859 SHESS SB 75

Jul 531

DR. CURTIS M. JOHNSON
DR. D. R. SCHMIDT
OPTOMETRISTS
330 SEVENTH AVENUE
FAIRBANKS, ALASKA 99701
Telephone [illegible]

Representative Thelma Bucholdt
Pouch V
Juneau, Alaska 99811

Dear Representative Bucholdt;

We support and urge you to support the passage of H. B. 79 which would allow optometrists to use diagnostic pharmaceutical agents.

SIGNATURE	ADDRESS
Patricia Rosen	PO Box 213 Fbks.
Diana Brockelsby	410 Wedgewood 3H, Fbks
Jeannette Kimberlin	SR Box 10413, Fbks. 99701
Rebecca R Owen	PO Box 10258 Fbks. AK. 99701
Lewis J Gibson	4636 8th St Fairbanks 99701
Anna Gibson	4636 8th St. "
Jeff Lucas	301 Glacier Ave
Heather L Sewell	PO Box 234, Clear, AK.
CURT DORAN	542 CRAIG AVE, FAIRBANKS
[illegible]	Box 60002 FBKS, AK 99706
Edgar Olsen	1213 - 5th Fairbanks 99701
Norma Carlo	136 Denkel, Fairbanks
Sharon Block	SR 50505 Fairbanks
Ken Fratt	Box 508 Nikiski AK.
Pat Driscoll	1126 Park Drive

E. E. BACH, O.D.
PHILLIP W. BACH, O.D., PH.D.
OPTOMETRY
SUITE 204 DENALI PROFESSIONAL CENTER
3401 DENALI STREET
ANCHORAGE, ALASKA 99503

March 1, 1980

The Honorable Robert H. Ziegler, Sr.
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Ziegler:

I am taking the liberty of responding to your letter of February 11 to Dr. Craig, a copy of which he has sent to me. Am sending a copy of this letter to Senators Hackney and Colletta since their committees are also involved in SB 75.

First, your exchange of letters between the two professions is an interesting and potentially useful means of furthering communication.

I can understand your reluctance to adjudicate, as a layman, a dispute involving technical considerations, though this occurs frequently in the legislature. However we are not asking you to decide the matter or even take sides; we are simply asking that you and your committee allow the bill to be considered by the full Senate. You can avoid taking sides by passing the bill out without recommendation.

As to the question of compromise you mentioned, you are probably aware of the meeting that took place in Sen. Colletta's office on February 11, perhaps after you wrote your letter. The ophthalmologists would accept nothing less than total withdrawal of the bill. Nevertheless we still developed an amendment (relating to a drug selection body) that would satisfy some concerns raised by Sen. Colletta.

The ophthalmologists do not have a case. And since Alaska is one of only 18 states that still prohibit the use of diagnostic pharmaceuticals by optometrists, I am sure you can understand that there is no way we are going to give up on this issue. You three gentlemen have the power to prevent this from becoming a long and bitter battle, one that the ophthalmologists are ultimately going to lose.

Very truly yours,

Phillip W. Bach

Phillip W. Bach, O.D., Ph.D.

PWB/sn

cc: Senator Glenn Hackney
Senator Mike Colletta

Alaska State Legislature

SENATOR
ROBERT H. ZIEGLER, SR.
307 BAWDEN STREET
KETCHIKAN, ALASKA 99901

POUCH V
JUNEAU, ALASKA 99811

Senate

CHAIRMAN
SENATE JUDICIARY COMMITTEE
IMMEDIATE PAST CHAIRMAN
WESTERN CONFERENCE - COUNCIL OF STATE GOVERNMENTS

VICE CHAIRMAN
SENATE RULES COMMITTEE

MEMBER
SENATE STATE AFFAIRS COMMITTEE
SENATE COMMITTEE ON COMMITTEES
LEGISLATIVE COUNCIL
WESTERN STATES LEGISLATIVE FORESTRY TASK FORCE

February 11, 1980

Dr. Ed Craig
Optometrist
348 Main Street
Ketchikan, Alaska 99901

Dear Ed:

I am sending a copy of this letter, as you will note, together with a copy of your letter to me of January 8, to Dr. Page.

I am enclosing a copy of Dr. Page's letter to me of January 31.

It is quite clear that the opthamologists and the optometrists are never going to see eye to eye (no pun intended). When feuding factions of any given profession can not agree between themselves as to what should or should not be done, and if those feuding factions want a layman to adjudicate their disputes, I personally resent it. If the warring cliques can't resolve their differences, what makes them think that I can?

I don't at this time intend to take any affirmative action on either HB 79 or SB 75. However, in the unlikely event a compromise is struck, I'll move right along.

Please, please, no more literature! I've seen enough from both sides in the last three years to last me a life time.

Regards,

Robert H. Ziegler, Sr.

cc: Dr. Page

Enclosure

RHZ:lk

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SB 5

PMS SEN GLEN HACKNEY

JUN

THE ALASKA STATE MEDICAL ASSOCIATION LEGISLATIVE COMMITTEE HAS REVIEWED SB75, AN ACT RELATING TOTHE PRACTICE OF OPTOMETRY. CORRESPONDENCE RELATING TO THE ISSUE DURING THE 1978 LEGISLATIVE SESSION WILL BE FORWARDED. THE POSITION OF ASSOCIATION REMAINS ESSENTIALLY THE SAME, NAMELY

1. WE ARE UNABLE TO DETERMINE HOW THIS LEGISLATION WILL IMPROVE EYE CARE OR SPECIFICALLY BENEFIT THE PUBLIC.

2. SPECIFICALLY WE KNOW OF NO DIAGNOSTIC USE FOT THE DRUG CLASS MIOTICS, REQUESTED; IN CONVERSE, THEIR USE WOULD BE APPROPRIATE FOR TREATMENT OF NARROW ANGLE GLAUCOMA, PRECIPITATED BY A MYDRIATIC/ CYCLOPEGIC USE. THIS CONDITION WE UNDERSTAND IS MORE PREVALENT AMONG THE ALASKA NATIVE THAN THE GENERAL POPULATION, SUCH THAT BUSH USE OF THESE DRUGS COULD CARRY INCREASED RISKS.

3. WE APPROVE THE EDUCATIONAL REQUIREMENTS ADDED IN THE 1979 LEGISLATURE. IT FOLLOWS THAT SHOULD THE LEGISLATURE BELIEVE THE PROPOSED LEGISLATION IS IN THE BROAD PUBLIC RATHER THAN FOR SPECIAL INTERESTS NO GRANDFATHER TYPE CLAUSE SHOULD BE ALLOWED.

SINCERELY, WINTHROP FISH, MD,

CHAIRMAN LEGISLATIVE COMMITTEE

ALASKA STATE MEDICAL ASSOCIATION

TELEGRAM

ROA ALASKA COMMUNICATIONS, INC.
P ONE [illegible]-6442
JUNEAU, ALASKA 99802

Ø2Ø94 NL ANCHORAGE ALASKA 159 Ø2-27 5ØØP AST

PMS SENGLENN HACKNEY

JUN

A POTENTIAL THREAT TO THE PUBLIC EXISTS BY THE PASSAGE OF SB75 WHICH ALLOWS NON-PHYSICIAN EYE CARE PRACTITIONERS (OPTOMETRISTS) TO ADMINISTER DANGEROUS EYE MEDICATIONS FOR DIAGNOSTIC PURPOSES WITHOUT PHYSICIAN SUPERVISION. THE DESIRE DRUGS ARE LISTED IN THE PROPOSED BILLS IN THE BROAD GENERAL CATEGORIES OF TOPICAL ANESTHESICS, MYDRIATICS, CYCLOPEGICS AND MIOTICS RATHER THAN BY SPECIFIC DRUGS NAMES WITH DOSAGES. EXAMPLES OF THE DRUGS FOUND IN THESE CATEGORIES INCLUDE SUCH POTENT MEDICATIONS AS COCAINE, ATROPHINE, SCOPOLAMINE, PHENYLEPHRINE, AND PHOSPHOLINE IODINE. ALL OF THESE MEDICATIONS HAVE POTENTIALLY DANGEROUS SYSTEMATIC SIDE EFFECTS. THE SPECIFIC CLASS BIOTICS CONTAIN NO DIAGNOSTIC DRUGS WHATSOEVER AS THEY ARE ALL THERAPUTIC MEDICATIONS USED FOR TREATMENT OF GLAUCOMA OR CERTAIN CASES OF CROSSED EYES. THE ANCHORAGE MEDICAL SOCIETY VOTED OVERWHELMINGLY TO OPPOSE THISE LEGISLATION AS PASSAGE WOULD PERMIT NON-MEDICAL PRACTITIONERS TO PRESCRIBE OR APPLY DRUGS. THIS IS CONTRARY TO THE HEALTH AND WELFARE OF PEOPLE OF ALASKA.

ANCHORAGE MEDICAL SOCIETY PRESIDENT, JERRY LITTLE, MD.

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

February 26, 1979

Senator Glenn Hackney, Chairman
Alaska State Senate
Health, Education, and Social Services Committee
Pouch V, Mail Stop #3100
Juneau, Alaska 99811

Dear Mr. Hackney:

The Alaska State Medical Association Legislative Committee has reviewed Senate Bill 75, an act relating to the practice of optometry.

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

(1) We are unable to determine how this legislation will improve eye care or specifically benefit the public.

(2) Specifically, we know of no diagnostic use for the drug class, miotics, requested; in converse, their use would be appropriate for treatment of narrow angle glacoma, precipitated by a mydriatic/cycloplegic use. This condition, we understand, is more prevalent amongst the Alaska natives than the general population, such that bush use of these drugs could carry increase risk.

(3) We approve the educational requirements added in the 1979 legislation. It follows that should the Legislature believe the proposed legislation is in the broad public rather than for special interest, no grandfather type clause should be allowed.

Sincerely,

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

WF:mlm

Enclosure

February 14, 1978

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

Dear Representative Parr:

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

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

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

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

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

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

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

(2) That the general level of training of the practicing optometrist in Alaska at present is at a standard which will preclude frequent mis-diagnosis, delay, duplication of expense and inappropriate trials of corrective lenses for non-refractive disorders of the eye.

(3) That the use of ophthalmologic drugs in the practice of optometry is free of risk.

(4) That the expanded drug use is necessary and essential to increased accuracy in refractive error diagnosis.

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

Sincerely,

WFish

Winthrop Fish, M.D.
Chairman, Legislative Committee

WF:mlm
cc. ASMA Council
ASMA Legislative Committee

ANCHORAGE MEDICAL SOCIETY
1135 W. 8TH AVE., SUITE 6
ANCHORAGE, ALASKA 99501
907-277-6891

February 26, 1979

Medical Society Position Paper

A potential threat to the public exists by the passage of HB 79 and SB 75 which allows non-physician eye care practitioners (optometrists) to administer dangerous eye medications, for diagnostic purposes, without physician supervision.

The desired drugs are listed in the proposed bills in the broad general categories of topical anesthesics, mydriatics, cycloplegics and miotics rather than by specific drug names with dosages. Examples of the drugs found in these categories include such potent medications as Cocaine, Atropine, Scopolamine, Phenylephrine and Phospholine Iodide. All of these medications have potentially dangerous systemic side effects. The specific class miotics contain no diagnostic drugs what-so-ever as they are all therapeutic medications used for treatment of glaucoma or certain cases of crossed eyes.

The Anchorage Medical Society voted overwhelmingly to oppose this legislation as passage would permit non-medical practitioners to prescribe or apply drugs. This is contrary to the public interest and a detriment to the health and welfare of the people of Alaska.

Anchorage Medical Society
Jerry Little, M.D., President

JL:ma

JAMES H. PATTERSON, M.D.
Diseases and Surgery of the Eye
Subspeciality Pediatric Ophthalmology
3500 LATOUCHE
ANCHORAGE, ALASKA 99504

Telephone 907: 274-2252

February 26, 1979

Chairman Glenn Hackney
Senate HESS Committee
Pouch V
Mail Stop Number 3100
Juneau, Alaska 99811

Dear Chairman Hackney:

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

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

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

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

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

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

Sincerely yours,

James H. Patterson M.D.

JHP:plz

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

Dear Mr. Hackney,

It is my understanding that Senate Bill 75 is under view by your committee in the eleventh legislature-first session. If at all possible I would appreciate being informed as to the status of this "act relating to the practice of optometry".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Maureen Rock

MEMORANDUM

February 5, 1979

TO: Senator Hackney
Chairman, HESS Committee

FROM: Margaret Branson
Representative

RE: SB 75 Optometry and Drugs

As the Chairman of the Committee of first referral, I thought this material on SB 75 properly belongs in your files for consideration by your committee.

FILE

Peninsula Eye Clinic
PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669

TELEPHONE 262-4462

February 1, 1979

Margaret Branson, Representative
Pouch V
Juneau, Alaska 99811

Dear Margaret;

Thank you for notifying me of SB 75! This is the second year for this bill as it was "killed" in the Senate last session. Ophthalmologists have very strong feelings toward this legislation because it is obvious that optometrists have no medical training what-ever (despite their claims) and it is not fair to the public to turn them loose dispensing eye drops. Optometrists are very well trained to fit eye-glasses, but the last few years have desired to expand their endeavours to include the use of eye drops.

Reasons for this desire are purely economic! Therefore - - see the arrival of a national health bill and want a guarantee that they will be included in this legislation as a "primary care providors".

Eye drops are absorbed into the blood stream and become systemic medications. Although rare they can produce serious side reactions such as high blood pressure and indeed shock! It is not fair to the public to relegate such serious matters to a non-medical practionor.

Medicine contends that if non-medical practionors wish to expand their endeavors to include medical functions they should re-cycle themselves thru the medical curriculum rather than going to the legislators and side-passing the educational pre-requisites.

Sincerely,

Peter E. Cannava, M.D.

Peter E. Cannava, M.D.

P.S. Enclosed please find a speech I gave to the local legislators before they departed to Juneau.

P.S. In addition you should be aware that a young Alaskan lost an eye because of an optometrist, in using eye drops, felt secure in making a diagnosis which turned out to be erroneous. The story is enclosed.

PEC/bc

American medicine has estabilished a tradition which dates back well over 200 years! Despite the ups and downs of certain aspects of American medicine the very basic integrity of the system has never and will never be challanged. This is fact because the system rests upon a foundation of sound scientific principle. American people may not like what type of treatment is offered them but they at least can rest assured that any prescription promulagated by our traditional medical system is based upon a scientific method, and those practitioner licensed with-in the system have completed a satisfactory curriculum approved by both private and governmental bodies who attest to the fact that medical practitioners are qualified to practice with the use of drugs and other modalities. In addition to the traditional modality of medical care there are two other broad categories of health care which our people choose to utilize. One is not based upon scientific methodology, cannot be supported by established objective data. Examples of these would be naturopathic healing and chiropractic. The second category of non-medical health care sought by Americans is based upon scientific principles but is not traditionally associated with medical education. Examples of those are psychology and optometry. In past years no major conflict has arisen between traditional medicine and other forms of health care. However, of late there is a movement on by non medical people to seek enactment of legislation which would grant them privileges which traditionally have been the provence of medical practitioners. Examples would include attempts by chiropractors to utilize medical facilities for laboratory testing and more germane to our state the attempt by optometry to seek legislation approved for their use of drugs within their practice.

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

SPECIAL TIMOTHY STEELE ISSUE

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

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.

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. ●

tates of America, defendant. In his opinion, Judge Fitzgerald stated, "An optometrist's responsibility is to observe during his eye examinations any mani-

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.

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

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.**

Mary Please have Legis. Affs. Sit
Please have one copy for Senator HESS.

Explorations in Living offers a stimulating learning opportunity for young people and for those who present and guide the program. Hopefully, this new kind of preventive mental health program will help students develop into more informed and responsible citizens.

Explorations in Living can be obtained from Paul B. Amidon and Associates, Inc., 1966 Benson Avenue, St. Paul, Minnesota 55116 (cost is $18.50 per unit).

A GUIDE TO FEDERAL HOUSING PROGRAMS FOR THE MENTALLY DISABLED

This guide is designed to provide specific information about Federal housing programs and their potential for helping develop residential options for people disabled by mental health problems. It is intended primarily for State and local mental health program development staffs and others involved in community care.

The guide begins with an explanation of the Federal housing programs which may be applicable to the mentally disabled. It also discusses funding alternatives for specific residential options. Finally, the guide summarizes various strategies which State and local agencies can use in both securing funds and developing residential programs. Appendices include a list of key people in HUD area and regional offices, names and addresses of relevent projects, and several other important supplemental materials and references.

Published by the National Institute of Mental Health, it is available from Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, Stock No. 017-024-00727-7, at a cost of $3.00 each.

THE SWITCH PROCESS IN MANIC-DEPRESSIVE ILLNESS

In manic-depressive illness, the process of change from a severely depressed to a manic phase can occur anywhere between a few minutes and a few days. Analysis of the "switch process" has given psychobiologists important insights into the chemical processes associated with changes in brain neurons in affective illnesses.

Dr. William E. Bunney, Jr., Chief of the Biological Psychiatry Branch of the National Institute of Mental Health's Intramural Research Program has studied manic-depressive patients, focusing on the neurotransmitter mechanisms that carry impulses from one neuron to another at the synapse. He theorizes that elevated or reduced levels of the neurotransmitters, norepinephrine and dopamine, may be responsible for the sudden shift from one state to the other. In the 14-page monograph, Bunney discusses the switch process and his study of what happens in the brain during the switch.

This publication, published by the National Institute of Mental Health, Division of Scientific and Public Information, is available from Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, Stock No. 017-024-00733-1, 90 cents each.

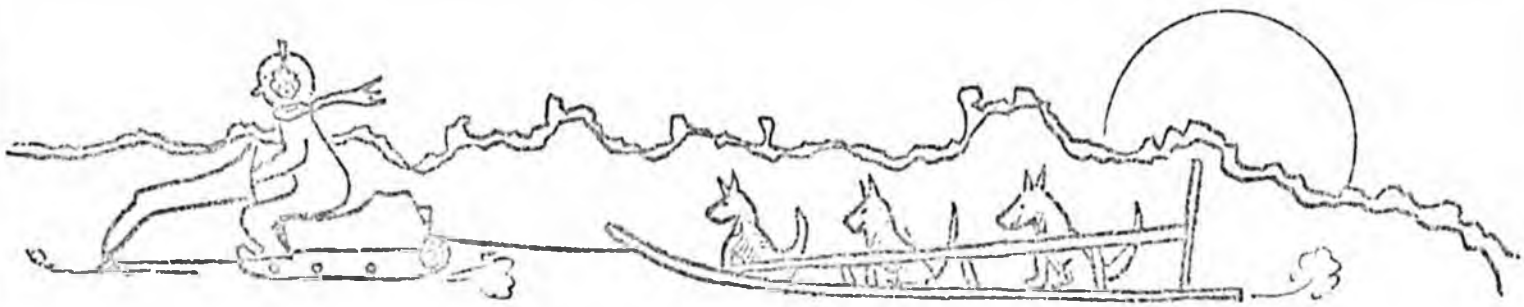
FAMILY VIOLENCE GRANT

The Department of Health and Social Services applied for and received a grant from the Law Enforcement Assistance Administration in the amount of $260,866 to operate a program called the Alaska Family Violence Program. A brief descriptive summary of this program that was taken from the grant award says, "The purpose of Alaska's Family Violence Program is to initiate and monitor a project directed at reducing the incidence of intra-family violance. The program will be implemented by agencies or citizen groups at eight (8) locations throughout Alaska...Nome, Bethel, Anchorage, Kenai, Fairbanks, Barrow, Kodiak and Ketchikan as well as many small communities within their respective locales.

"Various community-wide approaches will be tested. These approaches include: regional shelters and transportation shelters, "safe homes", crisis lines, volunteer advocacy, media and public education, training for criminal justice, medical and mental health personnel, alternatives to prosecution for offenders and innovative procedures for law enforcement personnel responding to family disturbance calls.

"The anticipated impact of this program will not only be an actual reduction in intra-family violence, but will also provide more effective and efficient mechanisms for agency coordination, a reduction in the number of repeat calls, an increase in the number of prosecutions and constructive alternatives to prosecution, decreased public tolerance for intra-family violance, and more information and understanding of the level and nature of intra-family violence in Alaska."

We hope to hear more about this new program as it gets underway. Meanwhile, if you want more information, please contact Sema Lederman, Project Coordinator, 400 Gamble, 3rd Floor, Anchorage, Alaska 99510 (276-1024).



The Division of Mental Health
and Developmental Disabilities
Pouch H-04
Juneau, Alaska 99811

Alaska Anthracite

File with SB —
opp. bill, please.

(3)

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

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

March 7, 1979

Honorable Glenn Hackney
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney:

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

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

1. It is the responsibility of optometrists to detect and refer pathological eye conditions.

2. Optometrists currently receive training in detection of ocular disease as well as in the use of pharmaceutical agents including management of side effects.

3. H.E.W. consultants on this report unanimously recommended that state licensure laws be revised to allow the use of diagnostic pharmaceutical agents by optometrists. (24 states now allow this practice)

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

Thank you.

Sincerely,

Boyd L. Walker, O.D.

Boyd L. Walker, O.D.

BLW:ah

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

• U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE • Public Health Service • Health Resources Administration •

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

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

Optometric Practice

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

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

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

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

ATTACHMENT B

BASIC ELEMENTS OF THE CURRICULUM OF SCHOOLS OF OPTOMETRY

1. Biological science knowledge base.

   a. Gross human anatomy and microscopic anatomy, with emphasis on head, neck, and thorax.

   b. Embryology, gross and microscopic anatomy of the human nervous system - concentrating on the central nervous system.

   c. General human physiology, including the study of the fundamental organ systems and the mechanisms which regulate body function. Emphasis is on the sensory, motor and cardiovascular systems.

   d. Basic concepts of general and cellular biochemistry, with study of nomenclature, structure, and reactions of organic molecules. Emphasis is on the visual system - tears, intraocular fluids, lens, retinal photochemistry, and actions of drugs upon these.

   e. Concepts of human genetics and genetic disorders, including the frequency and distribution of genetic disease, inheritance patterns, polygenic inheritance, chromosomal abberration syndromes, multifactorial genetics, and principles of genetic counseling.

   f. Gross and microscopic anatomy of the lids, orbit, orbital content, globe, muscles, nerves, and vessels, and embryology of the eye.

   g. Vegetative physiology of the eye, extraocular and intraocular fluids, corneal and lens metabolism, ocular circulation, retina and optic nerve metabolism.

   h. General pharmacological principles, methods of administration, various systemic drugs and their pharmacological action and side effects with emphasis on those that affect the visual system, such as cataractogenic and glaucoma-producing drugs.

   i. Pharmacology; uses, doses, contraindications, and adverse effect of drugs producing miosis, mydriasis, cycloplegia, accommodation, and ocular anesthesia. The pharmacology, use contraindications, and adverse effect of drugs commonly used in treating visual and ocular problems.

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

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

1. Refractive services for aphakic patients

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

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

2. Low vision services and aids

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

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

3. Prevention, health maintenance, and health education

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

4. Other service provided by optometrists

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

5. Administrative considerations

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

6. Cooperative working relationships between vision/eye care professionals

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

a. Development of joint educational programs at the undergraduate and graduate levels, including rounds, clinics, conference, and meetings and publications.

b. Establishment of interdisciplinary clinics with optometrists and ophthalmologists working together.

c. Facilitation of referral of patients between the optometrist and the ophthalmologist when in the best interest of the patient.

d. Joint development of quality standards for service and materials by peer review mechanisms. By materials, particular reference should be assigned to varying quality of lenses and frames and the need for furnishing laboratory invoices of material costs for reimbursement.

e. Joint development of appropriate revision to State licensure laws to permit use of diagnostic drugs (mydriatics and local anesthetics) by optometrists.

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

ROBERT N. PAGE, JR., M.D.
JUNEAU MEDICAL CENTER
R.R. 3, BOX 3051
JUNEAU, ALASKA 99801

PRACTICE LIMITED TO THE EYE

February 27, 1979

Honorable Glenn Hackney
Senator
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney:

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

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

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

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

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

Sincerely,

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

Enclosures

$250,000 awarded the Steeles 27 Feb 1978

SPECIAL TIMOTHY STEELE ISSUE

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 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."

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. ●

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.

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.**

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 a supper 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 reject 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

THE PEN....

VOLUME 3, NUMBER 1
DECEMBER 15, 1978 - JANUARY 1, 1979
ST. PETERSBURG, FLORIDA

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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

Continued on page 6

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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,

v.

UNITED STATES OF AMERICA, Defendant.

NO. F 75-27 Civil

OPINION

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 airevac 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,[2] 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 1430. Vitreous lesion in right eye caused from hemorrhage.

Upon completing the examination, Dr. Shank concluded that Timothy's eye problem was caused by an accomodative esotropia[3] 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 accomodative 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 optometry, 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 federal 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 also 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 abnormalies 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 article[5] published in the "American Journal of Tropical Medicine" in May, 1974.[6] After examining the medical records, including the pathology report, in Dr. Krupp's opinion the probability was 90 percent that the disease in Timothy's right eye was toxocara. Dr. Krupp, a principal government witness at trial, 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 granulomatous retinitis, 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-

Continued on page 6

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 larval migrans, the disease caused by toxocara 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 thiobendazole and steroids, generally used in combination. Thiabendozle 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. Shrank'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.

/s/ James M. Fitzgerald
United States District Judge

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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 Hemoglutination 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, M.D.
PEN'S International Advisory Board Chairman

"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 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 touraments 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 to 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____

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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 G. Bullington, M.D.
Charlotte, North Carolina

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

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UNITED STATES PHYSICIANS EDUCATION NETWORK

Statement of Purpose

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

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

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

"M.D. IS THE MAJOR DIFFERENCE"

THE PEN...

PRO BONO PUBLICO

Published in the Public Interest by Ophthalmology

VOL. 3, NO. 2 JANUARY 15, 1979

RHODES OF OHIO: "WE CAN TAKE NO RISKS"

Ohio Governor Vetoes Optometric Drug Law

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

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

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

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

He went on to point out that S.B. 163 "would allow optometrists to use drugs in order to make a full diagnosis of the medical condition of the eye. If the individuals involved were properly trained," the Governor said, "this procedure would be in the best interest of Ohio's citizens. However, without proper training, the bill would allow unwarranted risks without corresponding benefits. The drugs involved are dangerous and have the potential of causing a great deal of pain including blindness. The adverse reactions associated with these drugs are not common, but they do occur and emergency treatment must be administered in those instances."

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

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

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

Continued on page 2

HONORABLE JAMES A. RHODES
. . . acts to protect Ohioans

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

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

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

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

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

ARKANSAS

Hon. David Pryor
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WEST VIRGINIA

Hon. Arch Moore
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WHY "THE PEN?"

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

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DR. ALLEN'S

DIAGNOSES

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

1979 — All Eyes On West Virginia

Prohibition — often referred to as "the noble experiment" — was repealed by government because it failed.

In the eyes of those West Virginia lawmakers who, in 1976, truly believed that to permit the use of drugs to optometrists would bring eye health care to more West Virginians, the optometric drug use law was a "noble experiment."

In the single remaining eye of Mrs. Dent, whose tragic deposition appears on page 3, the "noble experiment" of 1976 has failed. She is one of many human guinea pigs who have suffered and is among a vanguard of victims who will suffer as optometrists convince themselves that they are capable of diagnosing disease and providing treatment despite the total absence of medical education.

In the eyes of medical experts throughout the nation, the 1976 West Virginia optometric drug use law is a disaster. It is inconceivable that such a law can remain on the books when available evidence in 1978 has prompted lawmakers in 13 states, last year alone, to fail to pass similar, less dangerous optometric diagnostic drug use proposals.

In two more states, these proposals were lobbied through, only to be vetoed by conscientious governors. In the eyes of Governor James A. Rhodes of Ohio (see page 1), to allow Ohio optometrists the use of diagnostic agents "would allow unwarranted risk without corresponding benefits."

In the eyes of Governor John N. Dalton of Virginia, the eye health of Old Dominion residents was threatened by H.B. 205, a diagnostic drug use proposal less ominous than the extant West Virginia law. In his veto message of April 11, 1978, Governor Dalton said: "There is concern of legislative appointment of 'medical' responsibility and authority to non-medical personnel."

In the eyes of optometric leader Dean Henry B. Peters, O.D., of the School of Optometry at the University of Alabama in Birmingham, the reckless 1976 West Virginia law was the result of a "display of legislative machismo" on the part of overambitious optometrists. "The practice of medicine is an inappropriate goal for optometry" the Dean wrote, commenting on passage of the West Virginia law.

Dean Peters further stated, "Not one of our schools is prepared by either faculty resources or availability of clinical experiences to accept this challenge (treatment of eye disease at this time . . .); no such resources exist for 1,000 graduating optometrists this year nor are they in prospect."

In 1976, West Virginia lawmakers were told that modern optometric education made restrictions obsolete. In 1978, the six non-ophthalmic physicians who serve as the medical Advisory Board to the ultra-modern University of Alabama at Birmingham, where optometric education has high standards, took a close look at their curriculum. In their eyes, their own graduates, receiving the O.D. degree, are not qualified to treat disease or use drugs. Its October 18, 1978 resolution (confirming Dean Peters' conclusion about the inadequacy of optometric education) states in part:

"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."

In 1976, optometrists argued that the new law would make eye care more available to rural residents. Rural residents know better than to take a horse to a blacksmith for colic, but unfortunately are unaware of the total absence of medical education in optometry.

In 1976, optometry promoted the conceptual myth of "primary care." We doubt that any thinking lawmaker would want his eye examined for disease by the least qualified. To place the optometrist in a position where he may overlook a fatal tumor is unfair to him as well as his patient, and to allow him to experiment with dangerous drugs will inevitably produce more unfortunate cases.

Mrs. Dent seeks repeal of the 1976 law. A growing Citizen's Committee seeks repeal. Medicine acknowledges its failure to present a coherent case in 1976, when confusion obfuscated the inherent danger to the public.

This is 1979. Since 1976, the motives of optometry to expand into medicine at the expense of the public health, by exploiting state legislatures have become apparent. Scores of legislative sessions have rejected these efforts, and West Virginia has the most dangerous law of all.

A mass of new incontrovertible evidence attesting to the danger of the 1976 law is ready for presentation. In the eyes of the presentors there is confidence that the 1979 West Virginia lawmakers will open their eyes and ears while taking a fresh look at eye health care.

M.D.s make mistakes. So do elected officials. To acknowledge them is statesmanlike.

The eyes of the nation are on West Virginia.

JHA

THE PEN....

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ST. PETERSBURG, FLORIDA

EDITORS

Medical Editors: James H. Allen, M.D., New Orleans, La.; Leonard B. Alexnick, M.D., Tacoma, Wash.
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Misinformation Provided Magazine Readers

American housewives are warned that there is a dangerous paragraph of misinformation which appeared recently in national magazines. The advertisement promoted ignorance regarding the possibility of fatal malignancy in the eyes of children.

The advertisement, sponsored by the American Optometric Association, stated:

"On the other hand, if a child who is 18 months or younger momentarily turns one eye in or out, there is probably no cause for worry. At this stage of growth your child lacks what is referred to as internal organization. He just can't seem to make anything . . . hands, feet, legs . . . work together.

"In any of these cases, your family optometrist can diagnose problems or reassure you that your child is normal."

No cause to worry?

James H. Allen, M.D., former senior surgeon at Tulane University, worries about the complacency which may result from this advertisement reassurance.

"This ad is irresponsible," he said.

Dr. Allen advises, "A child begins to coordinate eye movements in the first six months of life but may occasionally turn one eye in or out up to 12 months of age. However, if there is a constant turning in or out of one eye even before one year of age or if there is intermittent turning in or out of one eye after 6 months to one year of age, the child should have a medical eye examination.

"There are several things that can interfere with the development of coordinated eye movements, the most dangerous thing being a malignant tumor of the retina of the eye — which must be diagnosed early if the child's life is to be saved.

"Other causes, although not likely to be fatal, could destroy much or all vision in one eye if not diagnosed and treated properly as early as possible.

"An optometrist is not trained adequately to diagnose diseases of the eye or disease affecting the body as a whole. Therefore, he cannot reassure parents that their child is normal. There are numerous recorded examples in which an optometrist failed to recognize or diagnose diseases or tumors of the eye with the result that vision was lost or the life of the patient lost." ●

OHIO GOVERNOR VETOES

Continued from page 1

Commenting on Governor Rhodes' veto message, Lawrence L. Young, M.D., President, Ohio Ophthalmological Society said, "All of medicine in Ohio is impressed with the thoroughness of the Governor's investigation which led to the veto of S.B. 163. He has correctly assessed the danger to the public and his message reflects his deep concern for the eye health of the citizens of our state."

To date, four state governors have carefully reviewed the pros and cons of optometric drug legislation and concluded that passage of such a law would endanger the health of their citizens. In each instance these chief executives have exercised the power of their veto to protect their constituents. ●

An Ophthalmologist is an

M.D.

an optometrist is not.

AN OPEN LETTER SEEKS REPEAL

W. Va. Eye Victim Deplores Optometric Care

A West Virginia supermarket cashier, who is blind in her left eye and who has a serious problem with her right eye, has made a public appeal through an open letter for repeal of West Virginia's optometric drug law.

In a signed deposition, Mrs. Laura Dent of South Charleston, WV, states, "If my optometrist had been qualified to diagnose and treat diseases of the eye, maybe this disease would have been caught in time and I could read with my left eye. The people who passed this law (West Virginia law permits optometrists to use drugs for diagnosis and treatment), should stop and think what they have done; apparently some of them have never had serious eye problems or they would have known better than to do such a thing."

Saying, "I am firmly against this law allowing optometrists to prescribe medications and treat diseases of the eye, because they are not qualified," Mrs. Dent emphasized she was not offering an opinion, but was speaking from experience. Mrs. Dent related that in May of 1975 she went to see an optometrist for a general eye examination. At that time, she points out, the optometrist prescribed new glasses and advised that there were no signs of glaucoma or any other diseases of the eye. Within two weeks, Mrs. Dent said, "I was seeing distorted. I phoned my optometrist and asked what could be the problem. I was told to come in and be checked. I went in and was told it was only astigmatism, to wear my glasses all the time, and the problem would be corrected.

"It did not improve, I continued to get worse. I phoned my optometrist back in three weeks and asked just how long it would take to improve, and also asked if my family doctor could help. I was told maybe so. I will phone him; go ahead and see him.

"I went straight to my family doctor; the optometrist did not phone him. My family doctor took one look at my eye and panicked. He said there was this tremendous deterioration in both eyes, he did not know what it was, but there definitely was a problem. He sent me straight to Dr. Rashid's office. Doctors Rashid and Toma (both ophthalmologists) checked my eyes and told me I had histoplasmosis (a disease caused by a parasitic fungus) and said it was presently active in my left eye. Since I had had numerous attacks in both eyes in the past, it was likely I had the disease all my life."

Mrs. Dent further relates that after six months of treatment, the condition did not improve and in September the laser was used to arrest the disease. She says, "It stopped the disease, but it did not save my vision. *Medical editor's footnote: irregular toxis is a chronic disease characterized by the inactive phases the lesions are easily seen. In the inactive phases, treatment is neither effective nor necessary. In the active phases, treatment is available and frequently helpful to retard or eliminate visual loss. Thus, the patient should be observed by a physician with an understanding of the disease process in order to minimize loss of visual function.* I have no central vision in my left eye; I have peripheral vision but I cannot read; I cannot watch TV or do any close work at all with my left eye." In June of 1978 Mrs. Dent suffered a repeat attack in her right eye. This time the laser was used and Mrs. Dent advises she "is in pretty good shape except for the fact that I have a small blind spot."

Noting that the diagnosis made by Doctors Rashid and Toma was confirmed by Dr. Finklestein at the Wilmer Eye Institute in Baltimore, Mrs. for my left eye and it could happen again at any time in the right eye."

Calling on the legislature to take action now, Mrs. Dent writes, "I wish you would reconsider and repeal this law because a lot of innocent people are going to suffer unknowingly and maybe even go blind because they are trusting an unqualified optometrist." ●

FOUNDER SALUTED BY AMA NEWS — PART III

Ochsner: "The Harder I Work, The Luckier I Get!"

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," Conclusion:

Genial, optimistic, Alton Ochsner says that if he had his life to live over again, he would do nothing differently. Nevertheless, what was his greatest disappointment? Huey Long's dictatorship over Charity Hospital, Tulane's only teaching hospital, in Ochsner's early days in New Orleans. A boy wonder, at 31 appointed as Tulane's professor of surgery, Ochsner came south from Wisconsin, where he had been associate professor. "My family didn't arrive for six months, and I literally lived in the hospital. I slaved — and I loved it. I gave it

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

everything I had, developed a good teaching program as I had promised Dean Bass I would. Everything was going along fine." He pauses, shaking his head, "But this was in Huey Long's heyday, and I didn't include Huey in my reckoning — nor a doctor's desire for revenge on me for refusing to appoint him (the doctor) to the hospital staff. He was incompetent." He shrugs. "And later, while I made rounds, a letter was stolen from the pocket of my coat while it was hanging in the doctor's room of the hospital."

The letter was from the Medical College of Virginia inviting Ochsner to be professor of surgery there. As chairman ex officio of Charity Hospital's board and harboring no love for Ochsner's probity, Huey Long presented the purloined letter as evidence of Ochsner's "disloyalty" to the hospital. "Then and there, that Saturday morning, I was kicked out of the hospital. For two years, I couldn't go near our only teaching hospital. I decided that I couldn't stay in Louisiana under those circumstances, that I would take a job at the University of Illinois. But C. Jeff Miller, Tulane's professor of gynecology and my mentor, dissuaded me."

How? "Dr. Miller said, 'You can't leave under fire. You've *got* to stick it out.' 'But, Dr. Jeff,' I protested, 'Look what's happened to me. I've given this place everything I have and see how they've responded.' Dr. Jeff was adamant. He wouldn't let me quit. Because of him, I stayed." The big Ochsner smile creases his remarkably unlined face: "Sticking it out was one of the best things that ever happened to me."

Despite a life he describes as blessed by "Presbyterian luck" (defined by Ochsner as, "If you do the right thing, no matter what happens, it will turn out for the best"), personal tragedy has been no stranger to Alton Ochsner. His first wife's long terminal illness and death was a devastating blow. In the early 1950s, he obtained some of the first Cutter polio vaccine, which he

Continued on page 4

OCHSNER *Continued from page 3*

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

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

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

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

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

1978 American Medical Association©

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)

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THE PEN FORUM

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

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

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

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

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

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

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

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

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

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

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

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

William C. Frayer, M.D.
Philadelphia, Pennsylvania

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

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

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

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

Daniel W. Pieroni, M.D.
Sheffield, Alabama

UNITED STATES PHYSICIANS EDUCATION NETWORK

Statement of Purpose

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

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

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

"M.D. IS THE MAJOR DIFFERENCE"

THE PEN...

PRO BONO PUBLICO

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VOL. 2, NO. 9 MAY 1, 1978

VIRGINIA VETO MESSAGE

Governor John N. Dalton: "There Is Concern"

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

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

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

Honorable John N. Dalton . . .

63rd Governor of Virginia

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

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

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

Eight States Reject Optometric Drug Law Petitions In 1978

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

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

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

WHY "THE PEN?"

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

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DR. ALLEN'S

DIAGNOSES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

JHA

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

Massachusetts Wins Committee Victory

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

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

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

No action in the House has been reported.

BULLETIN AT PRESSTIME

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

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- Government at every level should cooperate with medicine in establishing these health safety standards.

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

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

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

Industry Co-sponsors Portland Eye Exhibit

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

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

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

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

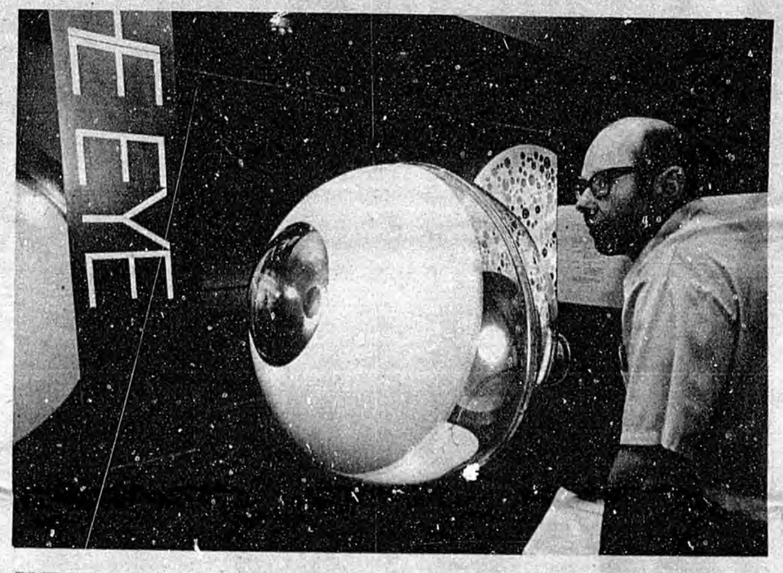
By pushing buttons, the viewer is able to activate functional parts of the exhibit to show how the iris changes its size related to changing levels of light. Supporting exhibits include visual acuity, peripheral vision, color vision, depth perception and even one which shows the viewer the pupil of his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

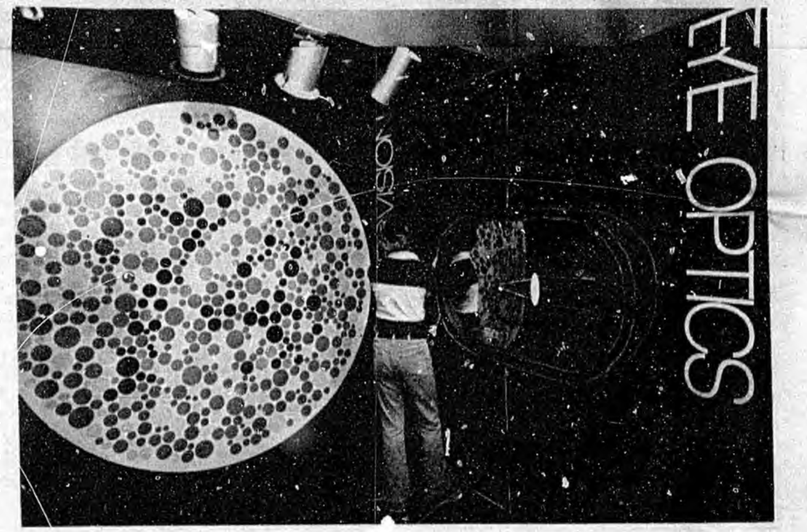
Under Mr. Levy's direction, and in cooperation with expert ophthalmologists, the entire concept, design and construction of the exhibit was completed by the OMSI Exhibits staff.

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

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

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





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

MARYLAND DAILY NEWSPAPER ADVISES READERS

THE SUN

A 14 BALTIMORE, THURSDAY, MARCH 23, 1978

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

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

Optometrists and Drugs

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

Under current Maryland law, optometrists are not allowed to use drugs in their practice. But a bill now in the Maryland Senate would give them that right in certain cases. Optometrists make superficially plausible arguments in favor of the bill, pointing out that, with amendments they support, it would allow them to use only four types of drugs, all ad[illegible] purposes, and that they would be required to take a minimum of 70 hours of training in pharmacology before they could use the drugs. They add that adverse side effects of the drugs are so rare as to be almost non-existent.

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

THE PEN FORUM

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

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

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

Dear Dr. Parker:

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

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

Sincerely,
Gus Yatron

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

Founded as O.P.E.N.

PEN CHARTER MEMBER APPLICATION

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

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

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

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

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

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

Date_____ 1978

Name_____

Address_____

City_____ State_____ Zip_____

Telephone: (Area)_____ Number_____

Ophthalmologist?_____ Other specialty_____

Profession, other than M.D.?_____

Check enclosed ($300)_____ Please bill me_____

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

Visual and Medical

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

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

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

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

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

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

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

Telephone {456-4010
452-3232

Dear Senator Hackney,

The attached bills, House Bill 79 and Senate Bill 75, are in committee and we expect them to be reported to the floor during the upcoming session. They provide for the use of certain diagnostic drugs by optometrists to aid them in detecting eye diseases. The drugs are instilled as eye drops. Optometrists are legally responsible for detecting eye diseases in the course of their examination.

The types of pharmaceutical agents and their uses are described briefly on the second attachment. These are not used routinely with every patient. They are used when needed to adequately examine the eye for pathology.

Doctors of optometry are well qualified to use drugs. The optometric curriculum includes courses in general and ocular pharmacology. These are circled in the attached curriculum of a typical optometry school. Pharmacology is the study of the mechanism of action of a drug, side effects, disposal by the body, etc. Any practitioner who graduated before pharmacology became a part of his school curriculum would be required to complete an appropriate course before being authorized by the licensing authority to use the drugs.

The fourth attachment shows the history of legislation pertaining to pharmaceuticals used by the profession. This is followed by a map showing those states that presently authorize the use of diagnostic pharmaceutical agents (DPAs) by optometrists. States show white, including Alaska, are those in which their use is not yet permitted.

It is in the interest of every member of the public to support this legislation. The professional man should be given all the appropriate tools of his trade. Therefore the Alaska Optometric Association endorses this bill, and we urge that you give it your support as well.

Very truly yours,

Curtis M. Johnson, O.D.

FUNDUS of the Human Eye

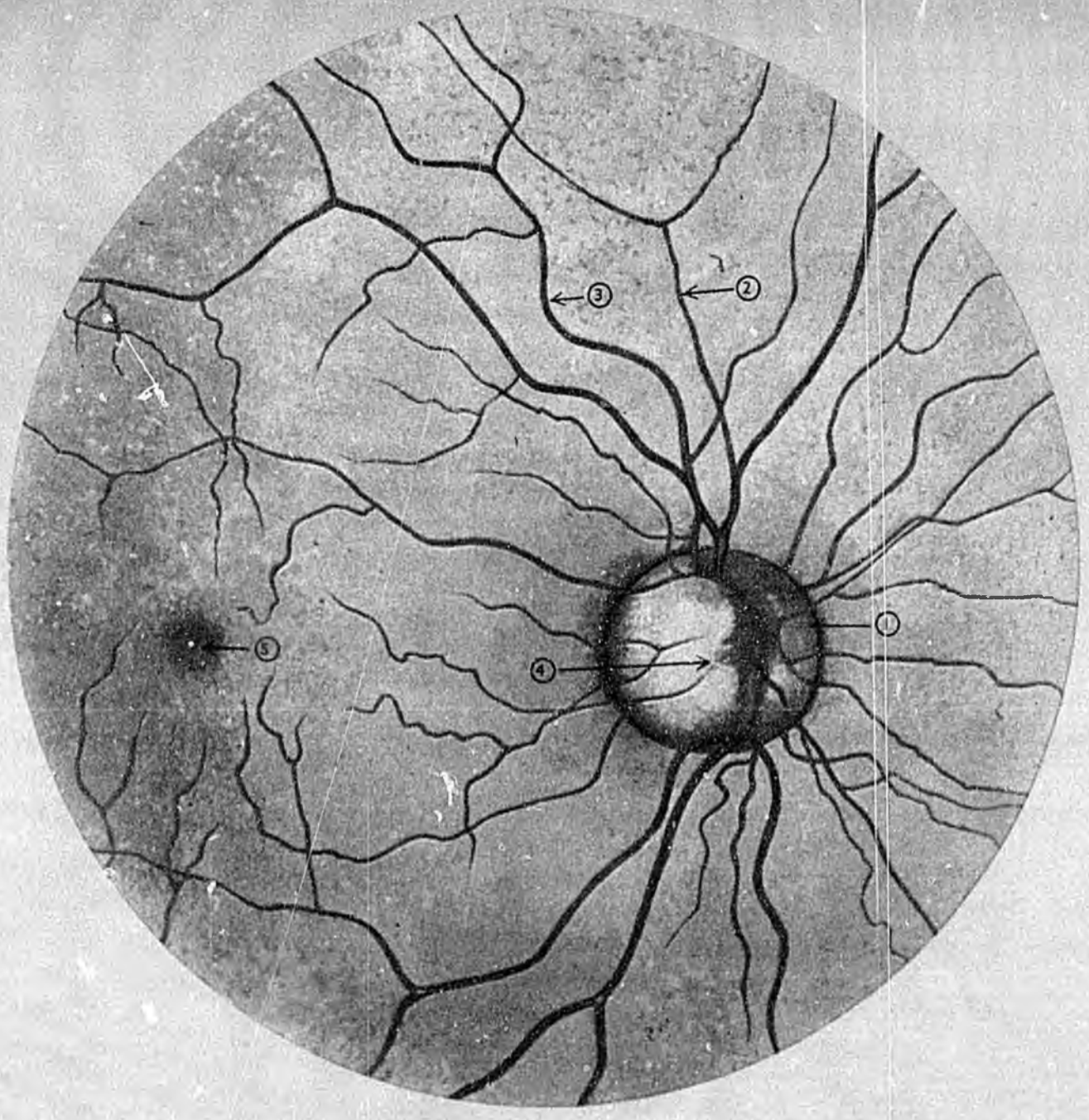
1 OPTIC DISC (NERVE HEAD)
2 ARTERY
3 VEIN
4 PHYSIOLOGICAL CUP
5 MACULA

Examination of the fundus with an ophthalmoscope allows us to see living blood vessels in their natural state.

The disc is examined for clarity of outline, color, shape, elevation above or below surrounding tissues.

Blood vessels are observed for condition, size ratio, tortuosity, regularity of caliber, exudates and hemorrhages.

Study of the fundus may reveal evidence of many systemic diseases as well as eye disease and abnormality.



AMERICAN OPTOMETRIC ASSOCIATION
7000 Chippewa St.
St. Louis, Mo. 63119

G-10 7/69 20L

E. E. BACH, O.D.
PHILLIP W. BACH, O.D., PH.D.
OPTOMETRY
SUITE 204 DENALI PROFESSIONAL CENTER
3401 DENALI STREET
ANCHORAGE, ALASKA 99503

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Very truly yours,

Phillip W Bach

Phillip W. Bach, O.D., Ph.D.

DEFINITIONS

Mydriatics - this type of pharmaceutical agent dilates the pupil to provide an improved view of the retina. This is particularly useful in patients with small pupils or those who have central cataracts (opacifications in the lens of the eye).

Corneal anesthetics - these temporarily remove corneal sensitivity to allow special viewing instruments to be placed in contact with the cornea.

Cycloplegics - used to inactivate the nearpoint focusing mechanism of the eye. This provides a better estimate of the required correcting lens power in certain cases, such as some farsighted individuals.

Miotics - these constrict the pupil and lower the fluid pressure in the eye in the rare cases where the pressure is raised abnormally by the mydriatic.

COURSE DESCRIPTIONS

ANATOMY (ANAT.)
BIOCHEMISTRY (BYC.)
MICROBIOLOGY (MIC.)
OPTOMETRY (OPT.)
PATHOLOGY (PAT.)
PHARMACOLOGY (PHR.)
PHYSIOLOGICAL OPTICS (P.O.)
PHYSIOLOGY AND BIOPHYSICS (PHY.)

PROFESSIONAL CURRICULUM

First Professional Year

FALL QUARTER

P.O. Visual Optics I.—Principles of geometrical optics as it applies to thin and thick lens systems, mirrors and prisms. Introduction to lens aberrations and methods of minimizing their effects. 3 hours lecture, 2 hours laboratory. (Rosenblum)

ANAT. Gross Human Anatomy.—Structure of the human body with special emphasis on anatomy of the head and neck. Anatomy of the orbit and adjacent structures; the cranial nerves associated with vision and their cortical connections. Blood supply to the eye and orbit; embryology of the eye. 4 hours lecture, 12 hours laboratory. (Lin)

OPT. Optometry and Health Care.—Introduction to concepts in health care, and health care professions, the profession of optometry, its history, education and health service. 2 hours lecture. (Eskridge)

P.O. Comparative Neurobiology of Vision.—Considerations of the physiological and anatomical mechanisms underlying behavioral responses to light and an introduction to visual science. 2 hours lecture. (Christensen)

OPT. Epidemiology and Public Health.—Introduction to principles and methods of epidemiology as they relate to visual and systemic health problems.

WINTER QUARTER

P.O. Visual Optics II.—Optics of the eye including refractive errors and retinal image size. Measurement and specification of visual stimuli including radiometry, photometry, and colorimetry. 3 hours lecture, 2 hours laboratory. (Christensen)

ANAT. Neuroanatomy.—Gross and microscopic anatomy of the human central nervous system. 3 hours lecture, 4 hours laboratory. (Lin)

OPT. Clinical Orientation.—Preview of some of the problems encountered in the clinical practice of optometry. Discussion of some of the elementary techniques used in examination of the human visual system along with clinic observation. 2 hours lecture and demonstration. (Eskridge)

HIST. Histology.—Microscopic structure of body tissues and organs as a basis for understanding function and as a background for studying abnormal structure.

Laboratory exercises to develop the student's ability in independent observation of microscopic detail. 3 hours lecture, 6 hours laboratory. (Mayne)

ANAT. Anatomy of the Eye.—Detailed macroscopic, and light and electron microscopic study of the eyeball, optic nerve, and visual pathways. Embryology of the eye. 3 hours lecture, 3 hours laboratory. (Hickey)

SPRING QUARTER

P.O. Visual Optics III.—Principles of physical optics including diffraction, interference, polarization, reflections, scatter, birefringence and holography. 4 hours lecture, 2 hours laboratory. (Rosenblum)

BYC. Introductory Biochemistry.—Introduction to biochemistry with emphasis on visual pigments and other ocular substances. 3 hours lecture. (McKibbin)

PHY. Mammalian Physiology.—Function of the body's major organ systems. Physiology of central, peripheral, and autonomic nervous systems, cardiovascular, respiratory, endocrine, digestive, and reproductive systems. 3 hours lecture, 3 hours laboratory. (Shoemaker and staff)

P.O. Visual Psychophysics and Physiology I.—Psychophysical methods. Absolute sensitivity of the visual system, light and dark adaptation. Visual photochemistry and retinal current generation. Color vision. Spatial and temporal factors in vision. Motion perception. Acuity. 5 hours lecture, 2 hours laboratory. (Greenspon, Christensen)

OPT. Introduction to Clinical Practice.—Continuation of Clinical Orientation I. 1 hour. (Eskridge)

Second Professional Year

FALL QUARTER

OPT. Clinical Examination of the Visual System I.—Procedures used for examination of the human visual system. Detailed use of direct and indirect ophthalmoscope, tonometer, biomicroscope and perimeter. 4 hours lecture, 6 hours laboratory. (Amos and Setzer)

P.O. Eye Movement Mechanisms.—Descriptive aspects of eye movement and their control mechanisms. Physiological and anatomical characteristics of the extraocular muscles and eye movements, accommodation and pupillary responses. 4 hours lecture, 2 hours laboratory. (Christenson and Wilson)

OPT. Ophthalmic Materials I.—History of ophthalmic materials, physical characteristics, lens power, ophthalmic prisms, multifocal lenses, lens specification, inspection, verification. 2 hours lecture, 3 hours laboratory. (Wild, Peters and A. Pierce)

P.O. Visual Psychophysics and Physiology II.—Features detection in the visual nervous system. Visual development and deprivation studies. Electrophysiological measures of vision function. 3 hours lecture and demonstration. (Greenspon and staff)

MIC. Microbiology.—Introduction to bacteriology, virology, and immunology and their application to the ocular system. 5 hours lecture, 2 hours laboratory. (Cassell and staff)

WINTER QUARTER

OPT. Clinical Examination of the Visual System II.—Optical and biological variables determining the refractive state of the eye. Subjective and objective methods of measurement and methods of correcting refractive anomalies; skiametry, keratometry, visual acuity, subjective refraction, amplitude of accomodation. 4 hours lecture, 6 hours laboratory. (Amos and Setzer)

P.O. Normal Binocular Vision.—Characteristics of normal vision with two eyes. Binocular correspondence, disparity detection, stereopsis, and integration of binocular stimulation. 4 hours lecture, 2 hours laboratory. (Staff)

OPT. Ophthalmic Materials II.—Lens aberrations, performance controlled lenses, transmission, reflection, special lenses, physical characteristics of frames, fitting and adjusting. 2 hours lecture, 3 hours laboratory. (Wild, Peters and A. Pierce)

P.O. Vegetative Physiology of the Eye.—Physiology of tears, cornea, intraocular fluids and lens. Intraocular pressure and mechanisms for its control. 4 hours lecture, 5 four hour laboratories. (Wilson)

SPRING QUARTER

OPT. Clinical Examination of the Visual System III.—Clinical examination and evaluation of oculomotor systems, binocular functions, and color vision. 4 hours lecture, 6 hours laboratory. (Amos and Setzer)

OPT. Diagnosis and Treatment of Anomalies of Binocular Vision I.—Diagnosis and treatment of amblyopia, strabismus, suppression, anomalous correspondence. 4 hours lecture, 2 hours laboratory. (Staff)

OPT. Ophthalmic Materials III.—Optics of eikonic lenses, low vision aids, contact lenses. Design, fabrication, verification, and modification of contact lenses. 2 hours lecture, 3 hours laboratory. (Norden and A. Pierce)

P.O. Visual Perception.—Perception as a constructive act. Attention. Role of vision in perception. Perceptual plasticity and adaptation. 4 hours lecture, 2 hours laboratory. (Greenspon)

OPT. Applied Behavioral Science.—Interpersonal relationships and communication, patient, professional and community. 2 hours lecture. (Wechsler)

Third Professional Year

SUMMER QUARTER

OPT. Clinical Practice of Optometry I.—Examination, diagnosis, treatment, and follow-up care for selected clinic patients. 16 hours clinic. (Optometry faculty)

OPT. Clinical Colloquia.—Consideration of special testing and diagnostic techniques used in optometric practice case reports. 2 hours seminar. (Eskridge)

FALL QUARTER

OPT. Clinical Practice of Optometry II.—Theory and practice of optometric clinical care of patients: prescribing of optical aids and ophthalmic dispensing. 8 hours clinic. (Optometry faculty)

OPT. Clinical Ocular Disease I.—Consideration of the symptomology and signs of ocular disease and ocular manifestations of systemic disease. 2 hours lecture. (Keller)

OPT. Diagnosis and Treatment of Anomalies of Binocular Vision II.—Diagnosis and treatment of oculomotor problems. 3 hours lecture, 2 hours laboratory. (Mohindra and Sawyer)

OPT. Advanced Clinical Topics I.—2 hours lecture, 2 hours laboratory. (Alexander and Norden)

PAT. Systemic Pathology.—General pathologic processes and diseases of the major organ systems. 4 hours lecture, 4 hours laboratory. (Hartley)

OPT. Pediatric Optometry.—Pediatric epidemiology. Considerations of examination, diagnosis, and treatment of vision problems of children. 2 hours lecture. (Mohindra)

WINTER QUARTER

OPT. Clinical Practice of Optometry III.—Continuation of Clinical Practice of Optometry II. 8 hours clinic. (Optometry faculty)

OPT. Clinical Ocular Disease II.—Continuation of Clinical Ocular Disease I with emphasis on the systematic study and classification of ocular diseases, and their ophthalmological management. 2 hours lecture. (Keller)

OPT. Clinical Medicine for Optometrists.—Signs and symptoms of systemic diseases especially related to the eye and vision. 4 hours lecture and hospital rounds. (Schnaper and staff)

OPT. Advanced Clinical Topics II.—2 hours lecture, 2 hours laboratory. (Alexander and Norden)

OPT. Contact Lenses I.—Historical development, physical and optical properties of contact lenses and their adaptation to the human eye, with emphasis on anatomical and physiological implications. 3 hours lecture, 4 hours laboratory. (Leach and Wechsler)

OPT. Developmental Aspects of Visual Performance.—Evaluation and care of patients with visual performance problems. Role of developmental and learning disorders in such problems. 2 hours lecture and 5 two hour laboratories. (J. Pierce and Schuller)

OPT. Aniseikonia.—Theory, diagnostic techniques and treatment of aniseikonic patients. Emphasis on use of eikonic lenses. 1 hour lecture, 3 two hour laboratories. (Eskridge)

SPRING QUARTER

OPT. Clinical Practice of Optometry IV.—Continuation of Clinical Practice of Optometry III. 8 hours clinic. (Optometry faculty)

OPT. Clinical Ocular Disease III.—Continuation of Ocular Disease II.—2 hours lecture. (Keller)

OPT. Low Vision.—Examination and care of partially sighted patients. 2 hours lecture, 2 hours laboratory. (Nowakowski)

OPT. Advanced Clinical Topics III.—2 hours lecture, 2 hours laboratory. (Alexander and Norden)

PHR. Systemic Pharmacology.—Drugs and drug actions. Role of systemic drugs in diagnosis and therapy. Side effects of drug use. 3 hours lecture. (Teague and staff)

OPT. Contact Lenses II.—Continuation of Contact Lenses I. 4 hours lecture, 4 hours laboratory. (Leach and Wechsler)

OPT. Geriatric Optometry.—Geriatric epidemiology. Consideration of examination, diagnosis, and treatment of visual problems of geriatric patients. Special emphasis on management of pre- and post-aphakic, convalescent, and senile patients. 2 hours lecture. (Potter)

Fourth Professional Year

SUMMER QUARTER

OPT. Advanced Clinical Practice of Optometry I.—Optometric examination, diagnosis and treatment of patients in outpatient clinics of the Medical Center on a rotating internship basis. Service performed independently by student clinicians under supervision of the clinic staff. 16 hours clinic. (Optometry faculty)

OPT. Special Clinical Practice I.—Clinical practice in contact lenses, aniseikonia, special optical aids for partially sighted, strabismus diagnosis, vision training and orthoptics, developmental vision. Services performed independently by student clinicians under supervision of the clinic staff. 2 hours lecture, 12 hours clinic. (Optometry faculty)

OPT. Clinical Colloquia I.—2 hours seminar. (Keller)

FALL QUARTER

OPT. Advanced Clinical Practice of Optometry II.—Continuation of rotating internship program in general optometry clinic service. 16 hours clinic. (Optometry faculty)

OPT. Special Clinical Practice II.—Continuation of Special Clinical Practice I. 12 hours. (Optometry faculty)

OPT. Clinical Colloquia II.—Continuation of Clinical Colloquia I. 1 hour seminar. (Eskridge)

OPT. Community Aspects of Optometry I.—Legal development; governmental relationships; licensing procedures; reciprocity; malpractice; state boards, detailed study of the optometric laws of at least one state; representative organizations in optometry; professional ethics and codes of ethics. 1 hour lecture. (Wechsler)

OPT. Ocular Pharmacology I.—Characteristics of drugs producing miosis, mydriasis, cycloplegia, accommodative spasm and anaesthesia of ocular surfaces. Use and side effects of commonly used ophthalmic drugs. 2 hours lecture. (Chang)

OPT. Contact Lenses III.—Continuation of Contact Lenses II. 2 hours lecture. (Leach and Wechsler)

WINTER QUARTER

OPT. Advanced Clinical Practice of Optometry III.—Continuation of rotating internship program in general optometry clinic service. 16 hours clinic. (Optometry faculty)

OPT. Special Clinical Practice III.—Continuation of Special Clinical Practice II. 12 hours clinic. (Optometry faculty)

OPT. Clinical Colloquia III.—Continuation of Clinical Colloquia II. 1 hour seminar. (Eskridge)

OPT. Community Aspects of Optometry II.—Establishment and management of an optometric practice; economics, taxes, insurance, accounting methods, office design, mode of practice, practice administration, and patient relations, professional organizations and societies. 2 hours lecture. (Wechsler)

OPT. Ocular Pharmacology II.—Continuation of Ocular Pharmacology I. 2 hours lecture. (Chang)

SPRING QUARTER

OPT. Advanced Clinical Practice of Optometry IV.—Continuation of rotating internship program in general optometry clinic service. 16 hours clinic. (Optometry faculty)

OPT. Special Clinical Practice IV.—Continuation of Special Clinical Practice III. 12 hours. (Optometry faculty)

OPT. Clinical Colloquia IV.—Continuation of Clinical Colloquia III. 1 hour seminar. (Eskridge)

OPT. Special Topics in Optometry and Visual Science.—Independent or joint study in selected topics of clinical optometry or visual science. 2 hours lecture. (Staff)

OPT. Community Health.—Role of the optometrist in community health care. Local, state, and federal organizations involved in health care. Study of comprehensive health planning and new trends in health care delivery. Hospital organization. 2 hour lecture. (Newcomb)

For nondiscriminatory policies and Title IX information, see page 13.

For information about any program of the School of Optometry, write:

Dean, School of Optometry
The Medical Center
The University of Alabama in Birmingham
University Station
Birmingham, Alabama 35294

UAB Bulletin
Vol. 9, No. 27, November 1976

EDITORS: **Ms. Dariene Jamison**
School of Optometry

Ms. Jerri Beck
UAB Office of Public Affairs

The University of Alabama in Birmingham
University Station
Birmingham, Alabama 35294

Equal Opportunities in Education and Employment

Published seven times in May and September; six times in February, November, and December; five times in January and October; four times in March and July; three times in April, June, and August

The University of Alabama in Birmingham

SCHOOL OF OPTOMETRY

Bulletin

Catalog Issue 1977-78

University Station
Birmingham, Alabama 35294

UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

NAME	DATE OF ENACTMENT
Rhode Island	July 16, 1971
Pennsylvania	March 1, 1974
Tennessee	May 8, 1975
Oregon	May 20, 1975
Maine	June 24, 1975
Louisiana	July 6, 1975
Delaware	July 10, 1975
*West Virginia	March 4, 1976
California	July 9, 1976
Wyoming	February 17, 1977
New Mexico	March 4, 1977
Montana	April 12, 1977 (at 10:10 a.m.)
Kansas	April 12, 1977 (at 2:00 p.m.)
*North Carolina	June 3, 1977
Kentucky	March 29, 1978
Wisconsin	April 29, 1978
Nebraska	February 13, 1979
South Dakota	March 15, 1979
Utah	March 21, 1979
North Dakota	March 22, 1979
Arkansas	April 2, 1979
Nevada	May 25, 1979
Iowa	June 8, 1979

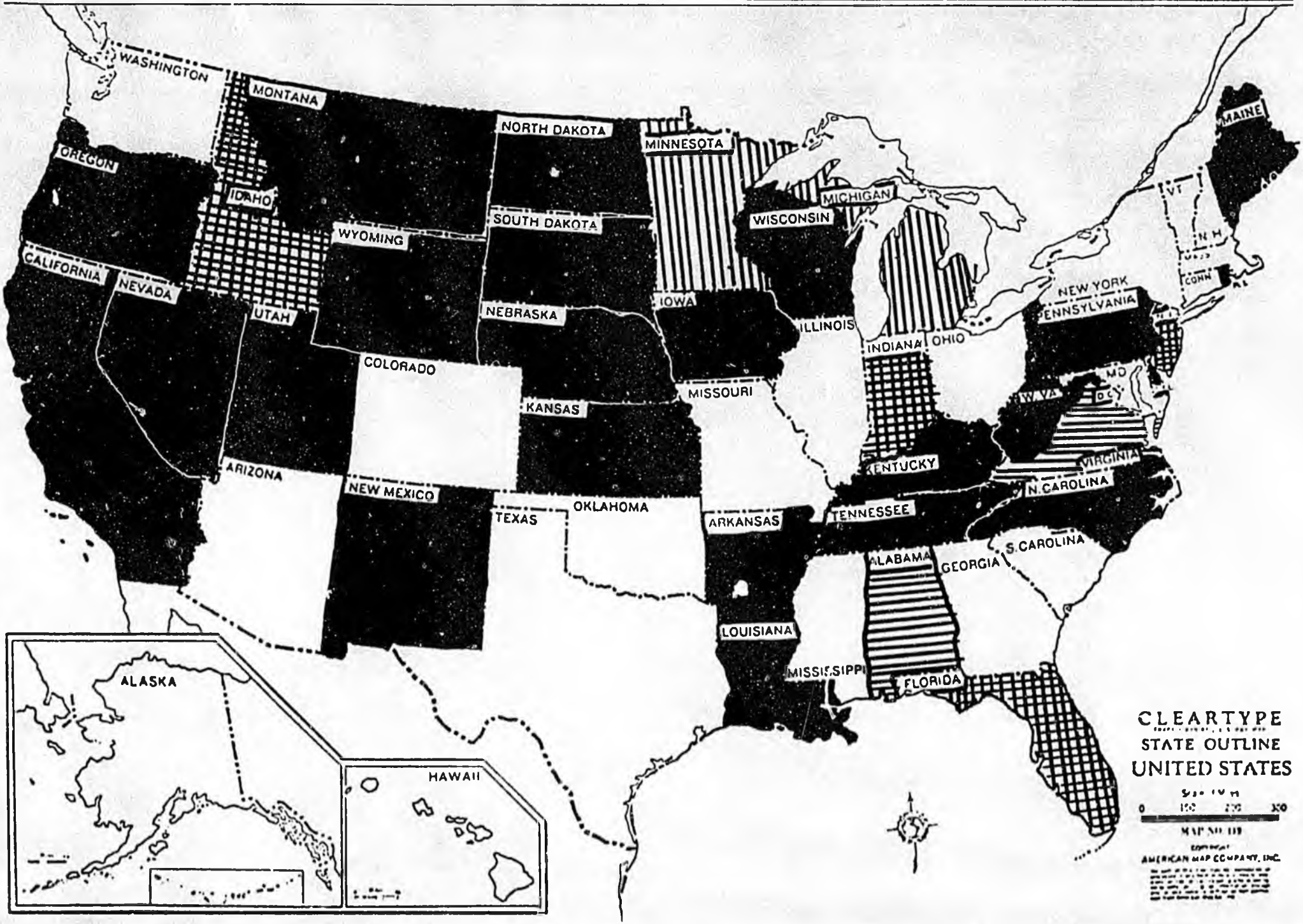
*both diagnostic and therapeutic

[In addition, there are eight (8) other states that do not statutorily prohibit the use of DPAs by optometrists; several of these states have attorney general opinions (+favorable) (-unfavorable) on this point: Alabama (AG-), Florida (AG+) Idaho (State Board Statement +), Indiana (AG+), Michigan, Minnesota, New Jersey (AG+), Virginia (AG-).]

For your information we are including an updated map showing geographically the utilization of pharmaceutical agents by optometrists as of June 8, 1979.

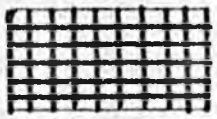
UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

JUNE 8, 1979

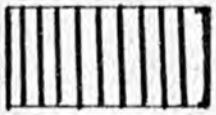


UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

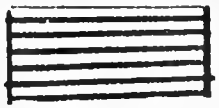
Authorized by Optometrists by Statute



Permitted by Opinion of Attorney General or State Board Statement



No Statutory Prohibition



No Statutory Prohibition but Negative A.G. Opinion

SRA 378-C
Anchorage, Alaska 99507
March 11, 1979

Senator Glenn Hackney:

As a taxpayer and voter in the state of Alaska, and as an ophthalmologist, I feel I should express an opinion concerning House Bill No. 79 (Senate Bill No. 75). I wish to point out that I am not in a private practice, and I will derive no financial benefit from the outcome of this bill.

First, both in its derivation as a word and its meaning from any dictionary, optometry has always referred to the measurement of the visual function of the eye so as to prescribe corrective lenses. The diagnosis and treatment of eye disease has always been in the realm of ophthalmology. In this framework, I know of no eye medications that are necessary for the practice of optometry. Certainly "diagnostic drugs" has nothing to do with optometry, and would serve as a seemingly clever (but dishonest) disguise to further confuse an already confused public concerning who's who in eye care. If the optometrists argue that certain drugs are necessary to their practice, then one might wonder how they have been able to practice their specialty all these years without them.

I am a bit chagrined to see such petty bickering at a professional level over one's image and income take up legislative time. I hope you realize that at the core of this dispute is what constitutes the practice of medicine, and this is not just a quarrel among eye care professionals. Improvement of vision through corrective lenses is a satisfying accomplishment for so many patients. I do not understand why optometrists are unhappy with their present situation. For those who want to involve themselves with eye disease, a medical school education and ophthalmology training is always available as proper prerequisites. I have met two optometrist-ophthalmologists and know of several others, so this educational path is in fact available. Please give careful thought to the average Alaskan who you represent and the need for such a bill. I think you will agree that when special interests are set aside, you all should be spending your time on more important legislation.

Sincerely,

James E Cox

James E. Cox, M.D.

February 14, 1979

Senator Hackney,
Thanks for your help last year.
Bill

Senator Glenn Hackney
Chairman, Senate HESS Committee
Pouch V
Mail Stop Number 3100
Juneau, Alaska 99811

Dear Senator Hackney:

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

1. Optometrists are not physicians. No optometrist in Alaska has had any instruction in pharmacology or drug side effects from anyone with a Ph.D. or masters degree in pharmacology, no optometrist in Alaska has ever had any instruction in anything from a full-time M.D. on any optometric school staff, and no optometrist in Alaska has ever had any formal classroom or clinical training by an ophthalmologist (a physician with specialty training in eye disease and management).

2. Legislation, as presented, would let the Optometric Board evaluate the qualifications for drug use by optometrists. The Legislative Audit Performance Review of 11-1-78, noted:

   a. The state licensing examiner was asked not to attend the last examination given by the Optometric Board.

   b. The Audit Committee also found evidence of examination results being changed, regrading of examinations, and deletion of examination questions.

   c. The Audit Review was unable to find recent oral, written, or practical exam questions and answers.

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

3. The trend across the country is to defeat this sort of legislation. In 1977, this type of legislation was defeated in 17 states and passed in four; in 1978, it was defeated in 15 states and passed in two; and already in 1979, it has been defeated in one state and passed in none. This legislation is not beneficial to the public welfare, further confuses the consumer as to who he is entrusting the care of his eyes, and endangers the public at the hands of nonphysicians.

4. "Diagnostic drops" is a misnomer. The drugs don't diagnose - people diagnose. Dilating the eye is not a prerequisite to making a diagnosis of eye disease, dilating the eye is not a prerequisite to supplying children with the proper correction for glasses, and anesthetic drops are not a prerequisite for the diagnosis of glaucoma.

5. Optometrists (non-M.D.s) have no training in the management of side effects of these medications; e.g., myocardial infarction (there were seven cases of documented heart attacks due to these drugs in the United States in the past 12 months) or narrow angle glaucoma caused from dilating the eyes (there's an extremely high incidence of this condition in Alaskan natives).

6. Optometrists are not trained in the detection of pathology. An optometrist, currently a member of the Alaska Optometric Board, caused an eye to be lost in a four year old child because of his inability to recognize disease and refer the child in a timely fashion. Please find enclosed an issue of PEN newsletter which, in detail, describes Judge James Fitzgerald's findings in the Fourth Judicial District, U.S. District Court in the State of Alaska in October of 1978.

7. Let me suggest some appropriate amendments to this legislation if you feel it is in the public's best interest:

   a. There should be mandatory referral if the vision cannot be corrected to 20/20 in each eye in an adult or 20/30 in a child under eight years of age (this is a current law in England).

   b. There should be no "miotic drop" inclusions. No one considers miotic drops as a diagnostic drug.

   c. It would be appropriate to ensure the availability of malpractice insurance to optometrists to protect the public.

   d. There should be no grandfather clause.

   e. Any pharmacology or pathology testing should be done by the American Board of Ophthalmology. They are the most experienced group and the logical group to design such an examination.

   f. There should be mandatory referral, as per Dr. Alfred Lemoine who is often cited by optometry as an ophthalmologist in favor of diagnostic drug use by non-M.D. optometrists (see enclosure - 10 points in the history, 33 points in the clinical evaluation).

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

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

Thank you for the time you have taken.

Sincerely,

Sam A. McConkey, M.D.

SAM:ls

SUMMARY

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

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

HISTORY

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

CLINICAL FINDINGS

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

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

Southern California College of Optometry
2001 Associated Road · Fullerton · California 92631 · (714) 870-7226

DR. RICHARD L. HOPPING
President

DISTRIBUTION: Dr. Lemoine
Senator Hackney
Dr. Thomas
Dr. Moscovice
Dr. Tietz

The enclosed catalogs and material are being sent to you as requested by Dr. Susan Klein. These materials were made available to the Project Advisory Committee at the recent meeting here at SCCO.

Edie Palmer

Edie Palmer
Secretary to Dr. Hopping

The logo of the American Optometric Association signifies, in simplest terms, a commitment to all the elements of a good vision examination and care. Doctors of optometry who are members of the American Optometric Association are concerned with far more than your eyes or fashionable glasses and frames.

In fact, an examination by an optometrist is also a good place to begin guarding your family's total health. Besides diagnosing vision problems and prescribing the lenses to correct them, an optometrist is qualified to detect eye diseases and abnormalities as well as health problems such as diabetes or high blood pressure. To become licensed to practice, today's optometrist must have a minimum of 2 to 3 years undergraduate education plus at least 4 years at a specialized college of optometry.

The doctors of optometry who are members of the American Optometric Association are totally committed to the ideal that every member of your family should receive the best vision care possible. And, for that reason, they want you to know what to look for in a thorough vision examination:

1 On your first visit, you should receive a comprehensive examination. This usually takes anywhere from 30 to 60 minutes.

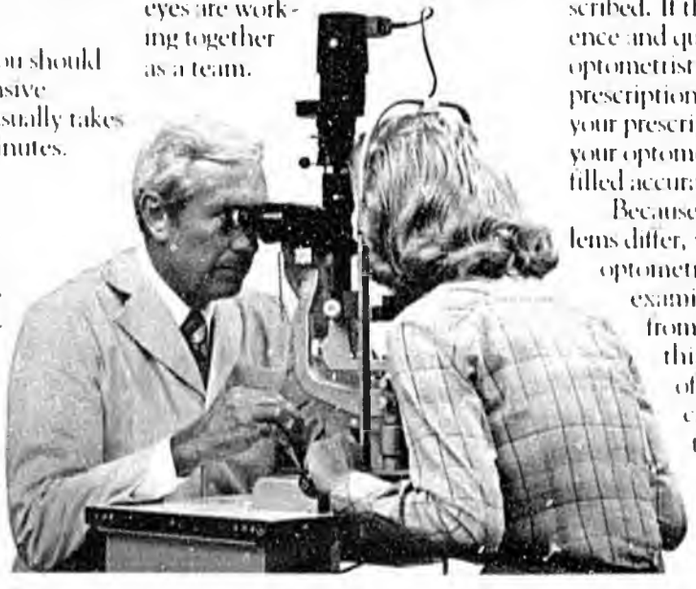
2 Your health history should most likely be taken before the examination begins. Allergies, diseases such as diabetes and ailments such as high blood pressure can affect the results of vision tests. So can certain prescription and non-prescription drugs you may be taking.

3 The exterior of your eyes and the surrounding area should be inspected for eye disease.

4 Then the interior of your eyes should be examined for any signs of systemic or eye diseases. It is here that your optometrist can see blood vessels in their natural state and can therefore detect certain signs or symptoms of diabetes or hypertension. When signs or symptoms are discovered, you'll be referred to your family physician or a specialist if necessary.

5 Your vision should be tested to evaluate how well you see at near and far distances. At the same time, the refractive state of your eyes should be measured to determine nearsightedness, farsightedness, astigmatism or other visual problems.

6 Your eye coordination and eye muscle control should be examined to be certain your eyes are working together as a team.



7 Finally, the ability of your eyes to change focus easily from far to near and near to far should be measured.

Those are the basics. However, if you are over 35 or if a need is indicated, it's likely that you'll be given other special tests such as one for glaucoma. You may also be tested for color perception, depth perception, field of vision, visual/perceptual abilities and other vision skills.

When your optometrist has completed your examination and evaluated all the results, corrective lenses or vision therapy may be prescribed. If that's the case, for convenience and quality assurance, your optometrist can properly fill your prescription. Or, if you decide to take your prescription elsewhere, have your optometrist verify that it was filled accurately.

Because people's needs and problems differ, you may find that your optometrist approaches your examination with variations from this list. However, one thing that you may be sure of: members of the American Optometric Association are dedicated to the principle that you and your family should have the highest quality total vision care possible.

Your Family Doctor of Optometry. The person to see. And keep seeing.

American Optometric Association

There are 7 things to look for in good vision care.

Here's one of the best places to start:

TM Trademark of the American Optometric Association

P. O. Drawer P, Boulder, Colorado 80302 • (303) 492-8666

WICHE
Western Interstate Commission for Higher Education
affirmative action/equal opportunity employer

January 30, 1979

The Honorable Glenn Hackney
State Capitol
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney,

I am sending along the enclosed information, as a result of your conversation with Phil. These materials were distributed at the Optometry Education Project Advisory Committee meeting in Fullerton on January 27, and Phil felt you should see this in light of your pending business.

Minutes of the meeting and related information will follow shortly.

Cordially,

Linda Dunham

Linda Dunham
Secretary

Please file with 3375

A REPORT TO THE PRESIDENT & CONGRESS

ON THE STATUS OF HEALTH PROFESSIONS PERSONNEL

IN THE UNITED STATES

August 1978

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Health Resources Administration
Bureau of Health Manpower
Manpower Analysis Branch

DHEW Publication No. (HRA) 78-93

VI. OPTOMETRY

Optometrists represent only a small proportion of all health practitioners, but they play a significant role in providing health services, mainly as the point of entry to the health care system for the provision of vision care services. Optometrists examine eyes for vision defects and other abnormal conditions, test depth and color perception, and when necessary prescribe lenses and treatment. As providers of primary health care, optometrists may refer patients for treatment of ocular and systemic diseases to ophthalmologists. Conversely, some of the vision services usually provided by optometrists may also be rendered by ophthalmologists.

From all indications, there appears to be a shortage of optometrists and other vision care practitioners in the United States. The number of optometrists has grown only slightly in recent years, and less growth is anticipated than in other health professions. Since a large number of optometrists graduated through the G.I. Bill and will likely be retiring in the next 10 to 15 years, the expected net addition of new practitioners in the field will have a somewhat smaller impact on total supply than in other health disciplines. However, by 1990 supply and requirements should be more or less in balance.

A number of issues and trends relate directly to the optometrist's role in the health care system and the provision of vision care services. A factor likely to affect the practice of optometry and provision of services is the increase in continuing education requirements as a pre-requisite to licensure renewal. Optometrists are increasingly being included in various health care programs, which should affect the overall provision of vision care and the requirements for their services. In organized health delivery settings more attention is being paid to quality assessment of vision care. Judgments about quality of care and practitioner proficiency are normally difficult, but optometry normally deals with readily visualized or measurable conditions and is more amenable to the comparision of practice to standards than are most health professions. Peer review may be used to measure and assure the quality of medical and optometric practice, but the role of optometrists in the review responsibilities of Professional Standards Review Organization has yet to be determined. Among other changes that will affect the profession is the increasingly widespread use of auxiliaries which will have an impact on provision of services and on the requirements for practitioners. New technological developments may also change the scope of practice.

A major issue that has surrounded optometry for many years, of course, is the relationship between optometry and ophthalmology. While some overlap in services, specifically refractive services, exists at present, there are specific unique roles in the provision of vision

care for both professions. Future interactions between the professions will impact on the provision of vision care services, on requirements for these services, and on training and education for both professions. These and other issues are important and developments must be monitored in order to evaluate the role of optometrists in the provision of vision care services.

Number and Characteristics of Optometrists

The number of active optometrists has increased only slightly in recent years, despite the impetus provided by recent Federal legislation. The number of new optometrists has only slightly exceeded the number of optometrists leaving the profession. In 1975, it is estimated that there were 19,900 active optometrists (civilian and military). Of these, approximately 19,200 were providing some form of patient care.

On the basis of limited historical data, the number of active civilian optometrists has increased only moderately in recent years, and has not kept up with population growth. Such increases in supply as have occurred are due to the rise in graduates from schools supported under the Health Professions Educational Assistance Act of 1963.

In view of the overall increase in the number of active civilian optometrists, the ratio of active optometrists to population has declined slightly, from 9.3 active civilian optometrists per 100,000 population in 1968 to 9.2 per 100,000 in 1973.

The effects of the G.I. Bill of the 1950's and the sudden increase in numbers of optometrists completing their education can still be seen today. One half of all optometrists are between 45 and 60 years of age. (Table A-VI-I) On the other hand, recent increases in supply are becoming increasingly evident, as nearly 20 percent of active optometrists are under age 35, and optometry is expected to become an increasingly younger group.

Relatively few women are in optometry, with the proportion of active female optometrists only slightly more than 2 percent. However, the population of females in schools of optometry now exceeds 10 percent, and the proportion of women is expected to rise somewhat in the coming years.

Overall numbers of minorities in optometry are also quite small, although the field appears to be unusually attractive for those of Japanese/Chinese descent (Table A-VI-2). Although only 480 active optometrists (2.5 percent of the total) in 1973 were members of racial/ethnic minority groups, fully three-fifths of this total were Japanese/Chinese. Intensive recruiting efforts have served recently to increase the number and proportion of minorities in the field.