



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 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.

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 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 "Sinu-tabs," 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.

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 optometrist 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."

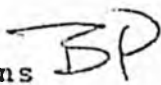
Mrs. Jones later told her ophthalmologist that vision loss was not the only way she suffered due to the optometrist's bold attempts to practice medicine.

"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. ●

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

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

Name	Address	Organization	Bill
John A. Boye	Pouch H-05	Dept. of H&SS	HB
Bill Ray	Pouch V	Home District 8	H&#
Randy Phillips	Pouch H 05 F	Office of Alcoholism & D.A.	# 58
George Wendell	RT 5 Box 5524 Juneau 99803	Occupational Licensing	# 7
Claire Harrell	RT 5 Box 5525 Juneau 99803	Physician	# 79
William Palmer		Physician	# 7
Robert Page			

3701 Richmond St. #16
Anchorage, Ak. 99504
June 13, 1979

Legislative Affairs Agency
1024 W 6th Ave.
Anchorage, Alaska 99501

Dear Sir:

Enclosed is a copy of a survey undertaken by myself in March 1979 on the use and experiences of ophthalmic pharmaceutical agents by all ophthalmologists in the state of Alaska.

The impetus for this survey to have been conducted was due to the fact of House Bill 79 in deliberation under the house Health, Education and Social Service committee. In view of this I believe that the resulting responses to questions two, four, five and six are significant indicators. To wit, pertinent information for the House HESS committee members material packets.

Upon your review of this survey, I would appreciate your consideration in submitting this as relevant data and information for the HESS committee members use &/or at their disposal.

Thank you for your time and consideration in this matter.

Sincerely,


Maureen C. Roche

A SURVEY
of the
EXPERIENCES IN THE USE OF
OPHTHALMIC PHARMACEUTICAL AGENTS

A survey was conducted in March, 1979 among the Ophthalmologists in the state of Alaska concerning their experiences utilizing dilating drops.

The format of that survey was patterned after a similar survey undertaken by the Texas Ophthalmological Association in 1976. In addition to the three questions posed by the Texas Ophthalmological Association, four more were composed for the survey undertaken in Alaska. A form was devised and mailed with an enclosed addressed envelope to all twenty three Alaskan Ophthalmologists as provided from the listings on record with the Alaska State Medical Association.

As of May 8, 1979 16 (71.8%) of the 23 survey forms had been returned and those responses compiled & calculated. Below is a summary of these seven questions and the results received.

Question 1. Do you see cases in your office that must be dilated cautiously & require close medical observation?

16 (100%) of all received survey forms had responded yes to this question.

In regards to this, several respondents reported that they were more concerned with cautious dilation in the native, elderly and infant individuals and group of peoples. One Ophthalmologist reported these individuals he sees are examined carefully with the slit lamp employing the gonioscope lens prior to use of dilating agents.

Question 2. Have you had cases of acute angle closure glaucoma from dilating drops that required medical &/or surgical care?

13 (81.3%) of the 16 respondents answered yes they had cases of acute angle closure glaucoma from dilating drops that required medical &/or surgical

care. 3 respondents of the 13 that replied affirmatively reported that they had seen "several" and "a number" of such cases. Yet, no specific number was supplied. 1 respondent commented that he had not seen this occurrence since his training. A total number of cases reported among these 13 respondents was three. Two of these cases required emergency surgery to remedy the situation.

2 of the 3 (18.8%) respondents whom replied no they had not seen cases of acute angle closure from dilating drops stated they employed the method of gonioscopy frequently if "suspicious of the safety of dilation". And if dilation be needed after this it would be performed with weak agents that could be counteracted readily.

- Question 3. If you are aware that a patient has extremely narrow angles anatomically, and must be dilated for further studies and evaluation of the retina...
- a) Do you dilate them in your office?
 - b) Admit them to a hospital for dilation and observation?
 - c) Request for a consult &/or refer them to another Ophthalmologist?

15 (93.8%) responded a) they dilate their patients within their office. Of these affirmative responses various comments were reported such as: "dilate with a weak agent that is reversible", "cautiously", "with phenylephrine", "dilate the patient in my office but do not let them leave my office until the pupil has returned to normal", "usually", "also prepare my patients for admission to a hospital if necessary". One respondent answering question 3 stated that he dilates his patients in his office and then stated "there is no way to predict what the patient will choose".

3 of the 15 replying affirmatively, revealed that they have offices in a hospital complex (2) or adjacent to a hospital complex (1).

1 respondent whom did not indicate whether or not he dilates patients in his office did state "if I have a patient with extremely narrow angles that appear occludable I admit the patient to the hospital and do peripheral iridectomies. Then I dilate and examine the peripheral fundus".

- Question 4. Estimate or if able, specify the number of patients you see in a year with narrow angles potential &/or precipitated.

(93.8%) reported a specific number of cases. 1 respondent failed to give a specific number when reporting; "a couple a year". Therefore this response

was disregarded in the statistical analysis. These 15 Ophthalmologists supplied a total number of 1,130 cases they would see in a year of potential and/or precipitated narrow angles. The average figure 75.3, is the number of patients PER Ophthalmologist responding, that would be seen a year with potential and/or precipitated narrow angles.

Question 5. From your use of topically applied pharmaceutical agents have you seen other side effects? (excluding narrow angle closure glaucoma)

(100%) of the respondents replied yes to this question.

Question 6. In conjunction with question #5, can you supply what pharmaceutical agents (mydriatics, cycloplegics, miotics and anesthetics either generic or brand name) have induced these side effects in some of your patients?

Please estimate by number or if able specify how many reactions have been induced by the said pharmaceutical agents in your practice for the year 1978.

Compilation of the data revealed 13 (81.3%) respondents citing reactions in the parasympathomimetic family. Of the cycloplegics used atropine and cyclogyl appeared to be the worst offenders for inducing reactions. 8 (50%) of the Ophthalmologists reported from their use of atropine such reactions as: "hypersensitivity", "poisoning", "confusion", "cardiac arrest", "rash & fever", "convulsions", and "hypertension". 9 (56.3%) of the Ophthalmologists cited reactions from the use of cyclogyl as: "sedation", "aloofness", "convulsions", "hallucinations", "seizures", "syncope" and "central nervous system reactions".

9 (56.3%) of the respondents reported reactions with the use of the agents in the sympathomimetic family. Neo-Syneprine (phenylephrine HCL) produced problems for 7 (43.8%) Ophthalmologists' patients. These were indicated as: "hypersensitivity reactions", "conjunctivitis", "toxic keratitis", "cysts", and "heart dis-rythmia". Euphoria had been induced in the adult patients of one Ophthalmologist from the use of 4% cocaine.

5 (31.3%) of the Ophthalmologists cited reactions induced from the miotics. These were reported as: "conjunctivitis", "retinal detachments" and "hypersensitivity reactions".

From the use of anesthetics 11 (68.8%) cited allergic reactions from the use of ophthaine (proparacaine).

3 (18.8%) of the responding Ophthalmologists stipulated they had seen many side effects from the use of pharmaceutical agents but did not report on these reactions nor state from what agents these side effects were induced from.

Question 7. In your practice up to date, being as accurate as possible how many patients are legally blind?

325 legally blind cases were supplied from 11 (68.8%) of the respondents. One Ophthalmologist reported "several cases" in his practice. This response was not calculated in the statistical figures. Three respondents (18.8%) stated such information was not available. One Ophthalmologist declared that 10% of his practice involved legally blind individuals.

SUMMARY and CRITIQUE

This survey had been initiated due to the current legislative situation in Alaska. The introduction of the so-called "drug bill", (use of pharmaceutical agents: anesthetics, cycloplegics, miotics, and mydriatics by the Optometric profession) has been in deliberation within the state house HESS committee. The subject in deliberation became of interest so much so that conducting this survey was of utmost importance to determine any established relevancy, primarily through the use and experience of dilating drops. These deliberations provided the impetus to undertake this survey.

It is a known fact among the Ophthalmologists and few others that the Native Alaskan is predisposed to narrow angle closure glaucoma. With this in mind and the awareness that dilating drops have the potential to induce and precipitate such an attack of glaucoma; questions two & four were directed at seeking a

determinacy of this precarious situation. It would be fair to say predicated from the responses to these two questions that narrow angle closure glaucoma is quite a significant matter in Alaska and cannot be denied.

Examination of all responses lends additional support that medical supervision or personnel medically trained perform dilation in order to deal with the aforementioned and unmentioned side effects that may arise. Most all respondents in this survey had indicated that they could report and list more side effects from the use of ophthalmic pharmaceutical agents. However, they declined from the arduous task of listing the vast array of side effects.

The results of this survey were forwarded to these twenty three Alaskan respondents.

Maureen Rabe
3701 Richmond #16
Anchorage, AK 99504



Juneau

MEDICAL SOCIETY

P. O. BOX 3-3000 • JUNEAU, ALASKA
99802

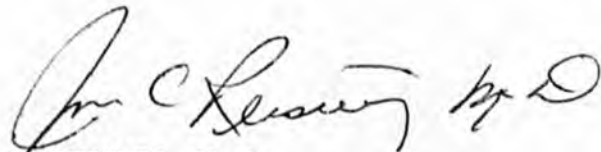
• TELEPHONE (907) 586-2611

March 9, 1979

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

HB 79 - AN ACT RELATING TO OPTOMETRY

The Juneau Medical Society at its regular meeting on Tuesday, March 6, 1979
unanimously went on record as being opposed to the above captioned
legislation as it would allow the practice of medicine by unqualified
persons.


JON REISWIG, M. D.
PRESIDENT

Peter E. Cannava, M.D.

OPHTHALMOLOGY

BOX 1629

SOLDOTNA, ALASKA 99669

TELEPHONE 262-4482

N: HB 77

March 13, 1979

Representative Hugh Malone
Pouch V
Juneau, Alaska 99811

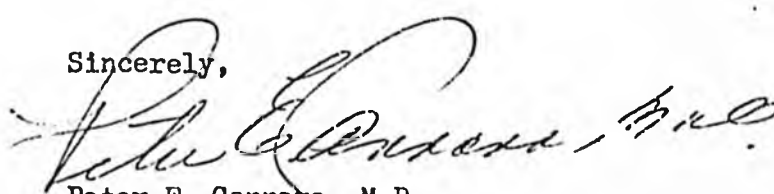
RE: HB 79

Dear Hugh:

There seems to be some confusion as to which drugs the optometrists are asking to use. That is one of the problems ophthalmologists see with the bill; it does not be specific as to drug but simply authorizes them to use broad classes of drugs. (anesthetics, mydriatics, cycloplegics) this of course will leave room for them to expand as they see fit rather than be limited to specific drugs as approved by the legislature.

Enclosed please find resolution from University of Alabama the optometrists claim that this institution qualifies them to use drugs on people. the resolution speaks for itself.

Sincerely,



Peter E. Cannava, M.D.

President Alaska State Ophthalmologists

PEC/bc

cc: Pat O'Conner
Margaret Branson
Joyce Munson
Charles Parr
Bill Miles
Nels Anderson
Vernon Hurlbert

THE FOLLOWING DOCUMENT(S) MAY NOT FILM
LEGIBLY BECAUSE OF POOR QUALITY OF THE
ORIGINAL.

University of Alabama School of Medicine Physicians Advisory Board
Adopted - 10/18/78

WHEREAS, physicians from many states have expressed appropriate concern for the fact that the existence of certain courses in the University of Alabama School of Optometry may be described by political opportunists as qualifying Optometry School graduates to attempt to safely perform medical functions; and,

WHEREAS, this Board recognizes that occasional lectures on medical subjects to optometry students are intended only to enable them to more accurately detect eye diseases and refer to physicians; and,

WHEREAS, this Board also recognizes the inherent dangers in optometry graduates believing that such cursory briefings might equip them to attempt the practice of medicine; and,

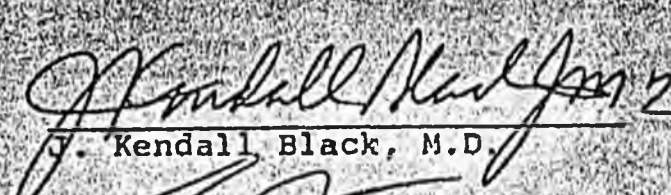
WHEREAS, Dr. Henry B. Peters has publically stated that the practice of medicine is an "inappropriate goal for optometry",

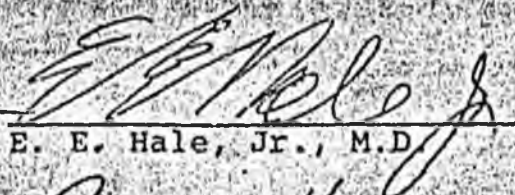
NOW Therefore be it resolved,

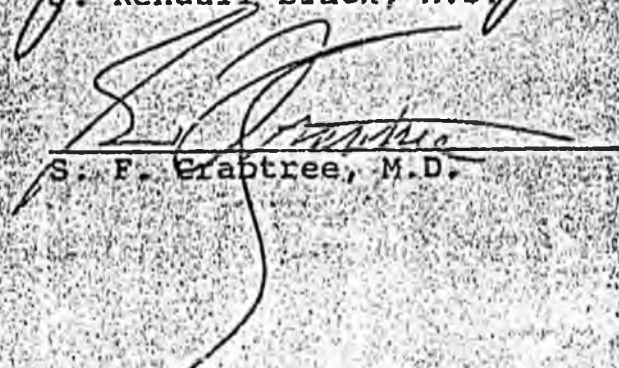
The University of Alabama School of Medicine Physicians Advisory Board recommends that the following public statement be issued and released to the physicians who have expressed concern:

"The education of optometrists ('specialists in the art or profession of examining the eye for defects and faults of refraction and prescribing correctional lenses or exercises but not drugs or surgery') at the University of Alabama in Birmingham is designed to teach optometry principles and to enlighten optometry students in the detection of disease so as to encourage appropriate referral to physicians. This education in no way prepares these graduates with the knowledge to prescribe or use drugs to treat eye disease. This training should not be viewed as a medical credential."


J. Richard Moore, M.D., Chairman


J. Kendall Black, M.D.


E. E. Hale, Jr., M.D.


S. F. Erabtree, M.D.


Ronald E. Henderson, M.D.

THE PRECEDING DOCUMENT(S) MAY NOT FILM
LEGIBLY BECAUSE OF POOR QUALITY OF THE
ORIGINAL.

HB 79

Peter E. Cannava, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99869
TELEPHONE 262-4462

79
(see previous
letters re
HB 179)

March 13, 1979

Representative Hugh Malone
Pouch V
Juneau, Alaska 99811

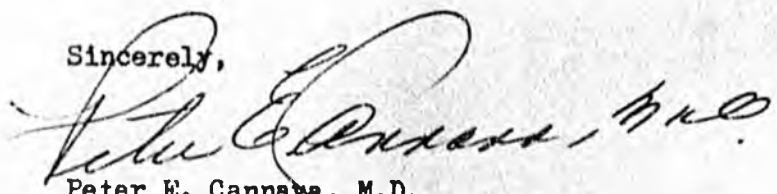
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Sincerely,



Peter E. Cannava, M.D.
President Alaska State Ophthalmologists

PEC/bc

cc: Pat G'Conner
Margaret Branson
Joyce Munson
Charles Parr
Bill Miles
Nels Anderson
Vernon Hurlbert

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

HB 79

April 20, 1979

Rep. Thelma Buchholdt
Pouch V
Juneau, Alaska 99801

Dear Thelma,

Here is a little follow-up information in regard to our conversation of Friday, April 20.

South Dakota passed an Optometric Drug Bill into law early in March. The House supported the bill by a 64 to 2 vote and the Senate by a 22 to 11 vote.

March 21 saw Utah's drug bill become law, with a 50 to 12 vote in the House and 20 to 4 vote in the Senate.

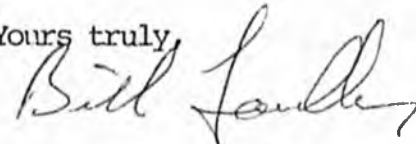
North Dakota's Optometric Drug Bill became law on March 22 (House support of 41 to 7 and Senate support of 85 to 10).

The wide margin of support in these states indicates the great need for the Optometric usage of diagnostic pharmaceutical agents.

As I'm sure you are aware, our bill passed the House by an overwhelming margin last year, indicative of the faith in the Optometric community in this State.

I would greatly appreciate your help in expediting our bill through your committee this session. Thank you.

Yours truly,



William D. Faulkner, O. D.

WDF/aeb

Municipality of Anchorage



POUCH 6-650
ANCHORAGE, ALASKA 99502
(907) 274-2525

GEORGE M. SULLIVAN,
MAYOR

MUNICIPAL HEALTH COMMISSION

March 27, 1979

Thelma Buchholt, Chairman
Senate Health, Education &
Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholt:

The Municipal Health Commission has reviewed and made a recommendation on House Bill 79 that is presently in your committee.

The Municipal Health Commission is a 33 member, community based group of concerned citizens. The Commission reviews community health issues, grants, problems and legislation and makes recommendations to the Municipal, State and Federal governments and legislative bodies, the general public, and the Regional Health Systems Agency. The Commission membership must meet rigid legal requirements that assure broad demographic and occupational representation as well as a consumer majority.

Attached is the review and recommendation on House Bill 79 as approved by the Legislative Committee on March 7, 1979. We hope that your committee will consider our review and recommendation before making a decision on this bill.

Thank you very much.

Sincerely,

A handwritten signature in cursive script, appearing to read "Charles Rigden".

Charles Rigden, Chairman
Municipal Health Commission

Attachment

LEGISLATIVE REVIEW

BILL NUMBER AND TOPIC: House Bill 79

BRIEF SUMMARY: An Act relating to the practice of optometry. This bill defines the term "optometry" and defines what is included in the practice. The bill also outlines the use of drugs for diagnosis.

BILL STATUS: House Bill 79 was introduced by Representatives Martin, McKinnon, Meekins, Miller, and Parr, and was referred to Health, Education and Social Services and Judiciary Committees.

The series of questions below are presented to assist persons responsible for reviewing proposed legislation. Answering each question will help the reader to better understand the intent or meaning of a specific bill. Question #12 asks the Legislative Advisory Committee to formulate a recommendation, which will then be forwarded to legislators, lobbyists, other review bodies, etc., as appropriate. Action taken by this committee automatically sends the bill and comments through 1) Municipal Legal Department, 2) Municipal Administration, and 3) Municipal Health Commission, time permitting.

1. What is the time frame for influencing the bill's outcome by this committee or Commission? This legislative session
2. What does the bill do? Allows optometrists to utilize certain classes of diagnostic drugs in their offices.
3. Who does it affect? Approximately 2/3 of the residents of Alaska who seek eye care.
4. How much does it cost? Will make no cost differences to the consumer.
5. Is it directed to a specific geographic area? No
What area? _____
6. How would enactment of this bill effect Anchorage? Enable the thirteen Anchorage area optometrists to utilize the diagnostic drugs.

_____ Individual Committee Members of the following Committees

_____ State Health Coordinating Council

_____ Governor

_____ Bill Sponsor

_____ Other: list

Committee procedure automatically sends the bill through:

1. Municipal Legal Department
2. Municipal Administration
3. Municipal Health Commission, if timely



NEWS

American Optometric
Association

Vol. 18, No. 5
March 1, 1979

Nebraska okays DPA usage

LINCOLN, NB — A signature by Gov. Charles Thone makes Nebraska the 17th state in the nation which has enacted legislation specifically authorizing optometrists to utilize diagnostic pharmaceutical agents (DPAs).

Gov. Thone, a former member of the U.S. House of Representatives, signed into law Legislative Bill No. 9 on February 13, the same day the state's one-house legislature passed the bill by a 33 to eight vote.

The legislation redefines and revises the 1943 state statutes relating to the practice of optometry and changes state license requirements, in addition to authorizing the usage of DPAs in Nebraska.

The legislation specifies that no optometrist presently licensed in Nebraska "shall use pharmaceutical agents in the practice of optometry unless such per-

son submits to the Board of Examiners in Optometry evidence of satisfactory
Continued on page 14

Carter proclaims 52nd SYVW

WASHINGTON, DC — To focus the attention of all Americans on the importance of good vision and the need for the public to take care of its eyes, President Jimmy Carter has proclaimed the week of March 4-10 as Save Your Vision Week (SYVW), the 52nd annual celebration of the national event.

'Good eyesight, like so many of life's blessings, is too often taken for granted,' the President stated in an official proclamation. "Today, millions of Americans must cope with the burden of impaired vision. In many of

Continued on page 11



Nebraska governor signs DPA legislation

Striking a formal pose following the signing of Nebraska's diagnostic pharmaceutical agent (DPA) law are, from left, James L. Nedrow, O.D., of Beatrice, NB, past president of the Nebraska Optometric Association (NOA); Bernard G. Mullen, O.D. of McCook, NB, NOA president; Gov. Charles Thone; Sen. Bob Clark, the introducer of the bill; and David Kunz, NOA executive assistant.

Nebraska okays DPA usage

Continued from page 1

completion of all educational requirements as adopted by the (state health) department upon the recommendation of the Board of Examiners in Optometry, and has been certified by the department upon the recommendation of

the Board of Examiners in Optometry as qualified to use pharmaceutical agents for diagnostic purposes."

With Nebraska's legislative action last month, there are 17 states with legislation authorizing optometrists to use DPAs, in addition to nine other states which do not statutorily prohibit the use of pharmaceutical agents.



According to Attorney D. John Pecorino, manager of Aetna's Marketing Department, Casualty & Surety Division. "We do not differentiate between states which have pharmaceutical agents and those which do not."

Currently, there are 16 states with legislation which specifically authorizes optometrists to utilize pharmaceutical agents. In addition, there are nine other states which do not statutorily prohibit the use of pharmaceutical agents.

According to Virgil L. Rhodes, O.D., of Manchester, TN, chairman of the AOA Advisory Committee on Statutory Definition, the recent Aetna reduction in malpractice coverage is important information for state legislators who are confronted by ophthalmological misinformation concerning DPA legislation.

Aetna reduces annual premium for insured AOA members

By RANDY L. WALLICK

HARTFORD, CT — More than two years of efforts between the AOA and the Aetna Life & Casualty Co. have prompted the Hartford-based insurance firm to reduce professional liability rates for AOA members by 18 percent.

About two-thirds of all AOA optometrists insured for professional liability by Aetna will realize a premium reduction of \$30 off the current annual primary professional liability premium of \$168.

Aetna representatives state the rate reduction combines with several other improvements in the insurance program which are designed to provide AOA members with greater membership services and to make the insurance package more flexible and more competitive.

Coupled with the 18 percent reduction is the removal of surcharges for AOA optometrists. The routine 20 percent surcharge made for partnerships and/or professional corporations and the 25 percent surcharge made for employed optometrists have been removed by Aetna.

Effective February 1st, the program changes and the \$30 premium reduction will be implemented upon renewal by the more than 6,000 AOA members currently enrolled in the Aetna program.

According to Ronald D. Solomon, O.D., of Colorado Springs, CO, chairman of the AOA Committee on Insurance, Aetna has agreed to provide special rates for property coverages written on a multiple account basis. "This can mean a possible 25 to 40 percent deviation

from the normal price AOA members currently pay for protection," Dr. Solomon said.

According to Roger Detrich, Aetna's account executive for the improved AOA program, "Although we will seek these new rates on a nationwide basis, it is possible that in certain states our existing rates, because of the restrictions of state insurance regulations, are now below the new rates.

"Our insured optometrists in these states will realize no change or a slight increase," Detrich said. He added, however, "This will affect only a minority," he said.

Called one of the best benefit services in recent years, the new Aetna program stems from more than two years of efforts by the Committee on Insurance to gain lower rates for AOA optometrists.

Aetna, which has insured AOA members since 1970, attributes the new
Continued on page 19

NOTE: Page 19 DOT 111-
CLOSED IN FILE.

ALASKA STATE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

Pouch Y - State Capitol
Juneau, Alaska 99811

REGIONAL INFORMATION OFFICE

1024 West 6th Avenue
Anchorage, Alaska
99501
(907) 278-3668

June 19, 1979

Dear Rep. Buchholdt:

The enclosed material is being forwarded to you as HB 79 is
currently in the House HESS committee.

Carol Dickason

LAA 11
(1-26-79 M)

THE PEN...



PRO
BONO
PUBLICO

Published in the Public Interest by Ophthalmology

VOL. 3, No. 1 DEC. 15, 1978 - JAN. 1, 1979

FEDERAL JUDGE RULES AGAINST U.S.

Optometric "Primary Care" Results In Loss of Eye For Four-Year-Old Boy

In a landmark decision that could cause the army to re-examine its policy permitting optometrists to provide initial eye care treatment, Judge James M. Fitzgerald, United States District Judge for the District of Alaska, ruled that Timothy Steele, now an eight-year-old dependent of a soldier in the U. S. Army, was entitled to recover for the loss of his right eye.

"I conclude that the plaintiff is entitled to recover in this action from the United States for the loss of Timothy's right eye."
JAMES M. FITZGERALD
U.S. District Court

Judge Fitzgerald's decision was rendered on October 20, 1978, in the case of Timothy R. Steele and Robert K. Steele, plaintiffs, vs. The United States of America, defendant. In his opinion, Judge Fitzgerald stated, "An optometrist's responsibility is to observe during his eye examinations any mani-

festation of disease visible in the eye. Upon detecting disease in the eye, it is then his obligation and duty to the patient to make known what the optometrist has observed. In such cases, he may not undertake to diagnose the disease, but should inform his patient that the matter is beyond his competence and advise the patient to seek a qualified medical doctor."

The litigation stemmed from a claim brought on Timothy Steele's behalf by his father against the United States for the loss of Timothy's right eye. Timothy Steele, as a four-year-old boy, was treated by John Shank, O.D., an optometrist in charge of the Eye Clinic at Bassett Army Hospital, Fort Wainwright, Alaska.

According to testimony in the case, it was in October and November of 1973 that Timothy's mother first noticed that his eyes were crossing. On December 19, 1973, she took him to Bassett Eye Clinic where he was seen by Dr. Shank.

During his examination, Dr. Shank measured Timothy's vision and found it to be normal. He then used drops to dilate the pupil and looked inside the eye. He diagnosed Timothy's eye condition as accommodative esotropia, which is correctable by eyeglasses. He wrote a prescription for eyeglasses and made an appointment for Timothy to return to the clinic on January 29, 1974, for a checkup.

On January 29, 1974, Timothy reported to Dr. Shank as requested. The optometrist wrote a different prescription for eyeglasses and instructed Mrs. Steele to make another appointment for Timothy four months after he would begin wearing the new glasses.

The testimony further reveals that in early May, Mrs. Steele noticed that Timothy frequently removed his glasses, saying sometimes he could not see well with them.

On June 10, 1974, Timothy was again examined by Dr. Shank and it was then that he discovered that the vision in Timothy's right eye was limited to light perception. At this point, Dr. Shank made an appointment for Timothy with ophthalmologist Bruce Wolf, M.D., of Fairbanks.

When Dr. Wolf, a medical doctor, examined Timothy on June 17, 1974, he found Timothy's visual acuity in the right eye limited to hand motions and capable of perceiving light. Essentially, his right eye was blind.

Recognizing the seriousness of the case, Dr. Wolf called in William Kinn, M.D., as a consultant. On July 9, 1974, Dr. Wolf and Dr. Kinn observed a retinal detachment of the right eye with a subretinal mass. Their diagnosis was possible retinoblastoma, but toxocara canis was also to be considered. Concluding that specific tests were necessary to identify the disease, Timothy was flown

to Letterman Army Medical Center where he was examined on July 12, 1974.

At Letterman, it was determined that, because the danger of retinoblastoma, a fast-spreading, life-threatening malignancy, Timothy's eye should be removed. With parental consent, the surgery was performed by Major Bradley C. Black, M.D.

When the pathological report ruled out retinoblastoma, Timothy was returned to surgery and an implant was placed in the socket. Although recovery appeared to be good, Timothy continued to suffer from periodic socket inflammation.

In September of 1974, Timothy returned to Letterman Medical Center where a prosthesis was inserted in the socket. Testimony revealed that since the prosthesis could not be inserted immediately following the operation, it is unlikely that it will ever appear similar to a natural eye. ●

A SAD SUMMARY:

- When Timothy was four, his mother noticed his eyes crossing.
- A military dependent, he was taken to an army hospital where he was seen by an optometrist, instead of an M.D. (Current standard U.S. military procedure).
- The optometrist disregarded disease, infection or malignancy as causes and prescribed eyeglasses. Despite three visits, two pairs of eyeglasses and advancing blindness, Timothy was not referred to an M.D. ophthalmologist for six months, until after his right eye was blind.
- Ophthalmologists immediately recognized the probability of either retinoblastoma (malignancy) or toxocara canis (a parasitic worm infection), either of which is treatable in the early stages.
- The doctors recommended to Timothy's parents that the right eye be removed, because of the danger of an advanced life-threatening malignancy, as well as a hopelessly blind eye.

THIS CHRISTMAS:

- Timothy, 8, has an artificial eye which will never appear similar to a natural eye.
- YOU - The U.S. taxpayers have been found liable for the loss of Timothy's right eye. Who should provide primary care?
- Tell your legislators.



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.

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.

**TIMOTHY — WE'RE SORRY — WE'RE TRYING**

In spite of the loss of his right eye, and the attendant loss of visual field and depth perception, perhaps the young Alaskan victim will grow up to have more "vision" than many U.S. officials. Nearsighted policy supported by these leaders guarantees that disasters like that which befell young Timothy Steele will continue to happen to our servicemen and women, their dependents, as well as our veterans.

The Timothy Steele case, while tragic, had a relatively happy outcome. The alternative probability — retinoblastoma — might well have resulted in death for the youngster because of the delay resulting from what optometry has designated "primary care."

The optometrist should not be judged harshly. It is provable that his education did not equip him to attempt to cope with the problem Timothy presented.

The dean of the Pacific University College of Optometry, a government witness, displayed an identical ignorance of the medical facts and identified Timothy's treatment as proper medical care. It is ignorance and over-confidence at the upper level of optometric education that produces large numbers of sincere optometrists, convinced that they know much more about eye disease than they in fact do.

It would be wrong to blame the Eye Clinic, Bassett Army Hospital, or even the Medical Army leadership at Fort Wainwright. The fact that Timothy was seen first by a person with the right to use dangerous drugs to open his eye to look for what he had no training to see is the fault of the defendant — *THE UNITED STATES OF AMERICA*.

And that, dear reader, means that a Federal Court has ruled that Timothy's right eye was wasted by you . . . and me.

We have thus far failed to communicate simple logic, i.e., that a non-medical measuring scientist cannot be substituted for an M.D., no matter how critical the M.D. military manpower shortage may be.

If it takes a "Doctor Draft," so be it. The current policy of both the Military establishment and the Veteran's Administration in allowing optometrists to experiment with their own invention called "primary care" makes a travesty of Abraham Lincoln's determination "to care for him who shall have borne the battle, and for his widow, and his orphan."

Judge Fitzgerald handed down his landmark decision on October 24, 1978. During the same week, the Chairman of the U.S. House of Representatives Committee on Armed Services, Congressman Melvin Price of Illinois, was responding to concerned M.D.s across the land, as follows: "We are also told that all military optometrists are bound by principles of acceptable and safe medical practice."

Respectfully, Congressman Price, in the light of Judge Fitzgerald's opinion, and the disaster which has befallen Timothy, who is telling you such nonsense?

Again respectfully, Mr. Chairman, would you really expect Robert K. Steele, as the "Natural father and next friend of Timothy R. Steele" to accept and/or respect the credibility of your informants?

Judge Fitzgerald has placed the responsibility on the American people, who look to you for leadership in this matter. We acknowledge that medicine has failed in the past to get the message to your military affairs committee, but perhaps the sad fate of Timothy Steele will at least serve the purpose of opening the eyes of your committee members to the grave danger which exists.

At this writing, a dollar value has not been placed on the loss of Timothy's right eye, but that monetary assessment, plus inevitable subsequent judgments resulting from the present policy of allowing optometrists to render medical services for which they are untrained, would serve to fund proper ophthalmologic care in the military, and provide some safeguards for the Timothys of tomorrow. JHA

Author Provides Basic Information On Crossed Eyes

JOHN EDEN, M.D.
"The Eye Book"



A medical examination would have revealed the cause of Timothy's crossed eyes. No ophthalmologist would have depended on eyeglasses alone without further "medical detective work" in a case which presented crossed eyes starting at four years of age.

In *The Eye Book* (Viking Penguin, Inc.) author John Eden, M.D. has provided basic information on crossed eyes as follows:

Strabismus, or crossed eyes, is the second of the common childhood onset eye problems. Like amblyopia, it can seriously impair the visual learning process if uncorrected before age six. Strabismus describes two eyes that are not perfectly parallel when viewing an object. This does not mean that the eyes have to be straight ahead; they simply must be parallel to each other whichever way they are turned. But like lazy eye, "crossed eyes" is a misnomer. Although it is possible in one type of strabismus for the lines of sight (visual axes) to cross, they are not always crossed and certainly at no time do the eyes themselves cross. Some other common names for strabismus are "a cast to the eye" and "wall eyes," but these terms are even less correct than "crossed eyes."

Although strabismus is often very obvious, it is frequently impossible to spot with the naked eye. All the same, it is no more possible to be a little bit cross-eyed than it is to be a little bit pregnant. Any degree of strabismus will have the same visual effect; whether it is a slight or major deviation, the damage done to vision is the same. A particularly unfortunate bit of misinformation that contributes to the number of children who are seriously and permanently handicapped by strabismus is the notion that they will grow out of a tendency to cross their eyes. Although it is true that a certain amount of random divergence or convergence is common in infants, children past the age of one or one and a half should be able to hold both eyes in alignment. Crossed eyes after that age is not normal and cannot be left to improve on their own.

By the same token, you cannot give yourself strabismus. The often-heard warning that rolling your eyes or crossing them in play might make you permanently cross-eyed is completely fanciful. Your external eye muscles are meant to be used, and they are designed to move your eyes in all directions, as well as to hold them parallel to one another. You cannot misuse or overuse these muscles.

Like amblyopia, strabismus is damaging because the brain is constantly given an unacceptable visual message and that interferes with the development of visual skills. Use of the two eyes together is impossible since they are viewing different things. Never having had the chance to receive two similar messages, the brain is unable to learn to assemble a three-dimensional image. Without this learned skill, the individual will never have normal depth perception. And, of course, the deviant eye can become amblyopic.

There are several possible causes of strabismus, some better understood than others. And in some instances we cannot identify the cause at all. The most obvious one — that the eye muscles themselves are too weak to hold the eye in alignment — happens to be relatively uncommon. There is no question that there is a hereditary influence; children whose families have a history of strabismus will have a greater tendency to develop it. Another possible cause is a malfunction of the nerve connection to the external eye muscles. A

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THE PEN....

VOLUME 3, NUMBER 1
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"TIME HAD RUN OUT"

Full Text of Federal Judge Fitzgerald's Decision

LONG BUT IMPORTANT

Judge Fitzgerald's opinion is lengthy, but you will find it interesting reading. State legislators will find it incontrovertible evidence that optometrists, who have no medical education, should *not* be allowed to experiment with eye drops and attempt to diagnose disease. U.S. SENATE AND HOUSE Military Affairs Committee members will find it **MUST READING** in terms of evaluating the use of optometrists in the military to provide "PRIMARY EYE CARE."

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ALASKA

ROBERT K. STEELE,)	
as the Natural father and)	
next friend of TIMOTHY R.)	
STEELE, and ROBERT K.)	
STEELE, individually,)	
Plaintiffs,)	
)	NO. F 75-27 Civil
v.)	
UNITED STATES OF)	
AMERICA,)	OPINION
Defendant.)	
)	
)	

Timothy Steele is an eight year old boy whose father is a soldier in the United States Army. Timothy received medical care as a medical dependent at the Eye Clinic, Bassett Army Hospital, Fort Wainwright, Alaska, in 1973 and 1974. This litigation stems from a claim brought on Timothy's behalf by his father against the United States for loss of Timothy's right eye. The Federal Tort Claims Act furnishes the required jurisdiction.

In October and November of 1973, Timothy's mother noticed Timothy's eyes crossing. On December 19, 1973, she took Timothy to the Eye Clinic, Bassett Army Hospital. There Timothy saw Dr. John Shank, an optometrist in charge of the clinic.

Dr. Shank made an extended examination and diagnosed Timothy's eye condition as an accommodative esotropia correctable by eyeglasses. Following his examination of Timothy, Dr. Shank wrote Mrs. Steele a prescription for eyeglasses and made an appointment for her to return Timothy to the clinic January 29, 1974, for a checkup.

During the January visit to the clinic Timothy's mother reported to Dr. Shank that she thought the eyeglasses were helping since Timothy's right eye was not crossing as frequently. However, Dr. Shank's clinical record noted "no good reflex" in Timothy's right eye. The optometrist wrote a different prescription for eyeglasses and instructed Mrs. Steele to make a follow-up appointment for Timothy four months after Timothy would begin wearing the new eyeglasses.

By early May, Mrs. Steele noticed that Timothy frequently removed his eyeglasses. When questioned, Timothy told her that sometimes he wasn't able to see well. An appointment at the eye clinic was scheduled for Timothy on June 10. When Dr. Shank examined Timothy on that date he found vision in Timothy's right eye limited to light perception. At this point Dr. Shank made an appointment for Timothy with ophthalmologist Dr. Bruce Wolf, close by in Fairbanks.

When Dr. Wolf examined Timothy on June 17th he found Timothy's visual acuity in the right eye limited to hand motion although capable of perceiving light. Essentially, Timothy's right eye was blind. The doctor diagnosed leucocoria, right eye, with right esotropia. In his medical opinion the

inflammatory cause was a vitreous hemorrhage with possible involvement of toxocara canis or retinoblastoma. Since either disease was extremely serious, Dr. Wolf ordered a complete workup by a pediatrician hoping to rule out one or both. The pediatric workup proved negative and Dr. Wolf then arranged for ophthalmologist Dr. William Kinn, as consultant. Dr. Kinn, a highly qualified ophthalmologist, before opening a practice in ophthalmology at Fairbanks, spent ten years as a military medical officer. His last three years of military service were spent at Fort Wainwright where he was chief of ophthalmology and supervised the optometrists assigned to Bassett Army Hospital.

On examination of Timothy July 9th, Dr. Wolf and Dr. Kinn observed a retinal detachment of the right eye with a subretinal tumor. "Tumor" in this context was defined as a mass rather than a malignancy. Their diagnosis was possible retinoblastoma, but toxocara canis was also to be considered. The doctors concluded specific tests were necessary so that the precise identity of the disease might be known.

Arrangements were made to aircac Timothy from Fairbanks to Letterman Army Medical Center at the Presidio in San Francisco. At Letterman, Timothy was examined July 12 by a team of medical doctors, including Dr. Michael Hogan who was internationally recognized in the field of ophthalmologic pathology.

(Life-threatening Malignancy)

On examination, the medical team observed a retinal detachment involving a grayish yellow tumor. The doctors diagnosed the cause of the tumor as possibly retinoblastoma or toxocara canis. Eye condition at that point in time made it impossible to differentiate between either disease. Because of the danger of retinoblastoma, a particularly fast-spreading and life-threatening malignancy, the doctors recommended to Timothy's parents that his right eye be removed. Timothy's parents immediately consented to the operation and Major Bradley C. Black, a resident assigned to the ophthalmology unit at Letterman, performed the surgery.

After the eye was enucleated it was sent to the ophthalmologic pathology laboratory at the University of California, Berkeley, California, for examination. The laboratory report revealed total retinal detachment of the eye with giant reaction and massive disorganization of the retina. The pathological examination ruled out a retinoblastoma but concluded the cause of the disease to be granulomatous retinitis, etiology unknown. Unlike as in most eye removals, an implant was not inserted into the socket of Timothy's right eye immediately following surgery as there was a substantial possibility that the pathology report might confirm retinoblastoma. The malignancy would necessarily require radiation treatment and a follow-up examination not possible with an implant. When the pathological report ruled out retinoblastoma Timothy was returned to surgery and an implant was placed in the socket.

Dr. Black continued to treat Timothy following the second operation until Timothy returned to Fairbanks. After Timothy returned to Fairbanks he was treated by Dr. Wolf who noted that Timothy's recovery was excellent with the exception of periodic socket inflammation.

Timothy returned in September to Letterman where a prosthesis was inserted into the eye socket with good cosmetic result. Probably the prosthesis will never appear similar to a natural eye since it could not be inserted immediately following the operation.

("Failed to provide adequate care")

It is claimed in this litigation that the optometrist, Dr. Shank, failed to provide adequate care required of an optometrist when he treated Tim-

Continued on page 4



TIMOTHY STEELE
... during infancy

Steeles Warn Other Parents

In an exclusive telephone interview with Timothy's parents who now live in Hawaii, where Army Sergeant Robert Steele is stationed at Schofield Barracks, PEN learned more of an unfolding tragedy.

Saying the subject was "extremely painful" to them, Sgt. and Mrs. Steele agreed to discuss the case because they wanted to warn other parents against relying on optometrists for "primary care."

Sergeant Steele told PEN that, confronted with a life-threatening alternate possibility, the family welcomed the diagnosis of toxocara canis, but he added, "We were pretty well under for about a week after they took out our boy's eye." The tragedy, Steele said, caused Timothy's mother great emotional stress that required medical treatment.

Confirming the words of attorney Nelson Parrish, Steele advised PEN that up until the time of this incident, Timothy had been a bright, well-adjusted youngster who could look forward to a promising future. Today, at nine years of age, Steele said Timothy is working hard to overcome his handicap and engage in normal activities, but despite his determination, he is encountering difficulties.

Timothy is ashamed of his condition, Steele said, and still suffers physically and psychologically. Mrs. Steele told PEN, "Timothy gets very upset if he finds out that other kids know he has an artificial eye — kids can be unkind."

While after five years, monetary damages have yet to be assessed, Mrs. Steele told PEN, "But nothing can replace Tim's eye." ●

From: Transactions of the American Ophthalmological Society — Vol. 67, 1969.

"It is well to consider that any child with strabismus (crossed eyes), and especially any child with strabismus and a poorly fixating eye, has retinoblastoma until proven otherwise."

Robert N. Ellsworth, M.D.
Director, Eye Tumor Clinic of
Edward S. Harkness Eye Institute
Columbia Presbyterian Hospital

JUDGE'S DECISION

Continued from page 3

othy in December of 1973 and January of 1974.

OPTOMETRIC RESPONSIBILITY

Dr. Shank graduated with a degree in optometry from Pacific University at Forest Grove, Oregon, in 1971. He was commissioned in the United States Army as a Captain in the medical services and during the summer of 1973 was assigned to Fort Wainwright, Alaska. In November of 1974 he left the Army and now is in the practice of optometry at Kodiak, Alaska.

When Dr. Shank made his first examination of Timothy's eyes on December 17, 1973, he recorded a brief history:

Past six weeks mother thinks patient is cross-eyed. Father amblyopic. Age 4. Negative medical history. Rubs eyes after playing up close. Notices no real problem with depth. No allergies.

In addition he also tested Timothy's unaided vision using a standard AO chart (pictures) for children. The best possible visual acuity when measured with an AO chart is 20/30. Dr. Shank recorded Timothy's visual acuity 20/30 OD and OS (both eyes). After dilating Timothy's eyes he made an internal examination and noted:

Preliminary scoping shows opacity in right eye. Dilated with 10 percent Neo at 1:30. Vitreous lesion in right eye caused from hemorrhage.

Upon completing the examination, Dr. Shank concluded that Timothy's eye problem was caused by an accommodative esotropia³ correctable by a prescription for eyeglasses. He did not think it necessary to refer Timothy to an ophthalmologist.

Dr. Willard Bleything, Dean of the College of Optometry, Pacific University, Forest Grove, Oregon, who was called as a government witness at trial, agrees with Dr. Shank. According to Dr. Bleything, the findings of Dr. Shank's December examination are entirely consistent with an accommodative esotropia, hence, there was no need to send Timothy to a medical doctor.

In his testimony Dr. Bleything touched on the scope of training provided in a school of optometry. A significant part of optometric training is given over to recognition of diseases in the eye. In this case no one questions the principle requiring optometrists to refer their patients to medical doctors once disease is detected in the eye.

(Vitreous Hemorrhage)

In Timothy's case, however, Dr. Bleything would distinguish between an active vitreous hemorrhage and an inactive vitreous hemorrhage. He classifies an inactive vitreous hemorrhage as a scar and suggests referral to a medical doctor is indicated only in the event that an active vitreous hemorrhage were detected. It is implicit by this reasoning that to Dr. Bleything a scar is not an indication of existing disease. Scar tissue, according to Dr. Bleything's opinion, when old or inactive, is typically black. This is consistent with Dr. Shank's testimony that the vitreous hemorrhage detected in his December examination was old because it appeared black or dark.

Actually a black or dark color in a vitreous hemorrhage has nothing at all to do with its age, but rather is a result of its magnitude or extent. The black or dark color indicates a lack of reflected light from the retina behind the hemorrhage. Blood in a vitreous hemorrhage is not black; it is only the shadow that appears black. Indeed, as Dr. Black states in his deposition, an old vitreous hemorrhage would appear as white strands in the vitreous and settle to the lower part of the vitreous. And Dr. Kinn testified that he had personally observed hemorrhages in the vitreous more than a year old which were red in color. He explained that a hemorrhage would appear to be black because it was sufficiently thick with blood to absorb all the light reflecting off the retina during an examination, not because of an innate darkness of color.

The interrelationship between optometric and medical responsibility is discussed in considerable depth in the scientific text referred to at trial, "The Optometric Profession," by Hirsch & Wick. The text notes that responsibility for recognizing eye disease has not always been a part of optom-

etry, nor indeed is it now a part of optometric services in parts of the world outside of the United States and English speaking countries. In some European countries an optometrist is expressly forbidden to examine the eye to determine whether it is healthy or not.⁴

Some of the diseases which may be discovered by examination of the eye are brain tumors, diabetes, kidney disorders, hypertension, as well as some diseases caused by microorganisms such as tuberculosis. Optometrists study about these and other diseases in order to recognize eye manifestations of diseases. An optometrist should not attempt to complete a definitive diagnosis but recognize this responsibility is part of the practice of medicine. This principle is clearly stated in "The Optometric Profession."



JUDGE JAMES M. FITZGERALD
U.S. District Judge - Alaska

"The difference between optometric and medical responsibility to the patient may be clarified by example. If an optometrist observes a hemorrhage in the fundus, he recognizes that it may be due to any of the diseases already enumerated. It also may have resulted from a vascular accident or from undue capillary fragility. The important consideration for the optometrist, however, is that he see and identify the hemorrhage. It is his responsibility to refer the patient to the appropriate medical practitioner for diagnosis and treatment of the disorder. The optometrist's understanding about disease is sufficient to recognize the various diseases that can cause hemorrhage. He does not attempt to differentiate between them. Medical technology has advanced so greatly in the past few decades that there are now many laboratory tests the physician can use in making the correct diagnosis. Disease is diagnosed by many procedures. The appearance of the eyeground is only one of them." *The Optometric Profession.*

I am not persuaded with Dr. Bleything's reasoning that referral to a medical doctor ought to depend on whether the optometrist has diagnosed a vitreous hemorrhage as active or inactive. The authors, Hirsch & Wick, suggest in their text that the important consideration is that the optometrist be able to see and identify the hemorrhage. It then becomes his responsibility to refer the patient to a medical doctor for diagnosis and treatment. Since Dr. Shank detected the vitreous hemorrhage of the right eye during his December examination, it was his immediate responsibility to promptly refer Timothy to a medical doctor. In point of fact, ophthalmological services were then readily available to military personnel at Fort Wainwright and to their dependents under a fed-

eral contract with Dr. Wolf.

Dr. Shank was aware of symptoms other than vitreous hemorrhage which are of significance to an optometrist. Esotropia in a child of four, Timothy's age in 1973, is a serious matter. Dr. Black states that esotropia in a four year old child is very rare. Most cases of congenital esotropia caused by muscle imbalance develop before age two. This condition is correctable by an operation on the muscles of the eye. Accomodative esotropia, such as diagnosed by Dr. Shank in December, 1973, develops in most cases at age two to two and a half, although it occasionally develops as late as age four or five. This condition is correctable by eyeglasses and the esotropia usually corrects itself after eyeglasses are worn. But esotropia may also indicate some type of retinal or vitreous pathology in the visual axis. This will often involve a disease in the macula, the central part of the retina. This condition reduces visual acuity in the eye and as a result the eye turns inward. In Dr. Black's opinion the most important thing to rule out when a child does present an esotropia is retinal or vitreous pathology. But even more, when a vitreous hemorrhage is observed in a child, it is very important that retinoblastoma be immediately considered until that disease can be completely ruled out.

Dr. Wolf, who treated Timothy at Fairbanks before and after his hospitalization at Letterman, agrees with Dr. Black that Dr. Shank should have referred Timothy to an ophthalmologist in December. Dr. Wolf believes that referral to a medical doctor ought to have been made immediately when Dr. Shank learned of the esotropia from Timothy's mother. Dr. Kinn, who consulted with Dr. Wolf, also agrees that referral was indicated in December. Indeed, Dr. Zimmerman, an eminent ophthalmic pathologist, who testified for the government at trial, concurs that further investigation should have been undertaken at the time the lesion was observed in Timothy's right eye.

(Credible Opinion Cited)

I am persuaded from credible, convincing medical opinion, as well as the scientific publication referred to, that Dr. Shank failed to meet the standards required of his profession when he examined Timothy in December of 1973. He knew that Timothy presented an esotropia and in the course of his examination he observed a vitreous hemorrhage in the right eye. An optometrist's responsibility is to observe during his eye examinations any manifestation of disease visible in the eye. Upon detecting disease in the eye, it is then his obligation and duty to the patient to make known what the optometrist has observed. In such cases he may not undertake to diagnose the disease, but should inform his patient that the matter is beyond his competence and advise the patient to seek a qualified medical doctor. Certainly in January when Dr. Shank detected the poor reflex in Timothy's right eye, he should have sent Timothy to a medical doctor. Instead, he delayed making a referral to an ophthalmologist until after his last examination in June, 1974. By that time Timothy was essentially blind in his right eye, and by then the retina had pulled away from the rear of Timothy's right eye. As it was to turn out, nothing thereafter could be done to save the vision or to save the eye. Time had run out.

Several questions arise at this juncture. Was the disease which ultimately caused the eye to be removed present when Dr. Shank made his examination in December, 1973? What was the nature of the malady and could it have been diagnosed? Could the disease have been treated had it been timely discovered?

There is general agreement in the testimony of the physicians that the disease which brought about the removal of Timothy's right eye was present when Dr. Shank made his initial examination.

When Dr. Wolf examined Timothy in June, 1974, he diagnosed a vitreous hemorrhage with the possibility of either retinoblastoma or toxocara canis. The team of medical doctors who examined Timothy at Letterman Hospital in July considered four possibilities. The first was persistent hyper-

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JUDGE'S DECISION

Continued from page 4

plastic primary vitreous, a congenital defect of the eye present at birth and generally noticed shortly after birth. With such a condition as persistent hyperplastic primary vitreous, the eye is usually a bit smaller. The front part of the eye is ordinarily not normal so there are distinguishing factors for that disease. The medical doctors at Letterman were able to rule out this possibility. They were so able to rule out a vitreous hemorrhage as a cause since the vitreous of the eye was fairly clear when the doctors made their examination. The two remaining considerations related to some type of inflammatory response, most probably either toxocara canis or retinoblastoma.

(A Dangerous Malignancy)

Retinoblastoma is an extremely dangerous malignancy sometimes found in the eyes of young children. When diagnosed, retinoblastoma requires removal of the diseased eye to prevent the malignancy from escaping outside the eye, possibly through the optic nerve into the brain.

Retinoblastoma was ruled out in the University of California pathological report following examination of the eye after the operation. A negative finding of retinoblastoma eliminated any need for radiation treatment. In Dr. Black's medical opinion the cause of the inflammation of Timothy's eye was probably toxocara canis. Dr. Black observed that although the larva was never found in the few sectionings of the eye, it is known that the larva may disintegrate or completely disappear in the eye.

Toxocara canis is a parasitic round worm frequently found in dogs. The eggs of the parasite may be ingested by children playing in dirt and the eggs hatch in the intestines of the child into a larva. The larva bores through the intestinal wall and enters the blood stream and is disseminated to different parts of the body. In every instance, with possible rare exception, the parasite is not able to complete its life cycle in a human host and the larva dies without developing into an adult worm. The most common locations where it has been found are in the liver or the lungs. Inflammation of the eye by toxocara is fairly rare. But when it does appear it tends to result in a massive inflammation which usually involves the retina and sometimes may intrude into other structures inside the eye. The presence of toxocara in the body often leads to visceral larva migrans syndrome. The child can have a fever and may have some type of lung disorder, his liver may be enlarged and tender and there may be some abnormalities in certain blood tests. However, an ocular toxocara inflammation frequently occurs without a visceral larva migrans syndrome occurring and some studies suggest that in only three or four percent of ocular toxocara inflammation is the syndrome present. With ocular toxocara, so long as the larva remains alive, there is usually not much effect on the eye. There may be a local inflammation in the retina or a small whitish elevated lesion in the retina at the site of the larva or where it penetrated the retina, but the stage at which the parasite usually becomes very damaging is when the larva dies and decomposes. This leads to an extensive lesion in the eye eventually resulting in a massive scar. If the larva is able to work itself into the vitreous cavity of the eye, it brings about an even more severe inflammatory process.

(Dr. Krupp's Testimony)

Dr. Iris Krupp of Tulane University in New Orleans, Louisiana, is a widely renowned expert in the field of parasitology. She began her work on toxocara as a graduate student in 1954. Since then, she, in association with several ophthalmologists, has done extensive work in the detection and treatment of toxocara. She developed a reliable serologic test for the detection of toxocara which was announced in an article⁵ published in the "American Journal of Tropical Medicine" in May, 1974.⁶ After examining the medical records, including the pathological report, in Dr. Krupp's opinion the probability was 90 percent that the disease in Timothy's right

eye was toxocara.

Ophthalmic pathologist Dr. Lorenz Zimmerman was a principal government witness at trial. He agreed that the University of California pathological report required that retinoblastoma be ruled out as a cause. However, he noted Dr. Helenor Foerster, a widely known ophthalmic pathologist, also performed a pathological examination on Timothy's eye. Dr. Foerster has published a number of important scientific papers, one of which presented the initial description of toxocara infection of the eye. Dr. Foerster prepared a pathological report in connection with a paper which she presented to the Western Ophthalmic Club. In her report, Dr. Foerster observed many pigment-laden macrophages and giant cells in the retina. Dr. Zimmerman believed this was significant since it implied substantial bleeding into the eye, or alternatively, that a foreign body containing iron might have been introduced into the eye. He postulated that bleeding may have been brought about by several causes, including persistent hyperplastic primary vitreous. In addition, Dr. Zimmerman suggested another possibility of the cause of the inflammation might be a low grade bacterial infection. He did not, however, conclusively rule out toxocara as a possible cause but noted that the larva was not found in either pathological examination. Also, in Dr. Zimmerman's opinion the iron pigment described by Dr. Foerster in her pathological report would not be characteristic of toxocara infection. For these reasons he discounted toxocara as the cause.

Dr. Zimmerman concluded that in this instance it is unlikely that the cause of Timothy's eye inflammation can ever be reliably known, hence the doctor's final diagnosis was chronic sclerosing endophthalmitis, cause undetermined.

It is true that the larva was not found during pathological examination. But as Dr. Black explained, the larva may decompose and disintegrate. The University of California pathological report following examination of the eye was prepared by Dr. Joseph Eliason, an ophthalmologist. In his deposition testimony, Dr. Eliason stated the pathological diagnosis was *retinoblastoma*, etiology unknown. As stated above, this is a general inflammation involving the retina. Toxocara canis characteristically causes this type of inflammation although other causes are possible.

In the course of the pathological examination, 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.

(Ophthalmic Procedure)

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 retinoblas-

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IRIS KRUPP, M.D.
Tulane University Professor

M.D. Expert Witness
Comments...

Iris Krupp, M.D., of New Orleans, an authority on parasitology who testified as an expert witness in the Steele case, has issued a warning to PEN readers to seek an early medical eye examination if symptoms similar to Timothy's are noticed. Delay, as in Timothy's case, can result in blindness.

In a letter to the editor of PEN, Dr. Krupp, a Tulane University professor, indicates that early treatment with steroids and thiabendazole (an anti-parasitic drug) and/or the laser could save the eye of a patient with visceral canis, which afflicted Timothy Steele.

Dr. Krupp also said that man is not a natural host for the roundworm of the dog (toxocara canis), but may affect children who have eaten dirt or food contaminated by fecal material of a dog containing the eggs of the parasite.

Once ingested, the eggs hatch and the larvae pass from the intestines into the blood stream and may settle in any organ of the child's body. Symptoms may include coughing and wheezing, excessive weariness, loss of appetite, seizures and changes in the ability to see.

Diagnosis can be made by studies of the blood and examination of the sites at which the larvae may be deposited.

Finally, Dr. Krupp emphasized that "It is extremely important that persons with ocular lesions be seen early by a physician experienced in the diagnosis and treatment of this infection, as delay may result in blindness." ●

A medical educator comments:

"In every patient with a misdirected eye and/or an abnormality in the eye, the possibility of a malignant tumor must be excluded."

Moss L. Antony, M.D.
Department of Ophthalmology
School of Medicine
Tulane University

Conclusion: Judge Fitzgerald's Ruling

Continued from page 5

toma. The ophthalmologist would have been able to examine the microscopic details with specific instruments and, if 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 1961.⁷ 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 antihelmintic 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.

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. *Richards 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 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.

(Judge's Conclusion)

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.

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.

ss: James M. Fitzgerald
United States District Judge

¹ 28 U.S.C. 1346(b). Plaintiff's original complaint founded jurisdiction on the Federal Torts Claims Act but mistakenly cited the section as 1366(b).

² Retinitis is an inflammation which chiefly involves the retina. "Granulomatous" is a type of inflammation. Thus, the pathology conclusion was that of a general retinal inflammation of unknown origin.

³ Esotropia, meaning pointing inward.

⁴ *The Optometric Profession* by Monroe J. Hirsch and Ralph E. Wick, (1968 edition) Chilton Book Co. at page 17.

⁵ Hemagglutination Test for the Detection of Antibodies Specific for Ascaris and Toxocara Antigens in Patients with Suspected Visceral Larva Migrans.

⁶ Since the article did not appear until May, 1974, the physicians who treated or examined Timothy were probably not aware of Dr. Krupp's serological test.

⁷ By Schneider at the Oxnard Clinic.

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.

⁹ *The Optometric Profession*, pp 6, 17.

EDEN: CROSSED EYES *Continued from page 2*

common, more readily explainable cause is an uncorrected high degree of farsightedness. Remember that young people can correct farsightedness by using their near-focusing ability. This involuntary action plays a part in strabismus because when near-focusing muscles are used the eyes automatically converge to take in the near object. Notice that when you shift from looking at a far object



Strabismus.

to looking at a near one your eyes turn in a bit. This is a natural and normal reflex, but when a farsighted child uses the near-focusing muscles to view far objects clearly, his or her eyes may converge. The reflex is stronger in some than in others, so it does not mean that all children with uncorrected farsightedness will develop strabismus, but it is a possibility.

A disease that causes poor vision in one eye is another possible cause. If one eye sees quite badly, there is not much visual benefit to be gained from using it. The brain will not tell the nerves to tell the external muscles to hold the eyes parallel, and the defective eye may simply turn in or out because there is little reason for it to hold itself parallel to the other eye.

What difference does all this make? Is strabismus more than just a cosmetic problem, a matter of looking a bit odd because the eyes are crossed? Indeed it is. Binocular use is not a skill mechanically achieved; it must be learned in that ever-important period before age six. If strabismus is uncorrected during that time, the child will never be able to learn to use both eyes together. Correction after age six will improve appearance, but it cannot provide a second chance to learn binocularity. Likewise, if the strabismus has caused the deviant eye to become amblyopic, correction of the deviance after age six will not cure the amblyopia.



Epicanthus.

Extremely misaligned eyes can be spotted by a parent or anyone looking at the child, but strabismus is often not that pronounced. An eye doctor, however, can readily discover strabismus during the routine eye examination and can determine how it should be treated.

A condition called *epicanthus* often causes parents of young children to suspect strabismus. At birth, a wide nose bridge normal to all babies is combined with an unusual eyelid fold that often makes it seem that one eye is turned in too far when the baby looks slightly to one side. In fact a large portion of the sclera is hidden by the *epicanthal fold*, but the eye is not turned in more than normal. This is an anatomical feature that is not at all related to strabismus, and it does not interfere with learning to see. The child may look abnormal, but he or she does not see abnormally. And in most cases, the epicanthus recedes as the child's nose narrows. ●

FOUNDER SALUTED BY AMA NEWS — PART II

Ochsner: "Treat The Whole Patient"

The accomplishments of Alton Ochsner, M.D., PEN's International Advisory Board Chairman, are legend in the annals of American medicine. Terming PEN, "The most potent communications effort I have ever observed in medicine," Dr. Ochsner has said, "Ophthalmology — medicine's protectors of one of God's greatest gifts — eyesight — finds itself in the trenches, doing grim battle against a potential epidemic of ineptitude foisted on the American public by some legislators who have heard only the exaggerations and half truths of the optometric side of a non-argument."

Free-lance author Nancy Yanes Hoffman, in an article titled "Alton Ochsner: 82 and Still Going Strong," which appeared in the *AMA Journal* on August 25, 1978, Vol. 240, No. 8, has captured the essence of this man's greatness. PEN wishes to express its appreciation to Ms. Hoffman and to the JAMA for permission granted to present this material in a series of articles.

"Alton Ochsner: 82 and Still Going Strong," Part II:

The trend in American medicine, as in American life, toward trying to get by with mere competence while not striving for excellence, worries Ochsner. "The other thing that worries me is that physicians rely too heavily on laboratory findings. I fear we are developing a group of competent technicians, treating disease but not treating the whole patient. I stress to our young people that they must sit down with a patient, take a complete history, do a careful examination, then evaluate the findings and arrive at a working diagnosis. After that, they should order laboratory tests. If the laboratory work confirms the clinical diagnosis, accept it. If it doesn't, disregard the laboratory findings and keep on looking. Sounds like heresy, I know, but it's true."

Ochsner remembers a South American woman (the Ochsner Medical Institutions draw many Latin American patients) who had been diagnosed as a hypochondriac with severe psychiatric problems. Although Ochsner protested, "I don't know anything about psychiatry," he saw the patient, became convinced that she had no more psychiatric difficulties than the rest of us, examined her and diagnosed her case as amebiasis. The laboratory test disagreed — as did the gastroenterologists. Ochsner insisted on instituting anti-amebiasis therapy. "Three days later she walked into my office and said, 'Doctor, I'm well for the first time in years.' What convinced me? Such things as tenderness over the appendix and the liver and listening carefully to the chronology of her symptoms: 'I wake up in the morning and I could whip my weight in anything. By ten o'clock, I can't drag one foot after the other.' This complete asthenia is characteristic of amebiasis. Doctors must listen to the patient, discard their hidebound preconceptions, track down every clue, have the courage of their convictions even when their peers oppose them. I can't emphasize this enough to students."

As Ochsner looks back at his diverse medical career, he believes that his most valuable contribution to medicine has been his teaching. "I'd like to be remembered as a teacher. As Tulane's professor of surgery, I've gotten my greatest satisfactions from teaching more than 3,600 medical students and from teaching our resident fellows here at the Ochsner Foundation Hospital." No student will ever forget those harrowing sessions in the "bull pen" with Alton Ochsner. At one of these "Why Clinics," as Ochsner dubs them, he was barraging a student with questions. "Why? Why? Why?" demanded Ochsner, forcing the student to analyze and defend every assumption that was not thought through. In a classic fight-or-flight response, the student fainted. When he was revived, Ochsner interrogated him just as vehemently — with one additional question: "Why did you faint?"

Who was his best student? "Mike DeBakey. Remarkable, brilliant." Ochsner considers DeBakey "indefatigable." As for himself: "I don't know if



ALTON OCHSNER, M.D.
PEN'S International Advisory Board Chairman

I have such prodigious energy. My friends say I work too hard. That's ridiculous. I love what I do. I have fun from the time I get up in the morning until I go to bed at night. I don't work hard; I put in long hours. I think that I'm basically lazy, but I'd be miserable if I didn't work." Ochsner insists that his fabled vigor comes from not wasting energy on disappointment or regret for the road not taken. "Then, too, I've never smoked. Tobacco is the most malevolent aging factor present today. Everybody gets older, but nobody has to get old. Chronological age is irrelevant to physical and mental age. Start with a good machine, take care of it, and it will last a long time."

How to age as well as Ochsner — or, at least, to try? "Three factors accelerate aging: tobacco, our modern sedentary life (people must exercise strenuously daily, until they're out of breath, huffing and puffing), and obesity." Ochsner himself eats sparingly, usually skips lunch, and never has permitted his trim body to lose the battle of the bulge. "If I ate what I wanted," he says, "I'd weigh 300 pounds."

What was Ochsner's most interesting case? An impossible question. Separating Siamese twins; the first successful resection of a saccular aneurysm of the aorta; a thyroidectomy on Tomas Gabriel Duque, then former President of Panama, in 1942, at Cordell Hull's request; surgery on the late jazz trumpeter Muggsy Spanier, who thanked him by writing the song, "Oh, Dr. Ochsner"; or treating Ben Hogan after an automobile accident. Six weeks after the accident, ready to be discharged from an El Paso Hospital, Hogan had suffered a pulmonary embolus, had received anticoagulation therapy, then had had a massive embolus five days later.

It was Mardi Gras time. After attending the Queen's supper, Ochsner had gotten to bed at 4 A.M., arisen at 5 A.M. and had worked all day until ten in the evening. He had finally fallen into bed, "dog-tired," when the phone rang. Could he fly to El Paso? Hogan was cyanotic and comatose. As soon as Ochsner saw Hogan he said, "He's got to have his cava tied — immediately" Ochsner remembers: "Hogan was bleeding profusely. His blood was absolutely incoagulable. His prothrombin time was 0. At noon, I began giving him protamine sulfate and vitamin K and blood transfusions. By midnight, his pro-time was 30%, but we couldn't wait any longer because he was sinking fast. I operated."

Ochsner flew home, got in at 8 A.M., went directly to the foundation hospital, and started work. Hogan got well and won tournaments after that.

Ochsner postscripts: "People are reluctant to tie off the vena cava, because it seems like such a horrible procedure, but it's not. It can be a life-saving act." Why? "Most patients don't develop a fatal infarction after a nonfatal pulmonary infarct, so surgeons and internists both gamble that every

patient won't have a fatal embolus. But every patient who's had a pulmonary embolus is a candidate for another one. He may be lucky and not have one, but it's dicey." Again, Ochsner repeats George Dock's dictum: the importance of being careful. "Many doctors will say wait until a patient has had two or three emboli, then ligate. In my opinion, that's playing Russian roulette. All medicine is judgment. I can bring anybody in off the street and teach him how to cut and sew in three months. It's knowing when to operate and when not to operate."

After teaching, Ochsner considers his most important contribution to medicine his work toward the establishment of a causal link between smoking and lung cancer and, subsequently, between smoking and its deleterious effects on the vascular system. "When I was a medical student in 1919, we admitted a patient with lung cancer to Barnes. As usual, the patient died, because the mortality was almost 100%. Dr. Dock had us witness the autopsy because he said that the condition was so rare that we'd never see another case as long as we lived. I didn't see another case for 17 years — until 1936. Then there were nine cases in six months. An epidemic. There had to be a cause. They were all men, all smoked cigarettes heavily, all began smoking in the first world war. When I researched the history of smoking, I found that very few cigarettes had been consumed prior to World War I."

"In 1936, I had the temerity to state — not suggest — that cigarettes caused this new plague." He sighs. "Not that anybody believed me or listened to me. Even in 1950, when I was president of the American Cancer Society, I used to have knock-down-drag-out fights with E. Cuyler Hammond [ScD], their chief biostatistician. [Dr. Hammond, vice-president for epidemiology and statistics, now agrees with Ochsner.] It took the American Heart Association even longer to take up the cudgels against cigarettes, though they are just as noxious to the vascular system as the respiratory system."

Part III of "Alton Ochsner: 82 and Still Going Strong" will appear in the next edition of *THE PEN*. ●

N.C. REPEAL RESOLUTION

The resolution of the Section on Ophthalmology of the North Carolina Medical Society, was inadvertently omitted in the December 1 issue of *THE PEN*. The complete text follows:

RESOLUTION:

WHEREAS, the medical doctors who are members of the North Carolina Ophthalmology Section of the North Carolina Medical Society are increasingly concerned about the jeopardy to the public health inherent in the 1977 law which allows the use of drugs with their inherent dangers by medically untrained optometrists; and,

WHEREAS, such drugs are unnecessary to the practice of optometry; and,

WHEREAS, AMA medical ethics Principle 10 mandates that physicians provide their efforts, resources and expertise to the benefit of the public welfare,

NOW THEREFORE BE IT RESOLVED, that the North Carolina Society of Ophthalmology in cooperation with the North Carolina Medical Society will have legislation introduced in the North Carolina Legislature for the purpose of repealing the 1977 optometric drug use law, and will publicly campaign for repeal, maintaining this action until such time as the mission is accomplished and the protection of the people of North Carolina is assured. Passed May 5, 1978

Pinehurst, North Carolina

H. Maxwell Morrison, M.D.

President, Section Ophthalmology, NCMS

David B. Sloan, Jr., Secretary

Section Ophthalmology, NCMS

Steele's Attorney Comments On Case

O. Nelson Parrish of Fairbanks, Alaska, attorney for the plaintiffs Robert K. Steele and Timothy R. Steele, provided PEN with his reaction to the decision as rendered by Judge James M. Fitzgerald.

"I think," Nelson Parrish said, "that the essence of the court's decision is that optometrists, and schools of optometry (compared to ophthalmology) will not be allowed to set their own standards as to what they can and cannot do. The court's decision recognized that optometrists are not sufficiently trained to make the same kinds of decisions that ophthalmologist M.D.s can, and should make, in situations similar to that presented in Timothy's case."

Continuing, Parrish stated, "The U.S. Government was, in fact, contending throughout this trial that since we (the plaintiffs) did not present an optometrist to say that what the optometrist treating Timothy did was wrong, our case ought to be dismissed. The Government, in fact, moved for a 'directed verdict' (to throw our case out of court) on the grounds that only an optometrist can say what is or is not wrong about what another optometrist does."

When questioned by PEN as to the judge's reaction to this line of reasoning, attorney Parrish replied, "The judge rejected it by saying, in effect that since an optometrist is not fully trained to recognize dangerous situations, such as presented in this case, he could not then say what he did or did not do is right or wrong. Having arrived at that point, the court then in effect said it was going to accept the position of all the medical doctors who testified, including the government's doctor, that the boy should have been referred."

In concluding his comments, Nelson Parrish told PEN that this case had convinced him that, "optometrists, with no medical education, are attempting to pull themselves up by their own bootstraps, into an invulnerable position of unaccountability." ❁

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

Public Service by Alabama
M.D.s Draws National Praise

As reported in the December 1 issue of THE PEN, the Medical Advisory Board to the University of Alabama has passed a resolution which declares that University Optometry School graduates are not trained to attempt to practice medicine. This action, to protect the public, is being saluted by M.D.s throughout the nation.

Dear Dr. Hale:

I want to thank you for the public service rendered by the Medical Advisory Board to the University of Alabama for publicly defining the limited role of optometrists. Their efforts over the past several years have been to mislead the public into the scope of services that they provide. It is important to make every effort to protect the medical well-being of the public.

Please be assured of my best wishes.

Robert A. Wiznia, M.D.
New Haven, Connecticut

Dear Dr. Moore:

Let me express my appreciation to you and the other physician members of the Medical Advisory Board of the University of Alabama. Your courage in opposing the attempts by non-practitioners (optometrists) to get into the practice of medicine is commendable. Defining the role of optometry is a public service and the actions taken by the Medical Advisory Board will be of great help in our fight to protect the high quality of medical care in this country.

Joe H. Woody, M.D.
Charlotte, North Carolina

Dear Dr. Henderson:

I found it most gratifying to see that wisdom has prevailed in the resolution to define the limited role of optometry in medicine through your efforts and convictions. The valuable limited services of optometrists has been recognized by medicine and by ophthalmology alike. False claims and false advertising, as well as impersonating physicians by optometrists is totally alien to the medical arts. Your clear perception of the problem, and your action deserves many thank-yous from all physicians, patients, and the public at large.

Georges Birenbaum, M.D.
Lexington, Kentucky

Dear Dr. Pittman:

I congratulate you, as a member of the University of Alabama Medical Advisory Board, for speaking out forthrightly regarding optometric education at your University. The public and legislators around the country need to know that optometrists are not trained to assume a medical role. Your resolution is a godsend.

The American people owes you a debt of gratitude.

Charles B. Bobo, M.D.
Greenwood, South Carolina

Dear Dr. Henderson:

As a practicing ophthalmologist and a citizen I wish to congratulate you for the role you have played and the service you have rendered to the public in defining the limited role of optometry. We all know at times it takes courage to stand up on your hind legs for what is right. But remember there is only one truth and all the local political and social pressures cannot alter that.

You have helped to open the eyes of the public as to the only proper role of optometry in vision care.

Walter C. Bullington, M.D.
Charlotte, North Carolina

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.

Dear Dr. Moore:

Today I received a copy of the resolution of the University of Alabama School of Medicine Physician Advisory Board concerning the education of optometrists at that institution.

It gives me a feeling of relief and appreciation that there are fellow medical doctors in this country who have the insight and understanding that is necessary to protect our lay population from the zealous political ambitions of those people who place ego and economics above personal ability in matters of the health care of this nation.

Please accept my thanks and appreciation for your efforts in this matter.

Jerome L. Byers, M.D., P.A.
Dallas, Texas

Dear Doctor Moore:

Congratulations to you for your great effort in defining the status of optometric education with regard to the practice of medicine in the resolution passed by the Medical Advisory Committee, at the University of Alabama School of Medicine.

It was a great public service to all of the people of our country.

James W. Clower, M.D.
Daytona Beach, Florida

Aloha, Doctor Pittman!

By publicly defining the limited role of optometrists, you and your colleagues on the University of Alabama Medical Advisory Board have done your patients a real service.

Thanks . . . or as we say in Hawaii,
Mahalo!

John M. Corboy, M.D.
Wahiawa, Hawaii

Dear Dr. Pittman:

Thanks for a job well done. Your recommendation in that we issue a public statement concerning the education of Optometrists is welcomed by all of us who understand the problems related to the eye. The resolution itself is a work of art, and describes optometric education exactly as it should be described.

Please know that your efforts are greatly appreciated.

R. H. Monahan, M.D.
St. Paul, Minnesota

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.

2/28/79

Name

Organization

Address

Bill No

DON HOSTAK

DIV OF OCC. LICENSING

1919 LATHROP, FBKS, AK

HB 79

SAM A. McCONKEY, M.D.

—

3500 LaTouche Alaska AK.

HB 79

Marvin Grendahl M.D.

—

RT 3 Box 3051 JUNO

HB 79

ROBERT PAGE M.D.

—

536 1/2 4th Ave

HB 79

Nelson Pavish L

—

Fairbanks -

Ren Telean MD

—

PO Box 8630 Ketchikan

Ray A. Boyer O.D.

Alaska Optometric Assn.

611 W. W. Wainwright

Boyd L. Walker, O.D.

ALASKA OPTOMETRIC ASSN.

1345 W. 9th Ave Anchorage
ANCHORAGE

AHARON STERNBERG, O.D.

1016 W. 6th Ave. Anchorage

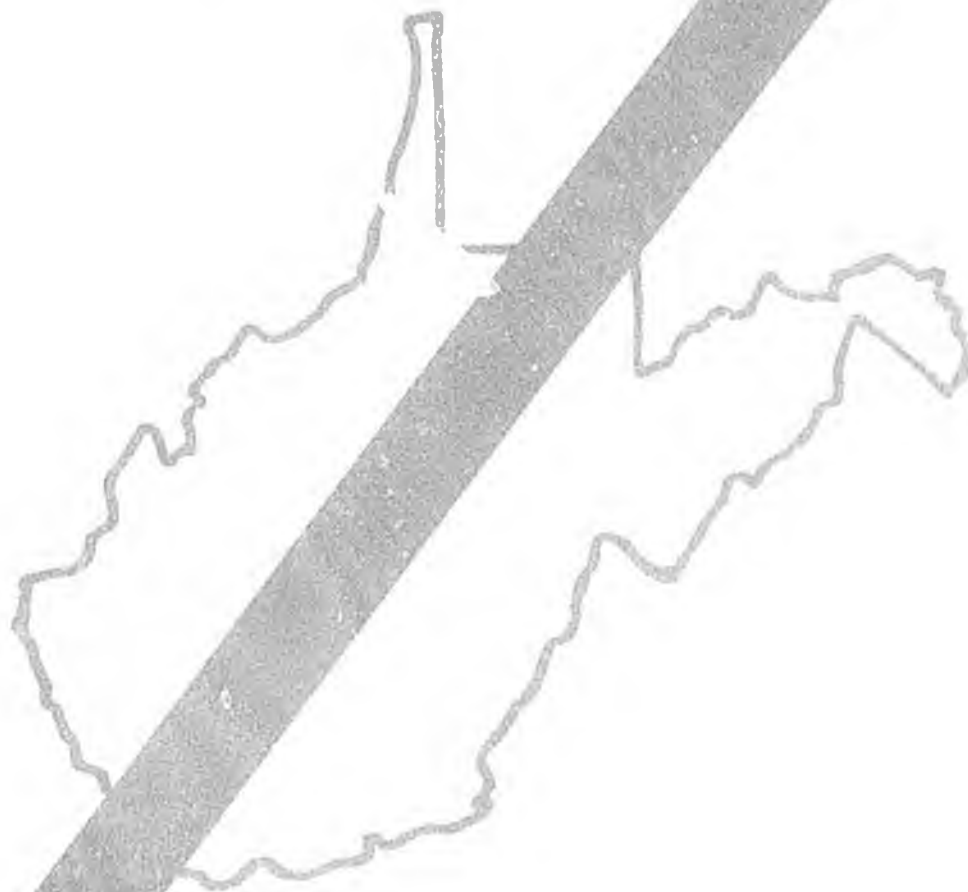
"

1016 W. 6th Ave. Anch. 99501

OPTOMETRY

1980

A Post Facto Report on
Enr. H.B. 1005 (1976)



Developed and Presented by
The West Virginia
Optometric Association



OFFICE OF THE
PRESIDENT
Freda J. Slaymaker, O.D.
P.O. Box 663
Charleston, West Virginia 25323
(304)342-3536
January 22, 1980

Dear Legislator:

This letter is an integral part of a report to you concerning the functioning of the 1976 updating of the West Virginia Optometry Law through H.B. 1005 which among other changes included diagnostic and therapeutic drug use by qualified optometrists.

To those of you who are "seasoned" legislators some of this is material of which you will perhaps be well aware. To those of you who have been recently elected, I will endeavor to provide you with as much pertinent material as possible without undue composition.

This law (H.B. 1005) has now been in effect since 1976 and has been functioning in the satisfactory manner as was intended by the legislature.

Optometrists have for over three and a half years been providing diagnosis and treatment to the many patients who live in the smaller towns in rural areas where no other eye care practitioners are available except the local optometrist. He, along with his colleagues, has administered drugs to Thirty Thousand Six Hundred Forty-Nine (30,649) patients with a savings of Four Hundred Fifty Thousand (450,000) miles (greater details enclosed for the team involved in this report).

Educational courses are being made available to the optometrists of West Virginia on a continuing basis providing them with newer diagnostic and therapeutic methods of treatment as they occur.

The inclusion of the use of drugs by optometrists is still a major bone of contention by a number of ophthalmologists who, through their efforts and financing, have been sending what has been referred to as a "poisonous pen" letter (prepared by a public relations firm) to legislators of which you no doubt will be a recipient.

The enclosed letter from Dr. Butterfield contains results of the most recent survey conducted by the West Virginia Board of Optometry of those optometrists currently certified to use pharmaceuticals. This will provide you with greater details of the functioning of the law from the standpoint of drugs used and treatment instituted with far less travel time of which many indigent patients would not have the means and, thus, could not otherwise have received proper



THE WEST VIRGINIA OPTOMETRIC ASSOCIATION



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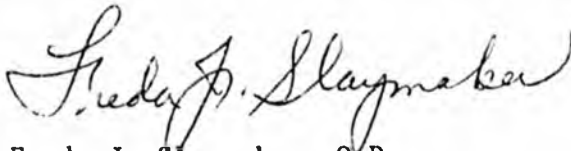
Affiliated with American Optometric Association

West Virginia Legislators
January 22, 1980
Page Two

treatment.

In submitting this report to you on behalf of the optometrists of the State of West Virginia we hope it will provide you with a better understanding of the results of your labor by supplying a means whereas the people of West Virginia are delivered an improved system of health care services.

Respectfully yours,

A handwritten signature in cursive script that reads "Freda J. Slaymaker". The signature is written in dark ink and is positioned above the typed name and title.

Freda J. Slaymaker, O.D.
President
West Virginia Optometric Association

FJS/scp

WEST VIRGINIA BOARD OF OPTOMETRY

J. GORDON BUTTERFIELD, O.D.

SECRETARY-TREASURER

WEST VIRGINIA BOARD OF OPTOMETRY

111 BROOKS STREET

CHARLESTON, WEST VIRGINIA 25301



January 22, 1980

The Honorable W. T. Brotherton, Jr.
President, Senate of West Virginia
State Capitol Building
Charleston, West Virginia 25305

The Honorable Clyde M. See, Jr.
Speaker, West Virginia House of Delegates
State Capitol Building
Charleston, West Virginia 25305

RE: Report on Enrolled H.B. 1005 of 1976

Dear President Brotherton and Speaker See:

The purpose of this letter is to report to each of you and your respective bodies on the Enrolled H.B. 1005 enacted on February 20, 1976 by the Sixty-Second Session of the West Virginia legislature. As you may recall, this law expanded the statutory definition of "optometry" to include, among other things, the limited use of drugs prescribable for the human eye for both diagnosis and treatment, under carefully prescribed certification authority delegated to the West Virginia Board of Optometry. This Board has endeavored continuously and faithfully to both certify and monitor the use of drugs by optometrists practicing under the registration of this Board.

Recent information compiled from the one hundred seventeen (117) West Virginia registered optometrists now certified by this Board for drug usage is as follows:

a. A total of sixty-three (63) different drugs prescribable for the human eye have been employed by these West Virginia certified optometrists since the law was enacted.

b. Thirty Thousand Six Hundred Forty-Nine (30,649) individual patients have been seen by these optometrists and conditions such as infectious or allergic conjunctivitis, corneal abrasions and blepharitis (granulated eye lids) have been treated by those certified in the compilation.

c. The distance those patients who otherwise would have had to travel to geographical locations other than those of the treating optometrists for treatment by ophthalmologists or appropriate medical specialists to whom they formally were referred would have required that over 450,000 aggregate miles be traveled by the 30,649 patients.

The Honorable W. T. Brotherton
The Honorable Clyde M. See, Jr.
January 22, 1980
Page Two

d. Forty-six (46) different pathological conditions have been diagnosed and treated by these West Virginia certified optometrists.

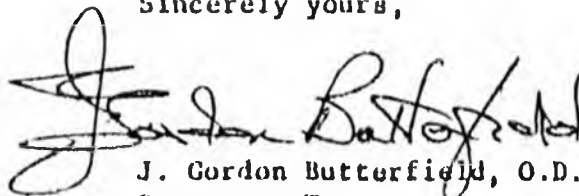
Those 117 West Virginia optometrists who have been certified are widely dispersed throughout our state and are now faithfully and well providing expanded eye health care benefits to the people of West Virginia. IT SHOULD BE ADDITIONALLY NOTED THAT THERE HAS BEEN NO REPORT TO THIS BOARD OF ANY ADVERSE REACTION IN THE DIAGNOSIS AND TREATMENT RENDERED TO PATIENTS INVOLVED BY ANY WEST VIRGINIA CERTIFIED OPTOMETRIST.

There have been reports in the newspapers during the past few months of adverse reactions allegedly caused by optometrists. These alleged reports have all been made by one ophthalmologist.

Registered letters sent to him by this Board seeking his cooperation in helping to identify and fulfill this Board's responsibility have been met with only silence. This Board, therefore, considers his alleged complaints to be just that.

Please be advised that this Board is quite aware of the full responsibility placed upon it by the legislature in the enactment of this law Enrolled H.B. 1005. This data was compiled in a continuing effort to support the trust which has been reposed in it. Each of you is encouraged to call upon this Board for any additional information which may be helpful.

Sincerely yours,

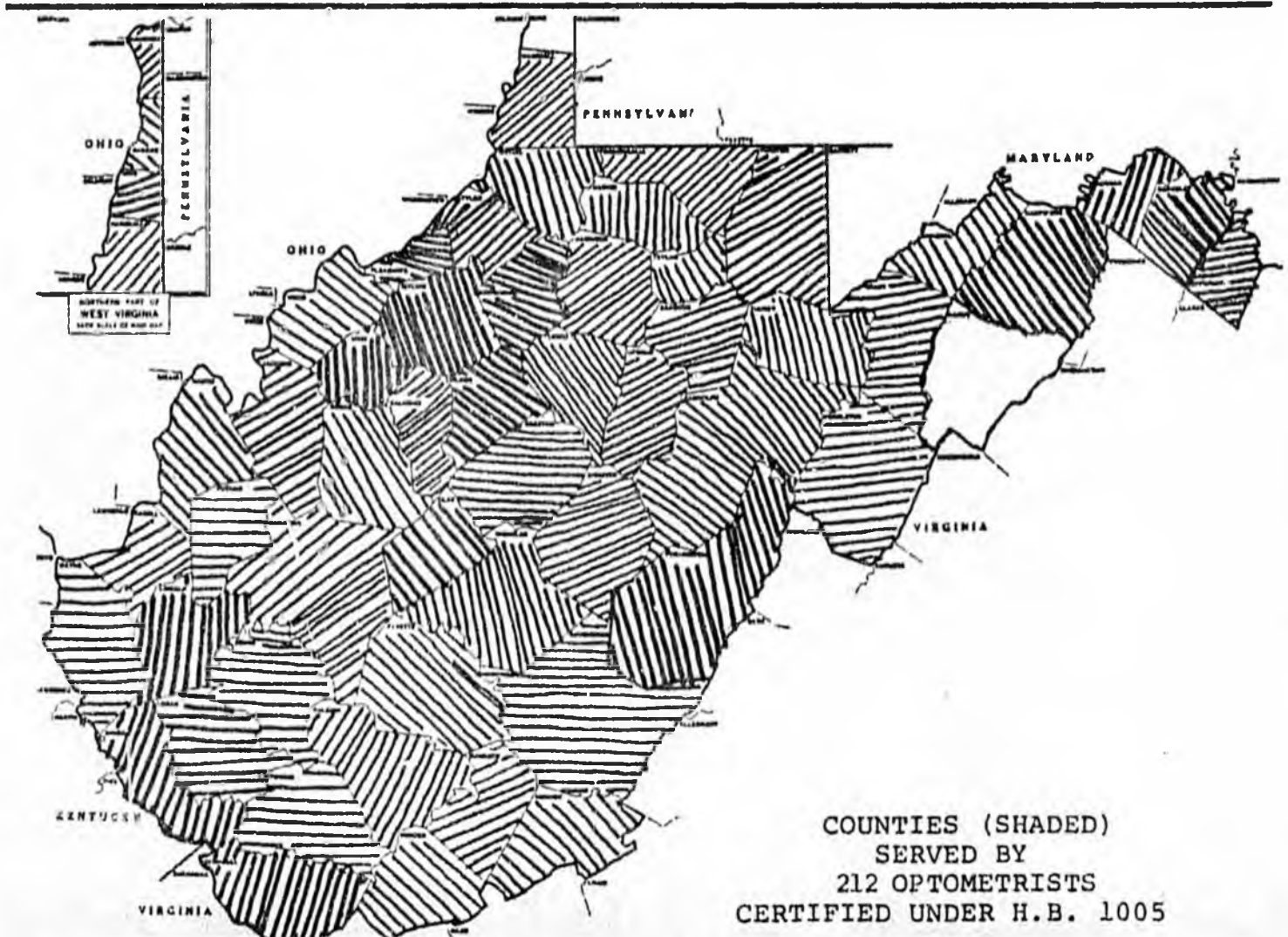
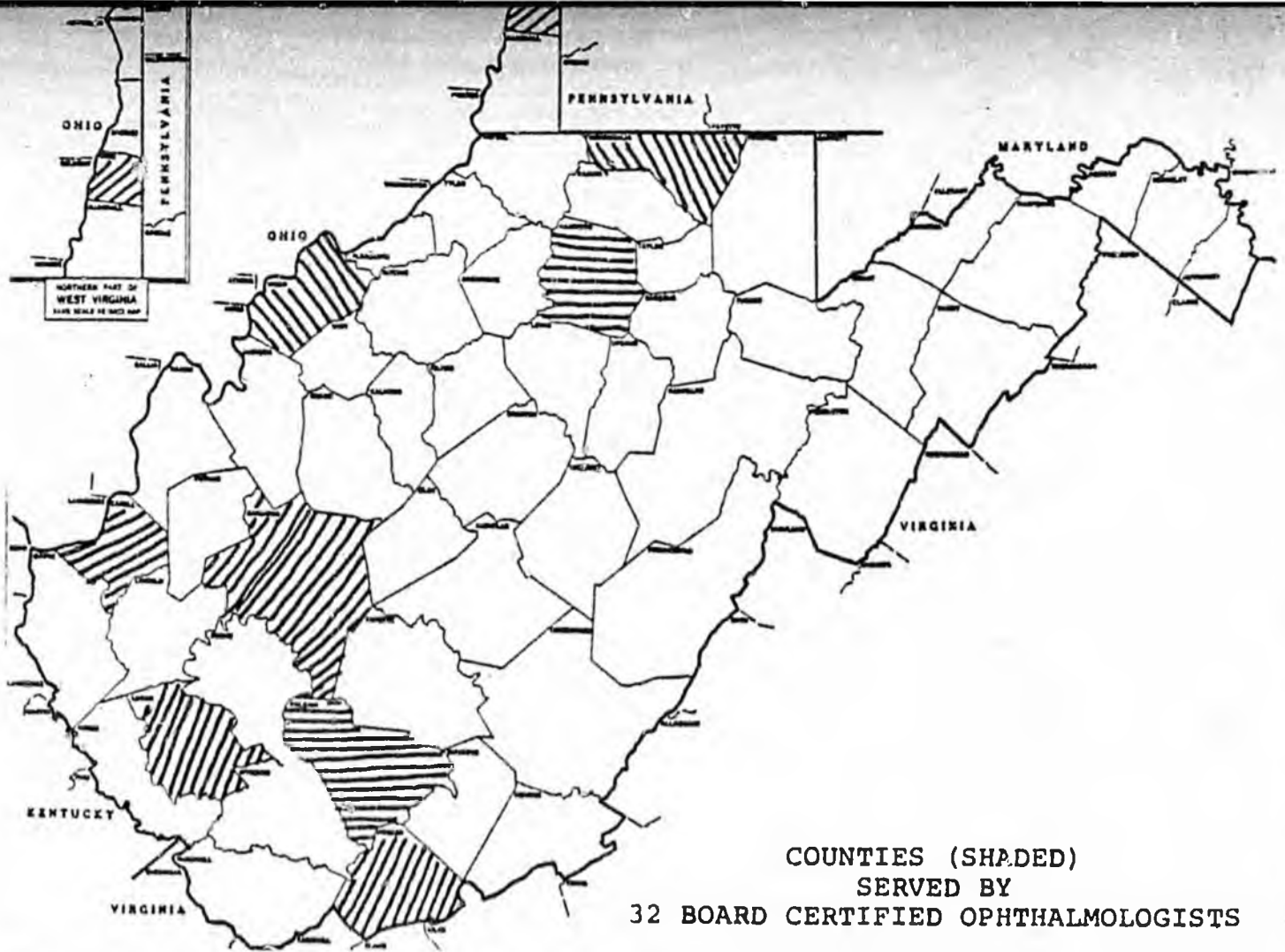


J. Gordon Butterfield, O.D.
Secretary-Treasurer

JGB/vcp

COMPARATIVE PHARMACOLOGICAL INSTRUCTION FOR
HEALTH CARE PROFESSIONS

<u>PROFESSION</u>	<u>SCHOOL</u>	<u>PHARMACOLOGY HOURS OF INSTRUCTION</u>	<u>REFERENCE</u>	<u>RESTRICTION ON DRUG USE IN WEST VIRGINIA</u>
Optometry	Southern College of Optometry	Total = 204 Lecture = 156 hours (Ocular & Systemic) Lab = 48 hours Plus 696 hours Clinical use of FDA Classified Drugs. Plus 180 hours of Elec- tive Seminars attended by 80% of students.	Catalog of Southern College of Optometry 1979-80	Topically applied Ophthalmic Drugs as permitted in Enrolled H.B. 1005 March 1976
Dentistry	University of Tennessee Center for Health Sciences/ Memphis	Total = 70 hours Lecture = 40 hours Lab = 30 hours Plus Clinical use of drugs	General Catalog The University of Tennessee Center for Health Sciences/ Memphis 1978-79	NONE
Medicine	University of Tennessee Medical Units Memphis	Total = 187 hours Lecture = 88 hours Lab = 99 hours Plus Clinical use of drugs for 17 months *Clinical use of ocular drugs probably less than 25 of other drugs since Ophthalmology represents only 1.1% of total cur- riculum	General Catalog The University of Tennessee Medical Units/ Memphis 1973-74	NONE
Podiatry	Pennsylvania College of Podiatric Medicine	Total = 176 hours	Pennsylvania College of Podiatric Medicine 1977-79	NONE
Osteopathy	Philadelphia College of Osteopathic Medicine	Total = 156	Bulletin of Philadelphia College of Osteopathic Medicine 1978-79	NONE



POSITION PAPER

SENATE BILL NO. 75
(Companion to 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 miotics by optometrists and as such would delete from the definition of optometry the restriction against the use of drugs. All eight of these are drugs which are instilled directly into the eye. Mydriatics are drugs which cause the pupil to open widely while miotics cause the pupil to close down. Cycloplegics cause temporary paralysis of the muscles which control the shape of the lens.

Approximately 31 states now allow optometrists to use diagnostic topical drugs, either through specific enabling legislation or through the lack of specific prohibition. The issue of use of such drugs by optometrists has been controversial and in recent years certain states have given permission while it has been denied in other states. Those in favor of the use of drugs by optometrists argue that optometric services are more widely distributed than ophthalmologic services and that the optometrist serves as an entry point for primary eye care. The use of diagnostic drugs is said to expand the ability of the optometrist to recognize eye abnormalities and to increase medical referral for diagnosis and treatment. The optometric group also states that the drugs which are proposed rarely have adverse effects.

On the other hand, the medical group argues that the use of drugs would not materially improve the capacity of optometrists to recognize abnormalities. Optometrists are not expected to diagnose diseases of the eye, and if a departure from normal is noted, the patient is expected to be referred to a physician for diagnosis. If empowered to use diagnostic drugs, the concern on the part of the medical community is that the optometrists would be making diagnostic judgments which the physicians do not believe them qualified to make. Moreover, the medical community notes that adverse reactions, while admittedly rare for certain of the drugs, can have extremely serious consequences when they do occur. For example, they cite a higher rate of predisposition to a certain type of glaucoma in Alaska Natives and the possibility of precipitating an attack through use of mydriatics.

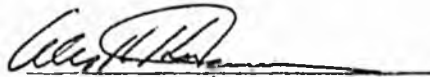
In some states which have permitted the use of diagnostic drugs, the permissive legislation has contained certain limitations, none of which appear in the current draft of the Alaska bill. For example, Rhode Island permits the use of mydriatics, miotics and topical anesthetics while Maine permits only the use of topical anesthetics and mydriatics. A bill which may still be under consideration in the Ohio legislature specifically prohibits use of pilocarpine (a drug which constricts the pupil), atropine and homatropine (drugs which dilate the pupil and temporarily paralyze accommodation of the lens) and 10% phenylephrine (a strong mydriatic). In Oregon, the Board of Optometry

is empowered to designate the diagnostic pharmaceutical agents for topical use, but provides that the designation shall be with the advice and guidance of the Board of Medical Examiners for the State of Oregon.

Some states define the type of training in pharmacology which would be required before an optometrist would be permitted to use diagnostic drugs. For example, Pennsylvania requires that the course given by an institution be accredited by a regional or professional accreditation organization recognized or approved by the Council on Postsecondary Accreditation or the United States Office of Education.

If the Legislature chooses to authorize use of certain drugs by optometrists, the Department of Health and Social Services suggests that definitions and restrictions similar to those in use in other states may be advisable, and that the professional opinion of the medical and optometric communities should be sought to insure the health and safety of the general public.

Approved by:



Helen D. Beirne
Commissioner

Date:

March 20, 1980

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB No. 79, SB No. 75
 Title "An Act relating to optometry."
 Requested by Commissioner's Office Date 3/18/80

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services
 Program Category Affected Health/Division of Public Health
 BRU, Program, or Subprogram(s) Affected _____

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	0	0	0	0	0
300 CONTRACTUAL	0	0	0	0	0	0
400 COMMODITIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Fund Source)	0	0	0	0	0	0

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Original: Legislative Finance
 cc: Budget and Management
 Prime Sponsor (First Legislator Named) 1x Beaver
 Prepared by: M. Deaver Date: 3/18/80
 Division/Office: P.H. Admin. PH: _____
 Department of Health & Social Services

Assuming the Department will fund five similar contracts on an annual basis, projected costs are as follows:

181,000 x 5 = \$905,000
 Adjusted for inflation, 10%/year x 2 years
 Total program costs = \$1,095,000

Administrative costs required by the Department are as follows:

Personnel Services \$94,300

Grants Administrator R 17	29,460	
Field Representative R 15	25,620	
PT Clerk Typist III	8,915	
PT Accounting Clerk III	10,010	
	74,005	
Sub total		
Benefits	20,311	

Travel \$16,000

Contract negotiation, monitoring and technical assistance

Contractual \$22,300

Phones	5,000	
Rents	5,600	
Printing and Advertising	10,000	
Copier services	1,000	
Postage	600	
Repairs and Maintenance	10,000	
	22,300	

Commodities \$ 1,500

Equipment \$ 3,800

1 typing desk	459.80	
1 typing chair	136.02	
2 executive desks	1,311.00	
3 executive swivel chairs	619.00	
1 correcting selectric typewriter	902.48	
1 5-drawer file cabinet	231.48	
1 bookcase	112.49	
	3,772.29	

Department staff, a Grants Administrator and a Project Field Representative, will be responsible for negotiating and executing contracts; monitoring and providing technical assistance; and providing statewide coordination.

(End Fiscal Note Analysis)

SECTIONAL ANALYSIS OF HOUSE BILL NO. 86

Section 1. Adds a new chapter to AS 08 (Business and Professions) entitled "Veterinary Practice Act." Each section of this new chapter will be analyzed separately.

ARTICLE 1. BOARD OF VETERINARY MEDICINE

Sec. 08.95.010. CREATION AND MEMBERSHIP OF BOARD. Creates a Board of Veterinary Medicine, composed of four veterinarian members and one public member, to replace the current Board of Veterinary Examiners.

Sec. 08.95.030. SOURCE OF APPOINTMENTS FOR VETERINARIAN MEMBERS. Directs the governor to appoint each veterinarian member of the board from a list of at least three candidates recommended by the Alaska State Veterinary Medical Association.

Sec. 08.95.040. BOARD MEETINGS. Requires the board to hold a regular annual meeting and permits the chairman to call other meetings.

Sec. 08.95.050. OFFICERS. Directs the board to elect a chairman, subject to the governor's approval, and a secretary to serve one-year terms.

Sec. 08.95.060. REPORT REQUIRED. Requires the chairman and secretary to submit a report on the actions of the board to the Department of Commerce and Economic Development at the end of each examining period.

Sec. 08.95.070. MEETING OF NATIONAL VETERINARY STATE BOARD OF EXAMINERS. Authorizes the board to send one of its members to the annual meeting of the National Veterinary State Board of Examiners at state expense.

Sec. 08.95.080. POWERS AND DUTIES OF THE BOARD. Directs the board to regulate the "practice of veterinary medicine" (as defined) in accordance with the Act, to adopt regulations implementing the Act, and to authorize the issuance, renewal, or reinstatement of a license, permit, or certificate of registration to any person entitled to it. Authorizes the board to adopt regulations interpreting, clarifying, and making specific the provisions of the Act. Directs that the powers granted to the board under the Act be liberally construed.

ARTICLE 2. LICENSING.

Sec. 08.95.200. LICENSE REQUIRED. Prohibits anyone but a licensed veterinarian from practicing veterinary medicine except

- (1) a veterinarian licensed in another state consulting with a licensed veterinarian in this state;

- (2) the holder of a temporary permit, acting under the direction of a licensed veterinarian, who has applied to take the veterinarian's examination;
- (3) a veterinarian licensed in another state who holds a temporary permit to conduct the practice of a licensed veterinarian during his absence;
- (4) a person performing tasks within his competence, other than diagnosis, prescription, or initiation of treatment, under the "general supervision" (as defined) of a licensed veterinarian and in accordance with board regulations;
- (5) a person performing artificial insemination of animals, who holds a permit to do so;
- (6) a person giving advice on livestock management or engaging in accepted livestock management practices in accordance with board regulations;
- (7) a faculty member of a "veterinary school" (as defined) engaging in his official duties;
- (8) a person lecturing, giving instructions, or performing demonstrations with the approval of the board, at a veterinary school, or in connection with a continuing education course or seminar sponsored by a veterinary school or approved by the board;
- (9) a veterinary student performing duties or actions assigned by his instructors;
- (10) a veterinary student acting under the general supervision of a licensed veterinarian;
- (11) a person engaging in scientific research that reasonably requires experiments with animals;
- (12) a person gratuitously giving emergency aid to animals;
- (13) the owner of an animal and his regular, full-time employees caring for and treating the animal, unless ownership of the animal was transferred to avoid application of the Act or the employees were hired primarily to treat animals;
- (14) a merchant or manufacturer selling at his regular place of business products used in the prevention or treatment of animal diseases;
- (15) a person selling or applying a pesticide or herbicide;
- (16) a governmental employee engaging in his official duties.

Sec. 08.95.220. QUALIFICATION FOR EXAMINATION. Sets out the qualifications for taking an examination to become a licensed veterinarian. These qualifications are substantially the same as under existing law except for a new provision allowing a person who was not graduated from a veterinary school to take the examination if he has passed the Education Commission for Foreign Veterinary Graduates examination in veterinary medicine.

Sec. 08.95.230. EXAMINATION FEE. Directs the Department of Commerce and Economic Development to establish a fee to accompany applications for licensing as a veterinarian, refundable if the applicant is found unqualified to take the examination.

Sec. 08.95.240. CONTENT OF EXAMINATION. Requires that the examination be in two parts, a national examination selected by the board and a state examination prepared by the board. Requires the examination to cover subjects and techniques commonly taught in veterinary schools and permits the board to require a practical demonstration of skills.

Sec. 08.95.250. EXEMPTION FROM NATIONAL EXAMINATION. Permits the board to exempt an applicant from the national examination who meets specified criteria involving years of practice as a veterinarian in another state and recent passing of a national examination.

Sec. 08.95.260. REEXAMINATION. Allows a person failing an examination to take a subsequent examination upon payment of the examination fee.

Sec. 08.95.265. INITIAL LICENSE AND RENEWAL FEES. Directs the Department of Commerce and Economic Development to establish a fee for issuance of a veterinarian's license and a fee for biennial renewal.

Sec. 08.95.270. TEMPORARY PERMIT TO PRACTICE WITH LICENSED VETERINARIAN. Permits a qualified applicant for a veterinarian's license who has not failed a veterinarian's examination to obtain a temporary permit to practice veterinary medicine under the direction of a licensed veterinarian, pending examination. Comment. The permit holder is required to be under the "direction" of a licensed veterinarian rather than his "general supervision." "General supervision" is defined in the Act but "direction" is not. The difference between these terms is not clear but might be made so by board regulation.

Sec. 08.95.280. TEMPORARY PERMIT TO TAKE OVER PRACTICE OF LICENSED VETERINARIAN. Allows a veterinarian licensed in another state, who would be qualified to take the veterinarian's examination in this state, to obtain a temporary permit, for no longer than 60 days, to conduct the practice of a licensed veterinarian during his absence. Directs the Department of Commerce and Economic Development to establish a fee for these temporary permits and any renewals that may be permitted by the board.

Sec. 08.95.290. REINSTATEMENT OF LAPSED LICENSE. Allows a veterinarian whose license has lapsed to have it reinstated without examination within three years of its lapsing.

ARTICLE 3. REGULATION OF PRACTICE OF VETERINARY MEDICINE.

Sec. 08.95.400. DISCIPLINE OF LICENSED VETERINARIANS. Authorizes the board to revoke or suspend the license of a licensed veterinarian or otherwise discipline a licensed veterinarian for specified reasons, including unprofessional conduct as defined in board regulations.

Sec. 08.95.410. REVOCATION AND SUSPENSION OF TEMPORARY PERMITS. Authorizes the board to revoke or suspend a temporary permit for a violation of the Act or a regulation adopted under it, whether committed by the permit holder or the licensed veterinarian with whom he is associated.

Sec. 08.95.420. ARTIFICIAL INSEMINATION OF ANIMALS. Directs the board to adopt regulations providing for issuance of permits to perform artificial insemination of animals. Authorizes the board to revoke or suspend such a permit for a violation of the Act or a regulation adopted under it.

Sec. 08.95.430. REGISTRATION OF VETERINARY TECHNICIANS. Directs the board to adopt regulations providing for the registration of "veterinary technicians" (as defined). Directs that these regulations require, for registration, the completion of college programs approved by the board, but permits the board to register veterinary technicians before July 1, 1981 who have been graduated from high school and completed two years of satisfactory work experience in lieu of college programs. Sets a fee of \$25 for registration and biennial renewal. Authorizes the board to revoke or suspend a certificate of registration for a violation of the Act or a regulation adopted under it. Emphasizes that a veterinary technician must be under the general supervision of a licensed veterinarian. Provides that this section does not require a veterinary technician to become registered, but authorizes the board to impose such a requirement by regulation.

Sec. 08.95.440. STANDARDS OF PRACTICE. Authorizes the board to establish standards of practice, including continuing education requirements, for (1) licensed veterinarians and holders of temporary permits; (2) holders of permits to perform artificial insemination of animals; (3) persons giving advice on livestock management or engaging in livestock management; and (4) persons acting under the general supervision of licensed veterinarians. Authorizes the board to

(1) classify persons acting under the general supervision of licensed veterinarians; (2) limit or qualify the duties which may be performed by members of a class; (3) permit or require members of a class to be registered or licensed; (4) establish qualifications for registration or licensing of members of a class; (5) provide for renewal, revocation, and suspension of certificates or licenses of members of a class; and (6) set fees for issuing and renewing certificates or licenses of members of a class.

Sec. 08.95.460. RESPONSIBILITY OF LICENSED VETERINARIAN. Requires employees of a licensed veterinarian to be under his general supervision. Makes the licensed veterinarian responsible for the performance of any person required to be under his direction or general supervision.

ARTICLE 4. ENFORCEMENT.

Sec. 08.95.600. UNLAWFUL PRACTICE OF VETERINARY MEDICINE. Makes the unlawful practice of veterinary medicine a misdemeanor punishable by a fine of not less than \$50 or more than \$500 or imprisonment for not more than 90 days. Makes each day of unlawful practice a separate offense.

Sec. 08.95.610. NO RIGHT TO COMPENSATION FOR SERVICES UNLAWFULLY RENDERED. Provides that a person is not entitled to compensation for services constituting the practice of veterinary medicine that are unlawfully rendered.

Sec. 08.95.620. INJUNCTION. Authorizes the board to seek an injunction to restrain a person from practicing veterinary medicine unlawfully.

Sec. 08.95.630. REMEDIES CUMULATIVE. Declares that remedies for enforcing the Act are cumulative and independent.

Sec. 08.95.640. INVESTIGATIONS. Authorizes the board to conduct investigations to determine whether violations of the Act or regulations adopted under it have occurred.

ARTICLE 5. ABANDONMENT OF ANIMALS.

Sec. 08.95.800. Authorizes a licensed veterinarian or temporary permit holder to dispose of an animal, by sale or otherwise, left in his custody and abandoned. Provides that abandonment is considered to have occurred if the animal is unclaimed within 10 days after notice is sent to the owner or his agent.

ARTICLE 6. GENERAL PROVISIONS.

Sec. 08.95.900. DEFINITIONS. Defines principal terms used in the Act, including "animal," "general supervision," "practice of veterinary medicine," and "veterinary technician."

Sec. 08.95.910. SHORT TITLE. Designates AS 08.95 as the Veterinary Practices Act.

Section 2. Makes the Board of Veterinary Medicine subject to the centralized licensing law.

Section 3. Directs the Department of Commerce and Economic Development to provide investigative services to the Board of Veterinary Medicine to assist it in matters of professional discipline.

Section 4. Gives the Board of Veterinary Medicine a termination date of June 30, 1985 for purposes of the sunset law.

Section 5. Reenacts a portion of the sunset law as a new section in the Alaska Statutes. This reenactment has no substantive effect. It is necessitated by the inclusion of the Board of Veterinary Medicine in the sunset law.

Section 6. Provides for a lien on an animal for veterinary services.

Section 7. Makes the Board of Veterinary Medicine subject to the administrative adjudication provisions of the Administrative Procedure Act.

Section 8. Repeals the current laws relating to the practice of veterinary medicine and a portion of the sunset law. The repeal of a portion of the sunset law is of no effect, other than to eliminate a reference to the Board of Veterinary Examiners, because its reenactment as a new section is provided for in Sec. 5.

Section 9. Provides for the validity of a temporary license to practice veterinary medicine issued under law that is being repealed.

Section 10. Provides for the validity of a license to practice veterinary medicine issued under law that is being repealed.

Section 11. Authorizes the reinstatement of a lapsed license to practice veterinary medicine, within five years of its lapsing, which was issued under law that is being repealed.

Section 12. Directs that the members of the Board of Veterinary Examiners automatically become veterinarian members of the Board of Veterinary Medicine and serve until their terms on the former board would have expired.

Section 13. Directs that the title "Board of Veterinary Examiners" in the laws of the state be read as "Board of Veterinary Medicine." Provides for continuation of proceedings begun, orders issued, and regulations adopted under law that is being repealed. Directs that property of the Board of Veterinary Examiners be transferred to the Board of Veterinary Medicine.

Section 14. Makes this Act effective July 1, 1979.

BILL ANALYSIS

ASSIGNMENT DATE _____

UNASSIGNED _____

DEPARTMENT	SPONSOR (PRINCIPAL)	BILL NO.
Commerce & Economic Development	Miles, Martin, Barnes, Buchholdt, Cotten, Phillips & Hayes	HB 86
DEPARTMENT POSITION		
Opposed as noted below.		
DIVISION DIRECTOR	DATE	COMMISSIONER
Occupational Licensing	February 2, 1979	
GOVERNOR'S OFFICE USE		
<input type="checkbox"/> POSITION NOTED	<input type="checkbox"/> POSITION APPROVED	<input type="checkbox"/> POSITION DISAPPROVED
BY:	DATE:	
SUMMARY		
(1) RELATED BILLS (SIMILAR OR CONFLICTING)		
(2) OTHER AGENCIES AFFECTED BY BILL		
(2) a. ORGANIZATIONAL SUPPORT FOR BILL	/ / / / /	(2) b. ORGANIZATIONAL OPPOSITION TO BILL
Alaska Veterinary Society		Unknown
(3) PROGRAM EFFECTS OF BILL		
Some major changes to existing practice act (AS 08.98) and increased costs in implementation.		
(4) FISCAL IMPACT: <input type="checkbox"/> NONE <input checked="" type="checkbox"/> FISCAL ANALYSIS ATTACHED		
(5) AMENDMENTS PROPOSED:		
(6) COMMENTS:		

The Division of Occupational Licensing opposes Secs. 1 through 14 of HB 86, "An Act relative to the practice of veterinary medicine; and providing for an effective date." Provisions in the Act for additional members, annual National meeting attendance, specialty permits (Sec. 420), and registration of technicians would entail substantial additional costs for regulation and administrative overhead. Many other aspects of the proposed Act are objectionable from the standpoint of standard statutory authority. These include, but are not limited to, (1) a requirement that board members be appointed only from a list submitted by the State association, (2) limits on voting power of public members,

(See reverse)

(3) a requirement that those applying for temporary permits may work only under supervision of a licensee, (4) that the board itself may conduct investigations, and (5) inappropriate revisions to AS 08.03 (Termination, Continuation and Reestablishment of Regulatory Boards).

We believe that the present practice act is workable but needs amendments. Appropriate recommendations have been made as a result of the Sunset review process that should be considered in increasing board efficiency. We do not believe, however, that the proposed new act would accomplish this nor would it be in the best overall interests of the public.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB 86

Title An act relating to the practice of veterinary medicine; and providing

Requested by for an effective date Date 2/15/79

Miles, Martin, Barnes, Buchholdt,
Cotten, Phillips and Hayes

FISCAL DETAIL

Agency Affected Commerce and Economic Development

Program Category Affected Public Protection

Budget Request Unit(s) Affected Regulation and Licensing of Professions

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES	-0-	-0-	-0-	-0-	-0-	-0-
200 TRAVEL	-0-	1.8	1.9	2.0	2.1	2.2
300 CONTRACTUAL	-0-	3.0	3.1	3.4	3.6	3.8
400 COMMODITIES	-0-	-0-	-0-	-0-	-0-	-0-
500 EQUIPMENT	-0-	-0-	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES	-0-	-0-	-0-	-0-	-0-	-0-
700 GRANTS, CLAIMS, ETC.	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL	-0-	4.8	5.0	5.4	5.7	6.0

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	4.8	5.0	5.4	5.7	6.0
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

FY 80 travel includes funding for two additional board members transportation and per diem to attend presently budgeted board meetings of two a year. There will be one person making one out-of state trip per year to national organization. Contractual expense includes costs for a hearing per year. This includes costs for a hearing office and court reporters preparation, recording, and reporting of the hearings before and after organization. Inflation is computer @ 6% per year. A detailed analysis of expenditures is attached.

IV. DATE 2/15/79

PREPARED BY Don Hostak

AGENCY Occupational Licensing

PHONE 465-2534

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

Travel

1 trip	Out-of-State Trans.	550
6 days	Out-of-State Per Diem	<u>300</u>
		850

Boards, Commissions and Legislators

2 trips for 2 additional members	In State Trans.	478
8 days	In State Per Diem	<u>440</u>
		918

Total Travel FY 80 1,768

Contractual

Cost for 8 hour hearing. This includes the cost for a hearing officer and court reporter's before and after preparation, recording, and reporting of the hearings activities.

3,000

Total Contractual FY 80 3,000

February 10, 1979

Dear Sally,

A pleasure to hear from you! Thanks for sending along the Veterinary Prctice Act. I have been wondering where it stood these days. I reviewed it and discussed it at length with two Veterinarians, and have one suggestion and a question. The Vets agreed with my suggestion, but declined to write and represent themselves...sigh.

The suggestion: Page 3, Art. 2, Sec. 08.95.200 ...(15) now reads:

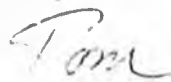
"No person may practice veterinary medicine in this state who is not a licensed veterinarian except...(15) a person selling or applying a pesticide or herbicide."

I thought seriously of dropping out of school to start selling pesticides and doing spays on the side! I think the intent is better reflected in this wording from the original draft of the act:

"No person may practice veterinary medicine in this state who is not a licensed veterinarian.
THIS ACT SHALL NOT BE CONTRUED TO PROHIBIT: ...
(15) a person selling..."

My question concerns the "one public member" of the board (page 1, Art. 1, Sec. 08.95.010), and also page 2, Sec. 08.95.030. The bill states that the governor shall appoint each veterinarian member, etc. It does not, at this time, say who appoints nor who nominates the public member. I assume the governor appoints, but should it be specified? Hopefully the appointee would have some relevant experience and interest in the profession. I wouldn't object to the position myself!

Take care,



Tom & Joan Welsh
P.O. Box 31067
Fairbanks, Alaska
99708