations, represent matters not directly responsive to the specific legislative charge as interpreted by the Department. These recommendations and comments, made unanimously by the consultants, are presented here to provide an opportunity to bring these matters to the attention of Department Agencies and the Congress. Because the following items go beyond the requirement of this report, the Department has not fully examined them and makes no recommendation at this time.

1. Refractive services for aphakic patients

Aphakic patients, specifically, should be considered as having special needs given their disabled condition. Refractive services for such patients represent non-routine and necessary services in the provision of prosthetic devices, i.e., lenses.

Study advisors recommend that consideration be given to extending coverage under Part B of Medicare to include refractive services for aphakic patients when provided by either ophthalmologists or optometrists.

2. Low vision services and aids

For those patients who have inoperable cataracts or have less than optimal results from cataract surgery, that is, those who have reduced visual acuity, low vision services and aids represent essential components of reasonable and necessary health care services for these patients.

Study advisors recommend that coverage under Part B of Medicare be extended to include the provision of appropriate low vision services and optical aids for the above-referenced patients, when provided by either ophthalmologists or optometrists.

3. Prevention, health maintenance, and health education

In the interests of health care cost advantages, effects on productivity, and the overall improvement of benefits that can be afforded our population, the expert consultants recommend that a more effective effort be made to improve preventive, health maintenance, and health education measures. While this is needed in all areas of health services, the vision/eye care field offers a particularly promising area for such approaches.

4. Other service provided by optometrists

Vision/eye care services currently covered by Part B of Medicare, when provided by ophthalmologists or other physicians, include eye conditions other than cataract and aphakia. Optometrists can provide appropriate services for some of these conditions. It is recommended that extension of reimbursement to include the services of optometrists for such appropriate conditions is a desirable subject for further consideration.

5. Administrative considerations

Also during the course of the study effort, expert advisors raised several concerns pertinent to the administration of the Medicare program. These issues, also applicable to other Medicare services, include the following: (a) inconsistent application of coverage and reimbursement policies by individual carriers, (b) the problem of payment duplication for services and reimbursement for similar diagnostic procedures when performed for specific individuals by more than one provider, and (c) need of improvement in coding and billing procedures for vision/eye care services.

6. Cooperative working relationships between vision/eye care professionals

It became clear during the course of this study that more effective working relationships between optometry and ophthalmology and other providers in the vision/eye care field would enhance patient care and result in improved services to individual patients. While improved interdisciplinary coordination applies to all the health disciplines and specialties, it is a problem of particular concern in the vision/eye care field. Such working relationships could be significantly strengthened by

- a. Development of joint educational programs at the undergraduate and graduate levels, including rounds, clinics, conference, and meetings and publications.
- b. Establishment of interdisciplinary clinics with optometrists and ophthalmologists working together.
- c. Facilitation of referral of patients between the optometrist and the ophthalmologist when in the best interest of the patient.
- d. Joint development of quality standards for service and materials by peer review mechanisms. By materials, particular reference should be assigned to varying quality of lenses and frames and the need for furnishing laboratory invoices of material costs for reimbursement.
- e. Joint development of appropriate revision to State licensure laws to permit use of diagnostic drugs (mydriatics and local anesthetics) by optometrists.

While such joint endeavors are evident in various areas of the country, they need to be broadened and routinized.

Eye-To-Eye 3/2/79

Currently before the House Health, Education and Social Services Committee is a bill (HB 79) which would allow optometrists to use certain drugs in eye drops for the purpose of making diagnoses. Optometrists could use these drugs only after completing an approved pharmacology course and passing an examination administered by the State Board of Optometry. The drugs involved would either open or paralyze the pupil of the eye or deaden pain.

Though the bill is relatively straightforward on the surface, it has acted to draw battle lines in the field of medicine in general and eye care in particular.

On one side of the line are optometrists, who historically view their profession as measuring the eye and fitting it with corrective lenses when needed. Optometrists in Alaska are required to have completed a six-year program through which they receive a doctor of optometry degree. They still may not prescribe drugs for the treatment of patients or perform surgery.

Optometrists argue that the use of the drugs would allow them to detect better problems with the eye. And as a result they argue, they could offer a higher level of service to their patients.

On the other side of the line are ophthalmologists, who argue that as medical doctors who specialize in the treatment of diseases of the eye, they should retain the sole right to administer drugs, diagnostic or otherwise, to patients. Other branches of the medical profession generally agree. Ophthalmologists also point to the potential danger of adverse reactions of patients to the drugs.

To understand the basis for the argument it is essential to clear up the blurred distinction between the two professions. As we stated previously, the optometrist is not a medical doctor as such. An optometrist concentrates on detecting defects and faults in the eye and prescribing correctional lenses or exercises but not drugs or surgery. Historically, optometrists refer their patients to ophthalmologists should the problem be beyond the scope of their practice.

Ophthalmologists, on the other hand, are medical doctors, who after completing medical school continue to specialize in their field. To complete the entire program of medical school and the study of ophthalmology requires 12 years.

The crux of the problem, however, revolves around the drugs the optometrists are asking to use. There are four types: mydriatics, which open the pupil; cycloplegics, which open the pupil and paralyze the focusing mechanism; miotics, which constrict the pupil; and anesthetics, which take away the feeling.

In rare instances, though, complications can arise from the administration of these drugs. Some of them can even be dangerous. Nervous disorders, convulsions and death are known to have resulted from the administration of these drugs in rare cases, according to the Boston Globe.

But one person seems to be lost in the argument between optometrists and ophthalmologists—the patient. What the optometrists' ability to use diagnostic drugs override the potential hazard of an adverse reaction to the drug? There is no black-and-white answer, but one conclusion can be drawn safely. The best-trained ophthalmologists in the state have agreed that the potential danger to the patient exists and that the bill under consideration contains inadequate safeguards to the public.

The question that has to be asked is if a patient of an optometrist does have an adverse reaction to one of these drugs, what would he do? Most sources agree that he would probably have to call a doctor—an ophthalmologist, to correct or treat the problem.

When it comes to the public's health, the Legislature, when approached with bills such as this, should take the prudent course and turn them away, unless there is overwhelming evidence that the public would benefit.

Without a doubt, the prudent course is to turn away HB 79.

HB 79

JAMES H. PATTERSON, M.D.

Diseases and Surgery of the Eye
Subspecialty Pediatric Ophthalmology
3500 LATOUCHE
ANCHORAGE, ALASKA 99504

Telephone 907: 274-2252

February 26, 1979

Senator Thelma Buchholdt
Chairwomen, Senate Judiciary
Committee
Pouch V
Mail Stop Number 3100
Juneau, Alaska 98111

Dear Senator Buchholdt:

As a physician and surgeon I am most concerned about SB 75 and HB 79 which propose to give nonmedical eyecare practitioners (optometrists) the privilege of applying potent medications to the eye for diagnostic purposes.

The proposed bill lists only broad general categories of the desired eye medications, not specific drug names and concentrations. The classes of drugs include such potent substances as Cocaine, Atropine, Scopolamine, Phenylephrine and Phospholine Iodide. All these drugs when applied to the eye are readily absorbed into the bloodstream and are capable of producing a wide range of total body effects.

Cocaine, a topical anesthetic and mydriatic (dilator of the pupil) is a controlled substance which is subject to wide spread abuse by addicts and requires a controlled substance registration certificate to dispense. Atropine and Scopolamine are cycloplegic agents which paralyze the eye's focusing power and in sufficient doses produce irritability, hallucinations and even coma. Phenylephrin (a mydriatic) has the ability to raise the blood pressure markedly and to alter the rhythm of the heart and has been implicated in deaths in older people through strokes and in children through cardiac arrhythmias. Phospholine Iodide, a miotic which constricts the pupil, is used in the treatment of glaucoma (elevated pressure in the eye) and in certain cases of crossed eyes, the active ingredients are related to the active substance in certain insecticides and nerve gas. This medication has been shown to produce retinal detachments and cataracts. Miotics are a therapeutic class of drugs and are listed incorrectly in the proposed bills as diagnostic drugs.

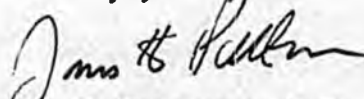
The above are only a few examples demonstrating what potential dangers exist in the various classes of the drugs listed in the proposed bills. By allowing wide spread use of these drugs by nonmedical persons the overall risk to the general public of potentially serious effects or untoward reactions are markedly increased.

Page 2

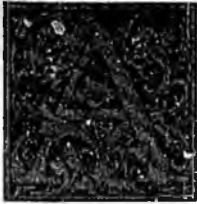
This type of legislation is not unique to Alaska. The initial nationwide optometric movement, in attempting to enter the practice of medicine, was successful and approximately 20 states have some type of optometric drug legislation. In the past 2-3 years as the full implications of such legislation became known optometric drug bills have been going down to defeat by about a 3 to 1 margin.

I would appreciate your support in helping prevent these bills from becoming law. I not only can but will readily answer any questions or document any items that I have commented on in this letter.

Sincerely yours


James H. Patterson M.D.

JHP:plz



HB 11



ALASKA STATE MEDICAL ASSOCIATION

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

February 26, 1979

Representative Thelma Buchholdt, Chairman
House of Representatives
Health, Education, and Social Services Committee
Pouch V, Mail Stop #3100
Juneau, Alaska 99811

Dear Ms. Bushholdt:

The Alaska State Medical Association Legislative Committee has reviewed House Bill 79, an act relating to the practice of optometry.

Enclosed is a copy of correspondence relating to the issue during the 1978 Legislative Session. The position of the Association remains essentially the same, namely:

- (1) We are unable to determine how this legislation will improve eye care or specifically benefit the public.
- (2) Specifically, we know of no diagnostic use for the drug class, miotics, requested; in converse, their use would be appropriate for treatment of narrow angle glaucoma, precipitated by a mydriatic/cycloplegic use. This condition, we understand, is more prevalent amongst the Alaska natives than the general population, such that bush use of these drugs could carry increased risk.
- (3) We approve the educational requirements added in the 1979 legislation. It follows that should the Legislature believe the proposed legislation is in the broad public rather than for special interest, no grandfather type clause should be allowed.

Sincerely,

Winthrop Fish, M.D.
Chairman, Legislative Committee
Alaska State Medical Association

WF:mlm

Enclosure

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 contemplated, 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.

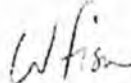
Before extending the scope of optometry, well beyond refraction and the sale of contact lenses and spectacles, into the intricate area of complex ophthalmological diagnosis, we ask that you assure yourself of the following:

- (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.

- (2) That the general level of training of the practicing optometrist in Alaska at present is at a standard which will preclude frequent mis-diagnosis, delay, duplication of expense and inappropriate trials of corrective lenses for non-refractive disorders of the eye.
- (3) That the use of ophthalmologic drugs in the practice of optometry is free of risk.
- (4) That the extended drug use is necessary and essential to increased accuracy in refractive error diagnosis.

We feel the answers to the above are not obvious, we see no urgency to enact the legislation without the most careful study of the implications and therefore urge that you allow ample time for its consideration.

Sincerely,



Winthrop Fish, M.D.
Chairman, Legislative Committee

WF:mlm
cc. ASMA Council
ASMA Legislative Committee

PUBLIC DANGER DOCUMENTED

SPECIAL SUPPLEMENT

ANNUAL REVIEW OF SELECTED CASE HISTORIES

As published in *THE PEN...—* during 1977-78

TUMOR OVERLOOKED

Mrs. Lois McWalters

Massachusetts Widow

Vol. 1, No. 1, July 15, 1977



The first issue of *THE PEN* featured a tragic testimonial headlined "Massachusetts Widow: 'It Seems Bizarre.'" Excerpts follow:

Five years ago my husband began complaining about his eyesight. He decided to see an optometrist and he continued to do so for 2½ months. As his vision deteriorated at this time, he experienced headaches so violent they would awaken him from a sound sleep. I pleaded with him to see an ophthalmologist or some person with a medical background. He became increasingly irritated at my suggestions and I was forced to bow to his decision or submit to an unhappy home life.

As each day passed, before my eyes his personality changed; this sweet gentle man became verbally abusive and the general tenor of our home was unbearable. At that time our four children were 6, 7, 8, and 9 years old. They watched their father hold a cup of coffee, his hand tremors so pronounced he would spill it and leave the table in a terrible rage.

I pleaded again, to no avail. How does a wife forcibly take a grown man to a doctor? He trusted the optometrist. The optometrist changed his glasses three times - each prescription being for stronger lenses - during those 2½ months. Each time his eyesight and the pain was not even slightly improved by the change of glasses. He was told it would take time to get used to them. The optometrist never suggested he see a medical person.

His suffering increased to such a point he could not work or concentrate. I suggested a vacation and he agreed. . . . He now had a black patch over one eye "to rest it" prescribed by the optometrist.

I was frightened; I felt he was dying and I was helpless. After a few days of rest I gently broached the subject again and very unlike me, burst into tears. . . .

Our vacation was cut short because he was so ill. He insisted upon going to work when we got home, but surprised me by phoning from the hospital. He had seen an ophthalmologist who immediately spotted the problem and within minutes called in a neurosurgeon. The neurosurgeon admitted him to the hospital at once. I discovered later that when the ophthalmologist's secretary heard the symptoms over the telephone, she had insisted Dick come to the office immediately.

The neurosurgeon told me frankly he felt that Dick had a brain tumor. At our community hospital, tests were done in the next few days; the consensus was a brain tumor.

Surgery was at nine. . . .

Bad news it was, a malignant brain tumor called an astrocytoma. "I would give him about eighteen months," the doctor said, "but be prepared for some horrible times ahead." Twelve days later God mercifully took his beautiful soul and left his tired, worn body. . . .

In retrospect, it seems bizarre to me that when one (in this case the optometrist) realizes a situation is out of his control, that he wouldn't immediately make a referral, especially when seeing a patient suffer so much. ●

SPECIAL ANNUAL PERSONAL EXPERIENCE REVIEW ISSUE

During its first year, *THE PEN* has published numerous carefully documented cases of eye damage resulting from attempts by non-medical practitioners to practice medicine. These four pages are a collection of selected excerpts of those cases which have prompted expressions of maximum interest from readers.

While there has been no official response or challenge from organized optometry, individual optometric lobbyists have advised legislators that these cases are "isolated instances." The steady flow of similar testimony pouring into *PEN* headquarters prompts us to suggest that the cases are not "isolated," but rather "the tip of an iceberg."

The Editors

OPTOM-PSYCHIATRY

Barbara Cosgrove

"Lack of Love"

Vol. 2, No. 3, Feb. 1, 1978



A Connecticut woman, interviewed by Jeffrey Gold, M.D. of New Haven, told how she claimed her child's blurred vision could be cured with "more love and understanding at home" in a story headlined "O.D. Calls Diabetes A 'Lack of Love.'" Passages of that interview follow:

Dr. Gold: "Mrs. Cosgrove, why did you bring Barbara to me?"

Mrs. Cosgrove: "We were referred here by our family doctor who just found diabetes in Barbara. She is 11 years old. I told him I had just had her eyes checked by an optometrist."

Dr. Gold: "Do you mean Barbara was examined by an optometrist lately?"

Mrs. Cosgrove: "Yes, she failed the school vision test in November and they said to have an examination. He (the optometrist) has a great big sign out in front, that says 'Doctor,' and I thought he was one."

Dr. Gold: "What did he find?"

Mrs. Cosgrove: "He said there was nothing wrong with her eyes and when I asked him why she kept getting blurred vision, he told me that she was a nervous child and when she gets up-tight, her eyes get blurry. My reaction was to take her to a social worker, but he (the optometrist) told me she just needs more love and understanding at home and that there was no reason to do any more than see him again next year."

Dr. Gold: "Then what happened?"

Mrs. Cosgrove: "I thought I was some kind of a rotten mother with such a nervous child, and I cried that night."

Dr. Gold: "Did you pursue the blurred vision at that time?"

Mrs. Cosgrove: "During December, Barbara seemed to have the flu, but it didn't go away and by Christmas Eve, I real-

Continued on page 6

DANGER AND WASTE IN THE VA

Robert B. Nolan

Disabled Veteran

Vol. 2, No. 8, April 15, 1978

Vol. 2, No. 11, June 1, 1978



In these issues, a totally and permanently disabled veteran told how he got less than the deserved in-depth investigation into the problem of allowing VA optometrists medical functions. Mr. Nolan again found more evidence of danger and waste in the VA. Excerpts from the first story follows:

"... The VA would not permit me to receive outpatient treatment from a private physician unless I lived 30 to 50 miles from a VA treatment center. I didn't, so I decided to pay for my own doctor and then go to the VA and see their M.D. for medication only.

"My wife called the VA in the federal building in downtown St. Petersburg for an appointment early in August of 1977. She told the girl on the phone that I needed an eye doctor because I had glaucoma.

"My first visit to the VA eye 'doctor' was August 22, 1977. I presumed that the doctor I saw was an M.D. ophthalmologist. His name was on the door and it said 'doctor.' . . .

"The 'doctor' finally tested my tension with and said the pressure was 10 in each eye. I showed him the prescription I had received from Kenneth Safko, M.D., my own ophthalmologist, and he said, 'Wait until I xerox this as it is no good here. I will have to write my own prescription.'

"After copying Dr. Safko's prescription and putting it in my file, he wrote his own prescription and took it next door to get it co-signed. . . .

"On my way to the pharmacy with my wife, she looked at the prescription and said it didn't look right. We took it back and the 'doctor' changed it from pilocarpine to 3/4% carbachol with six refills. Another doctor (probably an M.D.) co-signed the new prescription. . . .

"On our next trip to the VA center, my wife asked the woman at the front desk if the doctor we saw was an M.D. and an ophthalmologist. The woman at the desk replied, 'Yes, he is a full-fledged doctor and an ophthalmologist fully qualified to treat eyes.' . . .

"When I finally got the glasses, sometime in late November or early December of 1977, I discovered I could see much better without them.

"On my next trip to the VA on December 19, 1977, I returned the glasses. The 'doctor' told me the reason the glasses had been so long coming was because he rejected them two or three times, since they were not to his prescription. When he took the glasses to the next office to check them, my wife and I looked at his diploma on the wall. It said 'Doctor of Optometry.' When I told him we thought he was an ophthalmologist, he became very angry and said, 'Do you question my qualifications?' I told him I certainly did question his qualifications to treat glaucoma or any other eye disease. He told me that the people at the front desk didn't know the difference between an ophthalmologist and an optometrist. I said, 'If this is true, what if my eyes need surgery?' He said if that were the case I would have to go to the Tampa VA Hospital or the Bay Pines VA Hospital and some other doctor would operate. . . .

"Talking to people in the waiting room, we

Continued on page 6

Tragic Case Histories Dramatize The Need To

NETWORK TV WARNING

Totie Fields

Comedienne

Vol. 1, No. 8, Nov. 1, 1977



The following is a portion of an interview between TV-talk show host Merv Griffin and comedienne Totie Fields, during which she warned all diabetics to seek eye care only from ophthalmologists:

MERV: It was kept very quiet; but all of a sudden, about two months ago we all heard rumors that, now you were losing your eyesight from the diabetes.

TOTIE: It's true, it's true! — and you know why I want to talk about it?

MERV: Blue Cross must hate you!

TOTIE: They have lost so much money on me.

MERV: Have they?

TOTIE: Yeah, but you want to know? I didn't know it, Merv, I swear to you I saw 20/20! . . . this is what I want to make a point of, I went to an optometrist all the time and he said, "Totie you're doing wonderfully, everything is fine." . . . I've been a diabetic since I was nineteen years old, and you know how I watch myself; I weighed 200 pounds; all I ever thought about was eating. I swear to God they told me I couldn't eat and that was the end of it!!! I mean, I just ate myself into oblivion!! I used to do a show and in the middle I used to think where could I get a pizza around here; you know I thought of nothing but food, Mallomars, if I could only eat a Mallomar! Oreos, you know I was an Oreo freak . . . Oh, I talk about them and my mouth gets filled with saliva!!! I saw a little thing floating in my eye like a little hair, you know, that you couldn't get rid of and so I went to an ophthalmologist. Diabetics should never go to an optometrist, they must go to ophthalmologists because they see behind the eye. He said, "Totie, you've got to go . . . the best man in the country is in San Francisco and you must get to him right away." The next morning I was there and this man was telling me I was going blind, and I said, "You're crazy! Why didn't anybody else . . ." Well, they were so busy worrying about everything else, no one thought of my eyes, and I've never (incidentally, no one's ever heard this story before) — Well, to make a long story longer . . . yeah! I want, because I really want diabetics to be so aware because this operation is only two years old, Merv, and ironically enough, my dad died blind, my brother died blind, and I did have . . .

One day you get to that age where all the print is gone and the paper comes and you say why did they send me a white paper (laughter) — you know, and you'd go to the toilet and drop it on the floor and read it there (laughter) . . . you know what I mean. But, I can read proof! I mean, to open a menu and be able to see it without looking for my glasses is the most exciting thing, but I want you to know, everybody out there that is a diabetic, please go to an ophthalmologist . . . because you can be saved! You know the ironic part of this entire story,

I did "Fight for Sight" — the benefit "Fight for Sight" for about five, six years in a row and that's the money that helped this whole thing! (applause) To get this discovery! Isn't that incredible? (applause) And you won't believe how I can see every wrinkle in your face, Merv, every wrinkle in your face, I never could see them before . . .

GLAUCOMA UNDETECTED

Mrs. Agnes Karrman

Connecticut Housewife

Vol. 1, No. 5, Sept. 15, 1977



Appearing in this issue of THE PEN under the headline "Conn. O.D. Tells Housewife: 'You Don't Have Glaucoma'," a Conn. woman told of an optometrist who failed to recognize her glaucoma. Excerpts follow:

"I was a nervous wreck before I visited the ophthalmologist that day in October, 1975, and then the bottom had just dropped out of everything. My fears had been justified because the ophthalmologist had just told me that I was suffering from far-advanced glaucoma. For some time I had experienced increasing difficulty with my vision. I couldn't read the paper without a magnifying glass. My eyes were constantly watering and sometimes I awakened at night with a headache. I could no longer see well enough to play the piano or organ.

"...Yet, despite these complaints, my optometrist had assured me for over a year there was nothing seriously wrong with my eyes.

"I had been going to an optometrist regularly for about seventeen years — ever since he had opened his office. He was always pleasant and the glasses he fitted for me were generally satisfactory. In 1974 I went to him complaining of blurred vision. He gave me new glasses but they didn't help. I went back to him and he told me that they were the right glasses and that I just hadn't allowed enough time to get used to them. I told him that I was worried about glaucoma because my brother had had surgery for glaucoma and is almost blind, and my sister was being treated for glaucoma by an ophthalmologist. She is doing well because her problem was discovered early. The optometrist assured me that he had checked for glaucoma and that I didn't have it.

"Several months later, because of increasing trouble with my vision, I returned to the optometrist . . . He again changed my glasses. At that visit I again voiced my fear of glaucoma and once again he assured me that my eye pressure was normal and that I didn't have glaucoma. He said my eyes were just tired. Well, the new glasses didn't help at all. They seemed to be no different than the previous pair he sold me . . .

"... After another month and a half had passed I returned to the optometrist because my eyes pained at times and I often awoke at night with headaches. My vision was getting worse and my eyes watered constantly. This time I really pressed about my fear of glaucoma. He re-examined me and again sold me a pair of glasses — the third pair in less than a year! He told me that his \$3,000 special instrument measured accurately for glaucoma and that a referral to an ophthalmologist was not necessary. In fact, he told me that I had nothing to worry about, that my eyes were perfectly clear. He said, 'You don't have glaucoma and you don't have cataracts.' He gave me some eye drops to use three or four times a day. I used them regularly for the next four months until my sister finally persuaded me to see her ophthalmologist. In the

meantime, my vision had continued to get worse and I could no longer enjoy any activities that required good eyesight.

"As I said earlier, my first visit to the ophthalmologist was a shocker. It was such a different examination! Not only did the ophthalmologist find that my pressure was higher than normal, he also found that my optic nerves had been severely damaged by this long-standing pressure and that my side vision had been destroyed. I could only see as though I were looking down a gun barrel . . . He discovered that I did have cataracts, but they were only a small part of my eye health care difficulties.

"The ophthalmologist's diagnoses and explanation of the extent of my problems not only added to my nervousness but made me very angry. I was angry with myself for not having listened to my sister's advice months ago to see an ophthalmologist and not an optometrist, and I was plenty angry with the optometrist! The doctor told me that an optometrist is not trained in medicine nor to diagnose or treat eye diseases. How can an optometrist act like an 'eye specialist' and flatly assure people that he is capable of this type of decision making? How can he keep peddling new glasses and sell eyewash types of eyedrops with implied assurance that they can cure? How can he stand by and literally watch one of his long-time customers go blind?"

EXTENSIVE EYE DAMAGE

Denton Livensparger

Double Jeopardy

Vol. 2, No. 7, April 1, 1978

In a story headlined "Misuse of Drugs Plus Misdiagnosis Puts Floridian In Double Jeopardy," a Florida ophthalmologist told of how an optometrist missed signs of glaucoma and serious corneal abrasions requiring surgery in both eyes of a male patient. Excerpts follow:

"Misdiagnosis combined with the misuse of powerful drugs by untrained practitioners poses a frightening threat to public health and places our citizens in double jeopardy," says John D. Mallonee, M.D., a practicing ophthalmologist in Ft. Pierce, Florida. "The advanced years of many of our patients makes this menace even more serious and the public must be made aware of this grave danger," Dr. Mallonee said.

In support of his forthright statement, Dr. Mallonee detailed the following case history.

"On February 4, 1978, I first saw Denton Livensparger. This 65-year-old man came to my office of his own volition, and without referral. He told me he lived at 1196 Proctor Lane in Port St. Lucie, Florida, a nearby retirement community, and had been suffering severe pain in both eyes for some time. Mr. Livensparger voluntarily gave the following account of his experience to date.

"In early November 1977, I think it was the 8th," the patient said, "I went to see an optometrist about the pain I had in both eyes . . . I told them that for a long time, maybe nine or ten months, I felt as though I had something in both of my eyes, and that the pain was just getting worse all the time. After they examined me, they told me all I had was an eyelid infection and they gave me some antibiotic drops called Neodecadron. I went back again the next day and they told me I didn't have glaucoma, and all that was the matter with me was a minor eyelid infection that would clear up if I used the drops."

Continued on page 6

Protect The Public From Sub-Standard Eye Care

GLAUCOMA UNNOTICED

Mrs. Florence Hubbard

Blinded High School Student

Vol. 1, No. 2, Aug. 1, 1977



The following excerpts are from a byline story by a Massachusetts student headlined "They Call Themselves Doctors" . . . Blinded High School Student," in which she told how an optometrist could not recognize advanced glaucoma.

"In August 1967 I was walking home from a friend's house when I knocked over a trash can because I didn't see it. A couple of days later I noticed that things looked blurry. I couldn't read signs or make out faces and when I looked at lights, there was a rainbow around them.

"I went to an optometrist in September and told him about all of this and that I had a throbbing pain in my eyes. My left eye was worse than my right eye. The optometrist asked me to read his eye chart but I couldn't see where it was. He examined my eyes and told me not to worry, he could help me. He said I had a lazy left eye and astigmatism, and he had just the cure for me — he was going to prescribe some glasses.

"Before the glasses were ready, the pain got much worse and my eyesight got more and more blurry. However, I trusted the doctor. I figured you go to a doctor and he knows how to treat you. I had always thought optometrists were doctors. They call themselves doctor.

"When I went in to get my glasses in October, I told him that my vision was much worse and he set out the glasses and said, 'There should be no care of you.'

"I went home with the glasses but they weren't helping. I was banging into desks at school, I kept banging into people, I couldn't see the blackboard. I must have called the optometrist about 10 times and he kept telling me I would be all right, that I was getting too worked up and making myself not see.

"When my mother and I went to see him the next day, my mother said he looked a little worried. He told us that I lacked something in my body, that I had a deficiency, and he would make an appointment for me with an ophthalmologist but not until after Christmas. He said I should go home and have a nice Christmas.

"When my mother and I went to the ophthalmologist on December 27, it was the first time I heard the word 'glaucoma.' He said I had all the classic signs.

"The ophthalmologist found that I had a pressure of 95 in both eyes — normal is 20, and total blindness is 100, he said.

"In April the pressure in my eyes went up again and this time the ophthalmologist thought it would be necessary to operate. By now my parents were so upset they had decided that they should be extra careful and get another opinion and I should go to Massachusetts Eye and Ear Infirmary. I did and it was decided I should have surgery on both eyes, to save what little sight I had left. I've lost 99 percent in my left eye and I have only the very center of the vision in my right eye — I can only see things that are straight ahead.

"After I got out of the hospital and began to feel better, my little eight-year-old cousin began to take me all around Gloucester by the hand so I could learn my way around. I still don't like going to new places and there are some things I can't do for myself. Once I set myself on fire trying to reach something over the gas stove and I didn't even know it. I was lucky my husband was home and saw it."

Similar heartbreaking circumstances have accompanied many of the cases in PEN's growing file. Here's a random sampling.

● From the Wills Eye Hospital, a division of the Thomas Jefferson Medical School in Pennsylvania, — when a female patient complained of pain in the eye, an optometrist gave her an anesthetic drop to use. Later, he refused to see her. She developed a pseudomonas ulcer (infection) and the eye had to be removed.

● Also from Wills, a female patient told an optometrist that for seven years she had episodes of blurred vision brought on by reading. They usually lasted about an hour and when severe were associated with headaches. She was followed by an internationally famous optometrist throughout the seven years and was reassured nothing was wrong. Later, an M.D. found textbook symptomatology of chronic angle-closure glaucoma and advised immediate surgery on both eyes.

GOING BLIND

Mrs. Anita Oliver

Baltimore Cook

Vol. 1, No. 10, Dec. 1, 1977



The following passages are from an interview between a blinded Baltimore optometrist and a recent Larry Thompson, M.D. In a story headlined "Mrs. Oliver: 'I Told Him These Are My Eyes,'" she told how a vision-center optometrist became annoyed when she told him the glasses he prescribed did not work:

Mrs. Oliver: "I came to University Hospital because I was getting this blindness, and I couldn't see. I was at church on the fourth Sunday in July, and I fell down those steps."

Dr. T: "You were seen for your eyes before coming here — when, back in February of 1977?"

Mrs. O: "Yes, it was February."

Dr. T: "And you were seen at . . . Vision Center?" (an enterprise which employs optometrists, but has no medical personnel.)

Mrs. O: "Yes, I was there for glasses. They examined me but they didn't tell me anything. I asked the doctor why I couldn't see. The doctor got angry with me when I said I could not see out of my left eye like I should. I was trying to read the board, the letters and the numbers. And when he put the glass to my eye, I couldn't see and I told him that I couldn't see. He got very, very angry. He told me that he was doing the examination, not me. I told him that these were my eyes and I should know whether I could see or whether I couldn't."

Dr. T: "OK, he prescribed new glasses for you at that time. After you got those glasses, you could not see with those glasses, is that correct?"

Mrs. O: "Yes. I went back to them again and had that left lens changed. It was supposed to have been changed."

Dr. T: "Did they ever measure the pressure in your eye, touch your eye with anything to measure the pressure?"

Dr. T: "Did they ever measure the pressure in your eye, touch your eye with anything to measure the pressure?"

Continued on page 6

LED TO BLINDNESS

Charles B. Wilson

Arizona Steelworker

Vol. 1, No. 10, Dec. 1, 1977



The following are excerpts from the story of an Arizona man headlined "Arizona Steelworker 'Led To Blindness,'" in which he told how an optometrist informed him he would eventually go blind, but gave no reason, and his misadventures with more optometrists:

"When I first thought I needed glasses 25 years ago, there was only one place to go in my home town in Ohio — and that was to an optometrist. He had the whole works — he gave examinations and sold glasses.

"He checked me one time, gave me glasses and then he said, 'In about 20 years, you're going to think you're going blind.'

"I asked him why, but he wouldn't give me a definite answer. He just said, 'Well, your eyes are going to change that much and you're going to think you're going blind.' To this day, I still don't know what he was talking about.

"I just figured it was my nearsightedness or the opposite, whatever that was. I wasn't bothered with anything until I came out here 17 years ago.

"I worked in a steel mill and once my glasses got all burned up in there, so I went to an optometrist in Mesa.

"He just checked my eyes like everyone else does. I got a new pair of glasses there.

"In the meantime, the Union got into the plan to give us all new eyeglasses. So, another optometrist in Tempe gave me a cut-price for an eye examination, since I was an employee. It was a ridiculously low price. After that exam, I went to that optometrist all the time, about every two years. I went through this same routine for about 10 years.

"I started noticing that I was stumbling a lot out at the steel mill. I was falling and tripping over things, which I don't ordinarily do. I tried to get an appointment with the optometrist, but most of them in town were at a convention. I finally found one to examine my eyes.

"He examined me and said he saw something in one eye, but he admitted that he didn't know what it was. He recommended that I see an ophthalmologist.

(At this point, Mr. Wilson was asked whether or not the optometrist who checked him every two years for a decade ever checked anything besides his vision, such as his eye pressure.)

"No, sir, he never did anything like that. I figured I was getting a complete eye exam, like I'd had all of my life. He was called a doctor, and to me an eye doctor was an eye doctor.

"An ophthalmologist was just a long word as far as I was concerned! I'd never been around one, and where we came from there wasn't any. This last optometrist I asked point blank what was in my eye and he said he did not know and that he recommended my coming to see one of you fellas. He said you would have to 'lift the pupil up and look behind it and see what was in that eye' . . .

"Well, here I am. I was legally blind. Now I've had surgery to save what vision I had left, but I'm still in bad shape. I believe this other guy that I went to should have seen something and checked it. But I didn't know he should have looked into my eyes with all those lights and stuff that he didn't do. He never gave me a pressure check or anything like that.

"So now I'm disabled. I was led to blindness for 25 years."